# Welcome

## Adult Intake and Health History

File#________

### PATIENT INFORMATION

Patient Name ________________________________
Address ________________________________
City __________________ State ______ Zip _________
Cell Phone ________________________________
Home Phone ________________________________
Email ________________________________
Sex **M F** Age _______ Birthdate ________________
Marital Status ________________________________

Employer/School ____________________________
Occupation ________________________________
Spouse's Name ______________________________

IN CASE OF EMERGENCY, CONTACT:
Name __________________ Relationship _________
Contact Number ______________________________

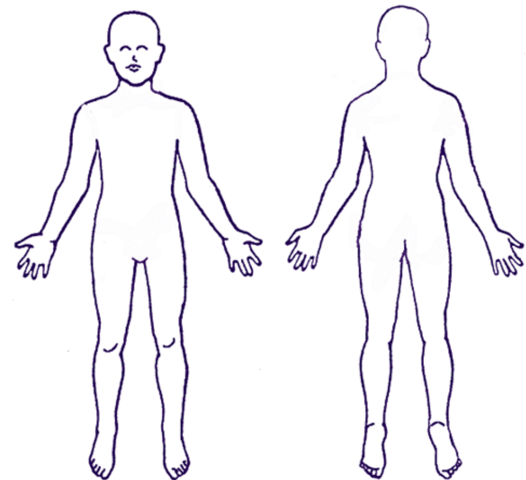
How did you hear about us? ________________________________________________

### HOW CAN WE HELP YOU?

What health concerns bring you in today (if applicable)? ______________________________
________________________________________________________________

How intense are your symptoms? **0 1 2 3 4 5 6 7 8 9 10**
No Symptoms Severe Symptoms

**Please circle areas to the right where you have pain or other symptoms:**



What does it feel like? (check where appropriate)

| | | | |
|---|---|---|---|
| Numbness | Sharp | Tingling | Shooting |
| Stiffness | Burning | Dull | Throbbing |
| Aching | Stabbing | Cramping | Swelling |
| Nagging | Other ______________________ | | |

Have you received care for this problem before? **Yes No**
If yes, please explain: ______________________________

When did the condition(s) first begin?
________________________________________________

How did the problem start? **Suddenly Gradually Post-Injury**
Is this condition: (circle all that apply below)
**Getting worse Improving Intermittent Constant Unsure**
What makes the problem better? ________________________________
What makes the problem worse? ________________________________

File#________

## IMPACT OF YOUR SYMPTOMS

Circle the aspects of your life in which your symptoms interfere:

| | | | | |
|---|---|---|---|---|
| Work | Energy | Exercise | Attitude | Recreation |
| Patience | Relationships | Productivity | Sleep | Creativity |
| Self-Care | Other ____________________________________________________________ | | | |

## ILLNESS HISTORY

Please **CIRCLE** any conditions you have or had:

| | | | |
|---|---|---|---|
| ADD/ADHD | Circulation Issues | Headaches/Migraines | Reproductive Issues |
| **AIDS/HIV** | Childhood Illnesses | Heart Disease | Ringing in Ears |
| Alcoholism | Depression | **Hepatitis** | Scoliosis |
| Anxiety | Diabetes | Hip Issues | Shoulder Issues |
| Arteriosclerosis | Digestive Issues (*Constipation/ Diarrhea/GERD/IBS*) | | Stroke |
| Arthritis | Elbow/Wrist/Hand Issues | Immune Deficiencies | TMJ Issues |
| Asthma | Endocrine Issues (*Thyroid*) | Lymphatic Issues | Urinary Issues |
| Cardiovascular Issues | Foot/Ankle Issues | Multiple Sclerosis | Vertigo/Dizziness |
| Cancer | Gout | Osteoporosis | Other ________________ |

Allergies (please list): ______________________________________________________________________

Do you have any health concerns for other family members? ______________________________________

## CHILDREN AND PREGNANCY

How many children do you have? __________________ Children's ages? ______________________________

Are you currently pregnant? No Yes, I am due _______ Number of past pregnancies? _________________

Children's health concerns? ____________________________________________________________________

## PRIOR CHIROPRACTIC/ACUPUNCTURE HISTORY

Are you currently interested in (circle one or more): **Chiropractic** **Acupuncture**

Have you ever visited a chiropractor? **Yes** **No** (If yes, how long has it been?________________________)

Have you ever had acupuncture? **Yes** **No** (If yes, for what condition?_____________________________)

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## TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries, or other injuries as an adult? **Yes** **No**
If yes, please explain ________________________________________________
Notable childhood injuries:________________________________________________
High School or College Sports? ________________________________________________
Any auto accidents? Yes No If yes, please explain ________________________________________________
________________________________________________
Please list all surgeries: ________________________________________________
________________________________________________

## TOXINS: Chemical and Environmental Exposure

Please rate your CONSUMPTION for each:

| | None | | Moderate | | High |
|---|---|---|---|---|---|
| Alcohol | 1 | 2 | 3 | 4 | 5 |
| Water | 1 | 2 | 3 | 4 | 5 |
| Sugar | 1 | 2 | 3 | 4 | 5 |
| Dairy | 1 | 2 | 3 | 4 | 5 |
| Gluten | 1 | 2 | 3 | 4 | 5 |

| | None | | Moderate | | High |
|---|---|---|---|---|---|
| Processed Foods | 1 | 2 | 3 | 4 | 5 |
| Artificial Sweeteners | 1 | 2 | 3 | 4 | 5 |
| Sugary Drinks | 1 | 2 | 3 | 4 | 5 |
| Cigarettes/Cigars | 1 | 2 | 3 | 4 | 5 |
| Recreational Drugs | 1 | 2 | 3 | 4 | 5 |

Please list any drugs/medications/vitamins/other that you are taking, and why. ________________________
________________________________________________
________________________________________________

## THOUGHTS: Emotional Stresses and Challenges

Please rate your STRESS for each:

| | None | | Moderate | | High |
|---|---|---|---|---|---|
| Home | 1 | 2 | 3 | 4 | 5 |
| Work | 1 | 2 | 3 | 4 | 5 |
| Life | 1 | 2 | 3 | 4 | 5 |

| | None | | Moderate | | High |
|---|---|---|---|---|---|
| Money | 1 | 2 | 3 | 4 | 5 |
| Health | 1 | 2 | 3 | 4 | 5 |
| Family | 1 | 2 | 3 | 4 | 5 |

## WHAT ARE YOUR HEALTH GOALS?

Immediate ________________________________________________
Short Term ________________________________________________
Long Term ________________________________________________

**How committed are you to correcting this issue?** **0 1 2 3 4 5 6 7 8 9 10**
Not Committed ... Very Committed

Patient Name: ________________________________ Date: ____________________