PARNO
FAMILY CHIROPRACTIC

Adult Intake Form

Last name: _____ First name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Sex: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____ Work #: _____

Email: _____ Marital Status: _____

Name of Spouse: _____ Name(s) of Children: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Have you ever received chiropractic care? ☐ Yes ☐ No With whom? _____

How long since your last chiropractic visit? ☐ Days ☐ Weeks ☐ Months ☐ Years

Current Condition

Current Symptoms: _____

Are your symptoms the result of a recent car accident or worker compensation injury? ☐ Yes ☐ No

How long have you had symptoms? _____ Cause of your symptoms? _____

Other doctors seen for this condition? _____ Treatments? _____

Have you had similar symptoms before? ☐ Yes ☐ No If yes, explain: _____

Have any of your relatives experienced similar symptoms? _____

What activities aggravate your symptoms? _____

What activities lessen your symptoms? _____

Are your symptoms worse during certain times of the day? ☐ Yes ☐ No If yes, when? _____

Do your symptoms interfere with your daily activities? ☐ Yes ☐ No If yes, how? _____

Rate the intensity of your pain/symptoms (0=none, 10=severe)

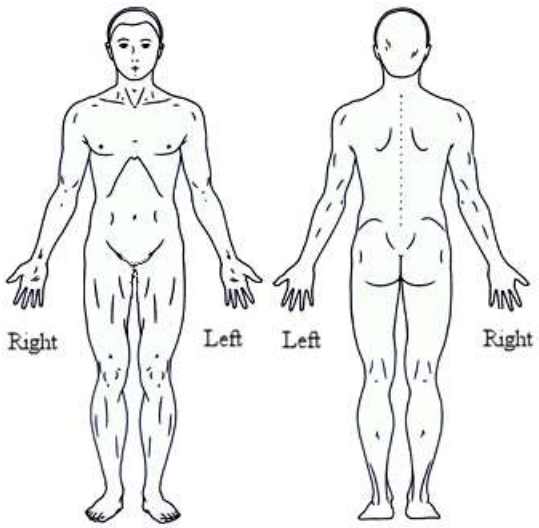
At their worst: 0 1 2 3 4 5 6 7 8 9 10
At their best: 0 1 2 3 4 5 6 7 8 9 10
Currently: 0 1 2 3 4 5 6 7 8 9 10

Are your symptoms getting progressively worse? ☐ Yes ☐ No

Choose the description below that best describes your symptoms:
☐ Numb ☐ Achy ☐ Burning ☐ Sharp ☐ Throbbing
☐ Other: _____

How frequently do you experience your symptoms?
☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Please circle the area(s) of your symptom(s) on the picture →



Have you been treated for any health conditions in the last year? ☐ Yes ☐ No
If yes, explain: _____

List any medications you are currently taking: _____

List any supplements you are currently taking: _____

Height: _____ feet _____ inches Weight: _____ pounds

Do you currently experience:

Unexplained weight loss/gain? ☐ Yes ☐ No explain_____
Pain that wakes you up at night? ☐ Yes ☐ No explain_____
Problems with bowel/bladder function? ☐ Yes ☐ No explain_____

Have you ever:

Broken Bones? ☐ Yes ☐ No explain_____
Been Hospitalized? ☐ Yes ☐ No explain_____
Been in an Auto Accident? ☐ Yes ☐ No explain_____
Been Struck Unconscious? ☐ Yes ☐ No explain_____
Had Surgery? ☐ Yes ☐ No explain_____

Social History (check all that apply):

Alcohol	☐ never	☐ occasionally	☐ often
Caffeine	☐ never	☐ occasionally	☐ often
Tobacco	☐ never	☐ occasionally	☐ often
Exercise	☐ never	☐ occasionally	☐ often
Stress	☐ never	☐ occasionally	☐ often
Processed Foods	☐ never	☐ occasionally	☐ often

Family History (check all that apply):

Arthritis	☐ grandparent	☐ parent	☐ sibling
Cancer	☐ grandparent	☐ parent	☐ sibling
Diabetes	☐ grandparent	☐ parent	☐ sibling
Heart Disease	☐ grandparent	☐ parent	☐ sibling
Hypertension	☐ grandparent	☐ parent	☐ sibling
Stroke	☐ grandparent	☐ parent	☐ sibling

Health History: Please mark "C" for current and "P" for past for all that apply

____ Aids/HIV
____ Alcoholism
____ Allergies: _____
____ Anemia
____ Anxiety
____ Arthritis: _____
____ Asthma
____ Autoimmune Disease
____ Bladder Infections
____ Bleeding Disorders
____ Cancer
____ Circulation Problems
____ Cholesterol: High/Low
____ Constipation
____ Depression
____ Diabetes: Type I / Type II
____ Diarrhea
____ Dizziness
____ Epilepsy
____ Excessive Thirst
____ Fainting
____ Fatigue
____ Fever
____ Gallbladder Problems
____ Headaches
____ Heartburn
____ Heart Disease
____ Hernia
____ Herniated Disc: _____
____ Hypertension
____ Hypotension
____ Joint Pain
____ Kidney Disease
____ Liver Disease
____ Nausea
____ Night Sweats
____ Numbness: _____
____ Obesity
____ Osteoporosis
____ Pacemaker
____ Pinched Nerve
____ Pneumonia
____ Ringing in Ears
____ Scoliosis
____ Skin Problems: _____
____ Sleep Disorder
____ Shortness of Breath
____ Stroke
____ Swelling of Feet/Ankles
____ Thyroid Disease
____ Urinary Problems
____ Vision Problems
____ Vomiting
____ Other: _____

Females Only:

____ Irregular Cycle
____ Excessive Flow
____ Painful Periods
____ Hormone Replacement
____ Breast Pain
____ Birth Control

Are you currently pregnant? ☐ Yes ☐ No

For Pregnant Females:

Is this your first pregnancy? ☐ Yes ☐ No How many births have you had? _____

How many weeks pregnant are you currently? _____ Estimated due date? _____

Are there any specific health concerns in this pregnancy? ☐ Yes ☐ No If yes, explain: _____

_____

Who is your birth care provider? _____ ☐ OB/GYN ☐ Family Doctor ☐ Midwife ☐ Other

Are you planning on having a doula attend your birth? ☐ Yes ☐ No ☐ Unknown If yes, who? _____

Where do you plan on delivering? _____

Previous Birth History (if applicable):

Have you had a cesarean section? ☐ Yes ☐ No

Did you experience back pain during your previous labor(s)? ☐ Yes ☐ No

Were any of your previous deliveries assisted with interventions such as forceps or vacuum? ☐ Yes ☐ No

Have you ever received an epidural? ☐ Yes ☐ No Have any of your labors been induced? ☐ Yes ☐ No

Have any of your pregnancies presented with abnormal fetal positioning (transverse, breech, etc.)? ☐ Yes ☐ No

Did you receive chiropractic care during your prior pregnancy(ies)? ☐ Yes ☐ No If yes, where? _____

Cancellation Policy

Our commitment to excellence in patient care requires that we receive **24 hour notice** to cancel your appointment. Failure to give adequate cancellation notice will result in a $25 missed appointment charge.

_____ **(Please Initial)** I have read and understand the cancellation policy.

HIPAA Policy

I have received or been given the opportunity to review the Notice of Privacy Practices for Parno Family Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the Notice of Privacy Practices.

_____ **(Please Initial)** I have read and understand the HIPAA policy.

I hereby certify that the statements and answers given on this form are accurate and complete to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.

Signature_____ Print Name_____ Date_____

Thank you for choosing Parno Family Chiropractic. We look forward to helping you achieve your health goals.