# Adult Intake Form

***Patient Information***

Name:________________________________________________________Date:______________________

Age:__________ Date of Birth:______________________Marital Status: ☐S ☐M ☐D ☐W ☐Other

Mailing Address:__________________________________________________________________________

Home Phone:( _____ ) __________________________ Cell Phone:( _____ ) __________________________

Email address:____________________________________________________________________________

Home Phone:( _____ ) __________________________ Cell Phone:( _____ ) __________________________

*In case of an Emergency* – Contact: ________________________________Relationship:_________________

Occupation:______________________________________ Employer:_______________________________

Do you primarily: ☐ Sit ☐ Stand ☐ Drive ☐ Perform repetitive tasks

Names and ages of children:_________________________________________________________________

How did you hear about us?_________________________________________________________________

If you are a female, are you currently pregnant? ☐ No ☐ Yes If yes, how far along:_______________weeks

\# of pregnancies:__________ #of vaginal births:__________ # of cesareans:___________

***Wellness Profile***

Are you seeking chiropractic care for:

☐ Relief Care - Symptom relief of pain or discomfort
☐ Corrective Care - Correcting and stabilizing spinal, joint, postural and nervous system concerns
☐ Wellness Care - Maximizing my body's ability for optimal healing, function and prevention

What is your primary concern today?____________________________________________________________

How long have you been aware of this concern? ________days ________weeks ________months ________years

On a scale from 1-10 (10 being the worst) how does it feel when it is at it's **worst**?________________

On a scale from 1-10 (10 being the worst) how does it feel when it is at it's **best**?________________

Does it travel to other areas of your body? ☐ No ☐ Yes If yes, where:______________________________

How often do you experience this concern? ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Comes and goes ☐ Constantly ☐ Morning ☐ Night

How would you describe the concern? ☐ Dull ☐ Achy ☐ Throbbing ☐ Stabbing ☐ Tight/stiff ☐ Burning ☐ Sharp ☐ Other:___________________________

Is it preventing you from: ☐ Sleeping ☐ Sitting ☐ Standing/Walking ☐ Running ☐ Eating ☐ Breathing ☐ Coughing/Sneezing ☐ Bending ☐ Lifting

What makes it feel **better**?_________________________________________________________________

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What makes it feel **worse**?________________________________________

***Healthcare History***

Have you had previous chiropractic care? ☐ No ☐ Yes

What was the primary reason for consulting previous chiropractic care?

- ☐ Relief Care - Symptom relief of pain or discomfort
- ☐ Corrective Care - Correcting and stabilizing spinal, joint, postural and nervous system concerns
- ☐ Wellness Care - Maximizing your body's ability for optimal healing, function and prevention

Which chiropractors have you worked with?________________________________

Was previous chiropractic care effective? ☐ No ☐ Yes

Have you had any imaging performed in the last year? ☐ No ☐ X-ray ☐ CT ☐ MRI ☐ US ☐ PET Scan

What was imaging performed on and for?________________________________

Were your results within normal ranges? ☐ No ☐ Yes

Have you had any blood work performed in the last year? ☐ No ☐ Yes

Were your test results within normal ranges? ☐ No ☐ Yes

If no, which results were abnormal?________________________________

Are you wearing: ☐ Heel Lifts ☐ Corrective Orthotics

Family Doctor:________________________________________

Other specialists/healthcare professionals you see:________________________________

***Physical Health***

Height:__________ Weight:__________ Blood Type:__________ # of Bowel Movements/day:__________

Are you able to perform physical activities that are important to you? ☐ No ☐ Yes

If no, please explain:________________________________________

On average, how many days do you exercise/week? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

What forms of exercise do you perform?________________________________

On average, how many hours do you sleep/night? ☐ <5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10+

Do you feel refreshed upon waking? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Which position do you sleep in? ☐ Back ☐ Stomach Side: ☐ Left ☐ Right

Number of **hours** spent in the car or commuting/**day**? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10-12 ☐ 13+

# Adult Intake Form

Number of **hours** spent at a desk or sitting/**day**? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10-12 ☐ 13+

Number of **hours** spent on electronic devices/**day**? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10-12 ☐ 13+

Have you ever been hospitalized or had surgery? ☐ No ☐ Yes

If yes, why and when:________________________________________________________________

Have you been diagnosed with any clinical condition or disease? ☐ No ☐ Yes

If yes, what:________________________________________________________________

Have you been in a motor vehicle accident? ☐ No ☐ Yes

If yes, what kind and when:________________________________________________________________

Have you had any non-vehicle accidents or falls? ☐ No ☐ Yes

If yes, please explain:________________________________________________________________

Please check all that apply (**P** = Past / **C** = Current):

| **P / C** | **P / C** | **P / C** | **P / C** |
|---|---|---|---|
| ☐☐Abdominal Pains | ☐☐Excessive Thirst | ☐☐Joint Stiffness | ☐☐Shakiness |
| ☐☐Ankle/Foot Pain | ☐☐Fainting | ☐☐Low Back Pain | ☐☐Sinusitis |
| ☐☐Blurred Vision | ☐☐Fatigue | ☐☐Low Blood Pressure | ☐☐Slow Heart Rate |
| ☐☐Chest Pressure | ☐☐Feel Loss of Control | ☐☐Lump in Throat | ☐☐Sore Muscles |
| ☐☐Clammy Hands | ☐☐Forgetfulness | ☐☐Menstrual Irregularities | ☐☐Sore Throat |
| ☐☐Confusion | ☐☐Frequent Urination | ☐☐Nausea/Vomiting | ☐☐Sweating |
| ☐☐Constipation | ☐☐Headache | ☐☐Persistent Cough | ☐☐Swollen Joints |
| ☐☐Convulsions | ☐☐Hemorrhoids | ☐☐Poor Appetite | ☐☐Teeth Grinding |
| ☐☐Decreased Sex Drive | ☐☐High Blood Pressure | ☐☐Poor Circulation | ☐☐Tingling in Feet |
| ☐☐Dizziness | ☐☐Hip Pain | ☐☐Rapid Heart Rate | ☐☐Tingling in Hands |
| ☐☐Dry Mouth | ☐☐Insomnia | ☐☐Neck Pain | ☐☐Unusual lumps |
| ☐☐Earaches | ☐☐Irritability | ☐☐Paralysis | ☐☐Weak Muscles |

***Mental/Emotional Health***

Rate your current level of **personal stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High ☐ Extreme
Rate your current level of **relationship stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High ☐ Extreme
Rate your current level of **health stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High ☐ Extreme
Rate your current level of **family stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High ☐ Extreme
Rate your current level of **occupational stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High ☐ Extreme

In what ways do you manage your stress?________________________________________________________________

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***Chemical Health***

Were you vaccinated as a child? ☐ No ☐ Yes

Any adverse reactions to vaccines? ☐ No ☐ Yes If yes, what?________________________________

Do you choose to get annual flu shots? ☐ No ☐ Yes

Have you used antibiotics in the last year? ☐ No ☐ Yes If yes, did you use probiotics?_________________

How many cups of water do you drink/day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many cups of coffee/energy drinks do you drink/day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many cups of vegetables do you eat/day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

Do you drink soda? ☐ No ☐ Yes If yes, what kind:_______________________________________________

How many servings of soda do you drink/day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Do you eat wheat products (bread/pasta/crackers/baked goods)? ☐ No ☐ Yes # of servings/day?__________

Do you eat refined sugar? ☐ No ☐ Yes #of servings/day?__________

Do you ingest artificial sweeteners (Splenda, Aspartame, Equal, Nutri-sweet, diet drinks)? ☐ No ☐ Yes

Do you have any food/drink allergies, sensitivities, or intolerances? ☐ No ☐ Yes:_________________________

Do you smoke? ☐ No ☐ Yes ☐ I used to for:__________years

Are you/have you been exposed to second hand smoke? ☐ No ☐ Yes

Do you take Probiotics? ☐ No ☐ Yes

Do you take Vitamin D? ☐ No ☐ Yes

Do you take Omega 3? ☐ No ☐ Yes

Medications: (Please list your current medications, date started, and reason prescribed)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Supplements: (Please list your current supplements, date started, and reason you are taking them)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

# Adult Intake Form

***Family Health***

At our clinic, we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention any health concerns you may have about your:

Children:________________________________________________________________________________

Spouse:________________________________________________________________________________

Mother:________________________________________________________________________________

Father:________________________________________________________________________________

Siblings:________________________________________________________________________________

***Goals & Consent to Evaluation***

What is your primary goal for consulting our clinic?__________________________________________________

I hereby grant permission to Dr. Alyssa to perform a thorough chiropractic evaluation including health history, thermal imaging scan, physical examination, orthopedic/reflex tests, and chiropractic treatment. Any findings will be communicated before consulting to commencement of treatment, if appropriate.

________________________________________________________ ______________________________

Consenting Adult's Signature Date