ADULT NEW PATIENT INTAKE FORM

Please complete the ENTIRETY of this form.

Patient Name (First, Middle initial and Last) ____

DOB: ____________ Sex: ☐M ☐F SSN: _____ - _____ - _____

Street Address: ______________________________ City, State, Zip: ______________________________

Cell Phone: ____________________________ Email Address: ____________________________________

Marital Status: ☐ M ☐ S ☐ W ☐ D How did you hear about us? _____________________________

Employment Status: ☐Employed ☐Student Occupation: __________________________________

Emergency Contact Name and Relation: ____

Emergency Contact Phone Number: ________________________________

Current Health Condition:

Chief Complaint (Why are you here today?): ______________________________Date of Onset: _____________

Have you seen any other physician for this condition? If yes, who? _____________________________________

Since onset, has anything helped you? If yes, what? ____

Are you currently taking any prescription medications? Please list. _____________________________________

Are you currently taking any supplements? Please list. ____

Are you currently under Chiropractic Care? ☐ YES ☐ NO If yes, who is your DC? _____________________

Please list any allergies (drug, non-drug, sensitivities, etc.): ____

How would you describe your diet? ☐POOR ☐ADEQUATE ☐GOOD ☐EXCELLENT

Please list any dietary restrictions. ____

How would you describe your sleep quality? ☐POOR ☐ADEQUATE ☐GOOD ☐EXCELLENT

How many hours each night, typically? ______

How much screen time are you exposed to each day? ☐MILD ☐MODERATE ☐EXCESSIVE

How often do you exercise? ☐NEVER ☐QUIT ☐DAILY ☐WEEKLY ☐MONTHLY

How often do you use tobacco? ☐NEVER ☐QUIT ☐DAILY ☐WEEKLY ☐MONTHLY

How often do you drink alcohol? ☐NEVER ☐QUIT ☐DAILY ☐WEEKLY ☐MONTHLY

How often do you use illicit drugs? ☐NEVER ☐QUIT ☐DAILY ☐WEEKLY ☐MONTHLY

How would you describe your daily stress levels? ☐NONE ☐MILD ☐MODERATE ☐EXCESSIVE

Complete Health History:

EYE/VISION- ☐ **NONE**	**BLINDNESS, WEAR GLASSES OR CONTACTS, CATARACTS, ITCHING, GLAUCOMA, TEARING**
NERVOUS SYSTEM- ☐ **NONE**	**DIZZINESS, MEMORY LOSS, LOSS OF CONSCIOUSNESS, NUMBNESS, SLEEP DISTURBANCE, STROKES, WEAKNESS, SEIZURES, HEADACHES, TREMORS**
EAR, NOSE AND THROAT- ☐ **NONE**	**BLEEDING, SNORING, SMELL LOSS, TASTE LOSS, SORE THROAT, SINUS OR EAR INFECTIONS, CONGESTION, TINNITUS, DIFFICULTY SWALLOWING**
CARDIOVASCULAR- ☐ **NONE**	**CHEST PAIN, HEART MURMUR, ORTHOPNEA (DIFFICULTY BREATHING LYING DOWN), SWELLING OF LEGS, ULCERS, VARICOSE VEINS, PALPITATIONS**
RESPIRATION- ☐ **NONE**	**ASTHMA, COUGHING UP BLOOD, COUGH, WHEEZING, SPUTUM PRODUCTION, SHORTNESS OF BREATH**
GASTROINTESTINAL- ☐ **NONE**	**ABDOMINAL PAIN, DIARRHEA, HEARTBURN, JAUNDICE, INDIGESTION, CONSTIPATION, RECTAL BLEEDING, ABNORMAL STOOL, HEMORRHOIDS, VOMITING**
ENDOCRINE- ☐ **NONE**	**COLD OR HEAT INTOLERANCE, EXCESSIVE APPETITE, DIABETES, EXCESSIVE THIRST OR HUNGER, HAIR LOSS, VOICE CHANGES, GOITER**
SKIN- ☐ **NONE**	**CHANGES IN NAIL TEXTURE OR SKIN COLOR, HIVES, ITCHING, RASH, SKIN LESION/ULCER, NUMBNESS, TINGLING, PRICKLING**
PSYCHOLOGICAL- ☐ **NONE**	**ANHODENIA, MOOD CHANGES, MEMORY LOSS, ANXIETY, BIPOLAR DISORDER, CONVULSIONS, CONFUSION, DEPRESSION, INSOMNIA**
ALLERGY- ☐ **NONE**	**ANAPHYLAXIS, ITCHING, FOOD INTOLERANCE, SNEEZING, NASAL CONGESTION**
HEMATOLOGY- ☐ **NONE**	**ANEMIA, BLOOD CLOTTING, BRUISES EASILY, BLEEDING, BLOOD TRANSFUSION(S), FATIGUE, LYMPH NODE SWELLING**
FEMALE- ☐ **NONE**	**BIRTH CONTROL, BREAST LUMP, CRAMPS, VAGINAL DISCHARGE, BURNING URINATION, HORMONE THERAPY, IRREGULAR MENSTRUATION**
MALE- ☐ **NONE**	**BURNING URINATION, ERECTILE DYSFUNCTION, IRREGULAR URINATION, HESITANCE/DRIBBLING, PROSTATE PROBLEMS**

Please list any previous injuries. ____

Have you ever had any surgeries or procedures? Please list. ____

For Women: Have you ever been pregnant? If yes, how many times? ___________

Any additional comments: ____

____

____

Please circle all that apply.

Childhood Illnesses: ☐ I deny having had any childhood illness(es) Other: ___________________________________

☐ ADD ☐ADHD ☐Allergies ☐ Anemia ☐ Asthma ☐Bed-wetting

☐Cerebral Palsy ☐Chicken Pox ☐Diabetes ☐Ear Infections ☐Eczema ☐Headaches

☐Measles ☐Mumps

Adult Illnesses: ☐ I deny having any adulthood illness(es) Other: ____

☐ Alzheimer's ☐ Anemia ☐Arthritis ☐ Asthma ☐ Cancer ☐ Crohn's ☐ CRPS

☐ Depression ☐ Diabetes ☐Emphysema ☐ Lung Disease ☐Lupus ☐ M.S. ☐ Kidney Disease

☐ Parkinson's ☐ Pneumonia ☐ Scoliosis ☐Shingles ☐STD/STI ☐Thyroid Issues

Immunizations: ☐ I deny having had any immunizations ☐ Diphtheria, Tetanus and Pertussis ☐ TB

☐Chicken Pox ☐Hepatitis A ☐ Hepatitis B ☐Hepatitis C ☐Influenza ☐ Polio

☐Measles, Mumps & Rubella ☐ Pneumococcal ☐ Small Pox ☐Whooping Cough ☐ COVID-19

Family Health History

FAMILY HISTORY	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER	CHILD
CANCER							
HEART							
DIABETES							
KIDNEY							
AUTOIMMUNE							
HEREDITARY							
PSYCHIATRIC							
OTHER							

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Patient Name: _____________________________ Signature: _____________________________Date: ________

Parent or Guardian: _______________________ Signature: _____________________________ Date: _________