

# ADULT INTAKE FORM- 12 YEARS OF AGE AND OLDER Please complete fully so we can help you best.

## PERSONAL INFORMATION

PERSONAL INFORMATION	Today's Date/
Name:	
Birth date:/ Age:	
Address:	City/State/ZIP:
Home Phone: Business Pl	hone: Cell Phone:
E-mail address:	
Employer:	Occupation:
Marital Status: Single Engaged Marri	ed Divorced Widowed
Spouse's Name: Spouse's	s Occupation:
Names and Ages of Children:	
Whom may we thank for referring you to our office?	
Favorite Hobbies or Interests:	
CHIROPRACTIC AND YOUR HEALTH	
Please select any of the applicable reasons for your purs	uing chiropractic care:
☐ I have a specific health issue, pain, or disability	and am here for resolution of these symptoms.
☐ I am interested in learning about strategies to p	revent problems from recurring.
$\hfill \square$ I am interested in general wellness and natural	health care for me and my family.
$\hfill \square$ I am continuing care from another chiropractor.	
HEALTH CARE PRACTITIONER HISTORY	
Have you ever received Chiropractic care? $\hfill\Box$ $\hfill$ $\hfill$ $\hfill$ $\hfill$ $\hfill$	
If yes, Name of D.C. & Practice:	
How long were you under care?   Days   Days	Weeks □Months □ Years
Date of last visit:/ Why did you stop care	?
Family M.D. Name & Practice:	
If required (after discussion with you) I give Drs. McGove	rn permission contact my physician. □ Yes □ No
FOR WOMEN Are you pregnant?	inant Due Date: / /
If x-rays are recommended, your signature is required (be	
Signature:	Date:/
Where will you be birthing your baby? $\hfill\Box$ Hospital $\hfill\Box$ Hom	e ☐ Birthing Center ☐ Other

#### **CURRENT HEALTH CONDITION**

Describe what brings you into the office today:	N
Have you had any previous treatment for this condition?	
□ Chiropractic □ Massage □ Physiotherapy □ Surgery □ Other	
When did this condition begin?	
What do you believe caused this condition?	
Is this the first time this has occurred? □ Yes □ No	
Circle the severity of your pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (pain as bad as it could be)	
Describe the nature of your pain: (sharp, dull, aching, etc.)	<u>—</u>
Is there anything that aggravates the pain?	
Is there anything that relieves the pain?	
Have you had any recent unexplained weight loss? □ Yes □ No	
Any unexplained fever or night sweats? ☐ Yes ☐ No	
Is this the result of an auto or work injury? If so, when?	
Surgeries you have had:	
Medications you currently take:	
Known Allergies:	

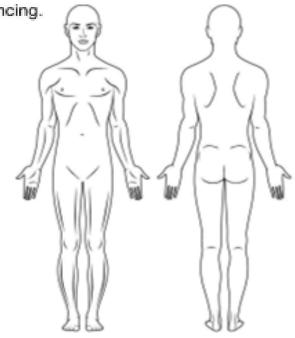
In the diagrams provided, please mark the areas of your body that you feel best

represent the discomfort(s) or sensation(s) you are experiencing.

Have you ever been diagnosed with cancer? \_\_\_\_\_ If so, what kind? \_\_\_\_\_

Use the symbols provided below.

1111 Numbness: Burning:  $X \times X$ Dull and aching: Pins and needles: Sharp and stabbing === Stiff and tight 222



### **CURRENT HEALTH CONDITION CONTINUED**



Below is a list of health issues that may seem unrelated to the purpose of your appointment.

However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

#### CHECK ANY OF THE FOLLOWING HEALTH ISSUES YOU HAVE EVER HAD:

□ Pneumonia	□ Mumps	□ Influenza
☐ Rheumatic Fever	□ Smallpox	□ Pleurisy
□ Polio	☐ Chicken Pox	□ Arthritis
□ Tuberculosis	□ Diabetes	□ Epilepsy
☐ Whooping Cough ☐ Cancer	□ Mental	Disorders
□ Anemia	☐ Heart Disease	☐ Thyroid Imbalance
□ Measles	□ Heart Attack	□ Eczema

#### CHECK ANY OF THE FOLLOWING HEALTH ISSUES YOU HAVE HAD IN THE PAST YEAR:

NERVOUS SYSTEM   Nervousness/anxiety   Poor Appetite   Sinus Infections   Excessive Appetite   Sinus Infections   Earaches   Hearing Difficulty   The following family members have the same or institute   Displayed family members have the same or institute   Displa		·	
Nervousness/anxiety       □ Poor Appetite       □ Vision Problems         □ Irritability/impatience       □ Excessive Appetite       □ Sinus Infections         □ Depression □ Excessive Thirst       □ Excessive Thirst       □ Earaches         □ Attention deficit       □ Excess Weight       □ Hearing Difficulty         □ Stress       □ Significant Weight Loss       □ Tinnitus         □ Dizziness       □ Frequent Nausea       □ Frequent Nausea         □ Forgetfulness       □ Gas or Bloating After Meals       ■ Menstrual Irregularity         □ Confusion       □ Heartburn       □ Menstrual Irregularity         □ Fainting       □ Vomiting       □ Menstrual Cramps         □ Convulsions       □ Diarrhea       □ Vaginal Pain/Infection         □ Contipation       □ Breast Pain/Lumps         □ Abdominal Cramps       □ Prostate Dysfunction         □ Hemorrhoids       □ Infertility Problems         □ Hemorrhoids       □ Infertility Problems         □ Headaches       □ Gall Bladder Problems         □ Diagnosed IBS, Crohn's, Diverticulitis, Colitis         □ Loss of Sleep       □ Black/Bloody Stool     FAMILY HISTORY			
Irritability/impatience			
Depression   Excessive Thirst		1 ''	
Attention deficit	** *	1	
Stress	·		
□ Dizziness       □ Frequent Nausea         □ Forgetfulness       □ Gas or Bloating After Meals         □ Confusion       □ Heartburn         □ Fainting       □ Vomiting         □ Convulsions       □ Diarrhea         □ Cold Extremities       □ Constipation         □ Abdominal Cramps       □ Prostate Dysfunction         □ Hemorrhoids       □ Infertility Problems         □ Hemorrhoids       □ Other:	☐ Attention deficit	1	· · ·
Forgetfulness	□ Stress	☐ Significant Weight Loss	□ Tinnitus
□ Confusion       □ Heartburn       □ Menstrual Irregularity         □ Fainting       □ Vomiting       □ Menstrual Cramps         □ Convulsions       □ Diarrhea       □ Vaginal Pain/Infection         □ Constipation       □ Breast Pain/Lumps         □ Abdominal Cramps       □ Prostate Dysfunction         □ Hemorrhoids       □ Infertility Problems         □ Hemorrhoids       □ Other:	□ Dizziness	□ Frequent Nausea	
□ Fainting □ Vomiting □ Menstrual Cramps □ Vaginal Pain/Infection □ Vaginal Pain/Infection □ Vaginal Pain/Infection □ Vaginal Pain/Infection □ Breast Pain/Lumps □ Abdominal Cramps □ Prostate Dysfunction □ Infertility Problems □ Infertility Problems □ Other: □ Oth	□ Forgetfulness	☐ Gas or Bloating After Meals	MALE/FEMALE
□ Convulsions       □ Diarrhea       □ Vaginal Pain/Infection         □ Cold Extremities       □ Constipation       □ Breast Pain/Lumps         □ Abdominal Cramps       □ Prostate Dysfunction         □ Hemorrhoids       □ Infertility Problems         □ Headaches       □ Gall Bladder Problems       □ Other:	□ Confusion	□ Heartburn	□ Menstrual Irregularity
□ Cold Extremities       □ Constipation       □ Breast Pain/Lumps         □ Abdominal Cramps       □ Prostate Dysfunction         □ Hemorrhoids       □ Infertility Problems         □ Hemorrhoids       □ Other:	□ Fainting	□ Vomiting	☐ Menstrual Cramps
GENERAL  Hemorrhoids Liver Problems Gall Bladder Problems Gall Black/Bloody Stool Allergies  Prostate Dysfunction Infertility Problems Other: Diagnosed IBS, Crohn's, Diverticulitis, Colitis Black/Bloody Stool FAMILY HISTORY	□ Convulsions	□ Diarrhea	☐ Vaginal Pain/Infection
GENERAL    Hemorrhoids	□ Cold Extremities	□ Constipation	☐ Breast Pain/Lumps
□ Hemorrhoids     □ Liver Problems     □ Other:       □ Headaches     □ Gall Bladder Problems     □ Diagnosed IBS, Crohn's, Diverticulitis, Colitis       □ Loss of Sleep     □ Black/Bloody Stool       □ Allergies     FAMILY HISTORY		☐ Abdominal Cramps	☐ Prostate Dysfunction
□ Headaches     □ Gall Bladder Problems       □ Migraines     □ Diagnosed IBS, Crohn's, Diverticulitis, Colitis       □ Loss of Sleep     □ Black/Bloody Stool       □ Allergies     FAMILY HISTORY	GENERAL	□ Hemorrhoids	□ Infertility Problems
□ Headaches     □ Gall Bladder Problems       □ Migraines     □ Diagnosed IBS, Crohn's, Diverticulitis, Colitis       □ Loss of Sleep     □ Black/Bloody Stool       □ Allergies     FAMILY HISTORY	□ Hemorrhoids	□ Liver Problems	□ Other:
□ Loss of Sleep □ Allergies □ Black/Bloody Stool FAMILY HISTORY	□ Headaches	☐ Gall Bladder Problems	
□ Loss of Sleep □ Allergies □ Black/Bloody Stool FAMILY HISTORY	□ Migraines	☐ Diagnosed IBS, Crohn's, Diverticulitis, Colitis	
□ Allergies FAMILY HISTORY	•		
	·	, ,	FAMILY HISTORY
	□ Fatigue	CARDIOVASCULAR/RESPIRATORY	The following family members have the same or
□ Fibromyalgia □ Chest Pain similar problem(s) as I do:	•	· · · · · · · · · · · · · · · · · · ·	
□ Asthma □ Mother	=	□ Asthma	·
GENITO-URINARY	GENITO-URINARY	☐ High Blood Pressure	□ Father
□ Bladder Trouble □ Irregular Heartbeat □ Sister		=	
□ Discolored Urine □ Stroke □ Brother		_	
□ Painful Urination □ High Cholesterol □ Spouse			
□ Excessive Urination □ Child		a riigii cirolesteror	·
Excessive difficulties	Excessive officiation		Ciliu

### STRESS TEST

dy. CHIROPRACTIC

The following areas of stress can cause misaligned vertebrae (subluxation) and dysfunction of your body. CHIROPRACTIC
Which of these stresses have you experienced? Please circle when you experienced these stresses.

Birth Trauma  Slips or Falls  Automobile Accident  Sports Injuries  Physical Abuse  Poor Posture  Work Injuries  Extensive Computer Work  Sleeping on Stomach  Sitting on Wallet  Carrying a Heavy Purse/ Bookbag/ Child  Repetitive Lifting / Bending  Driving for Many Hours  Continuous Hours Sitting/ Standing  Career Stress  Relationship Stress  Concealed Feelings  Quick Tempered  Smoker/ 2 <sup>nd</sup> hand smoke  Amount:  Poor Nutrition Habits  Excessive Sugar Consumption:  Caffeine Consumption  Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?	Physical/ Emotional/ Chemical Stress:	Child	Teen	Adult	Comments
Automobile Accident Sports Injuries Physical Abuse Poor Posture Work Injuries Extensive Computer Work Sleeping on Stomach Sitting on Wallet Carrying a Heavy Purse/ Bookbag/ Child Repetitive Lifting / Bending Driving for Many Hours Continuous Hours Sitting/ Standing  Career Stress Relationship Stress Concealed Feelings Quick Tempered Smoker/ 2nd hand smoke Amount:	Birth Trauma				
Sports Injuries Physical Abuse Poor Posture Work Injuries Extensive Computer Work Sleeping on Stomach Sitting on Wallet Carrying a Heavy Purse/ Bookbag/ Child Repetitive Lifting / Bending Driving for Many Hours Continuous Hours Sitting/ Standing  Career Stress Relationship Stress Concealed Feelings Quick Tempered Smoker/ 2nd hand smoke Amount:  Poor Nutrition Habits - Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  we information is true and accurate to the best of my knowledge.	Slips or Falls				
Physical Abuse Poor Posture Work Injuries Extensive Computer Work Sleeping on Stomach Sitting on Wallet Carrying a Heavy Purse/ Bookbag/ Child Repetitive Lifting / Bending Driving for Many Hours Continuous Hours Sitting/ Standing Career Stress Relationship Stress Concealed Feelings Quick Tempered Smoker/ 2nd hand smoke Amount:  Poor Nutrition Habits - Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  Te information is true and accurate to the best of my knowledge.	Automobile Accident				
Poor Posture  Work Injuries  Extensive Computer Work  Sleeping on Stomach  Sitting on Wallet  Carrying a Heavy Purse/ Bookbag/ Child  Repetitive Lifting / Bending  Driving for Many Hours  Continuous Hours Sitting/ Standing  Career Stress  Relationship Stress  Concealed Feelings  Quick Tempered  Smoker/ 2 <sup>nd</sup> hand smoke  Amount:  Poor Nutrition Habits - Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.	Sports Injuries				
Work Injuries  Extensive Computer Work  Sleeping on Stomach  Sitting on Wallet  Carrying a Heavy Purse/ Bookbag/ Child  Repetitive Lifting / Bending Driving for Many Hours  Continuous Hours Sitting/ Standing  Career Stress  Relationship Stress  Concealed Feelings Quick Tempered Smoker/ 2nd hand smoke Amount:  Poor Nutrition Habits - Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.	Physical Abuse				
Extensive Computer Work  Sleeping on Stomach  Sitting on Wallet  Carrying a Heavy Purse/ Bookbag/ Child  Repetitive Lifting / Bending Driving for Many Hours  Continuous Hours Sitting/ Standing  Career Stress  Relationship Stress  Concealed Feelings Quick Tempered Smoker/ 2nd hand smoke Amount:  Poor Nutrition Habits - Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.	Poor Posture				
Sleeping on Stomach Sitting on Wallet Carrying a Heavy Purse/ Bookbag/ Child Repetitive Lifting / Bending Driving for Many Hours Continuous Hours Sitting/ Standing Career Stress Relationship Stress Concealed Feelings Quick Tempered Smoker/ 2nd hand smoke Amount:  Poor Nutrition Habits - Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.	Work Injuries				
Sitting on Wallet  Carrying a Heavy Purse/ Bookbag/ Child  Repetitive Lifting / Bending Driving for Many Hours  Continuous Hours Sitting/ Standing  Career Stress Relationship Stress Concealed Feelings Quick Tempered Smoker/ 2nd hand smoke Amount:  Poor Nutrition Habits - Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.	Extensive Computer Work				
Carrying a Heavy Purse/ Bookbag/ Child  Repetitive Lifting / Bending Driving for Many Hours  Continuous Hours Sitting/ Standing  Career Stress Relationship Stress  Concealed Feelings Quick Tempered Smoker/ 2nd hand smoke Amount:  Poor Nutrition Habits - Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.	Sleeping on Stomach				
Child  Repetitive Lifting / Bending Driving for Many Hours Continuous Hours Sitting/ Standing  Career Stress Relationship Stress Concealed Feelings Quick Tempered Smoker/ 2nd hand smoke Amount:  Poor Nutrition Habits - Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.	Sitting on Wallet				
Driving for Many Hours  Continuous Hours Sitting/ Standing  Career Stress  Relationship Stress  Concealed Feelings  Quick Tempered  Smoker/ 2nd hand smoke Amount:  Poor Nutrition Habits  - Excessive Sugar Consumption: - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?					
Driving for Many Hours  Continuous Hours Sitting/ Standing  Career Stress  Relationship Stress  Concealed Feelings  Quick Tempered  Smoker/ 2nd hand smoke Amount:  Poor Nutrition Habits  - Excessive Sugar Consumption: - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?	Repetitive Lifting / Bending				
Career Stress  Relationship Stress Concealed Feelings Quick Tempered Smoker/ 2nd hand smoke Amount:  Poor Nutrition Habits - Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.					
Relationship Stress Concealed Feelings Quick Tempered Smoker/ 2 <sup>nd</sup> hand smoke Amount:  Poor Nutrition Habits - Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.	Continuous Hours Sitting/ Standing				
Concealed Feelings Quick Tempered Smoker/ 2 <sup>nd</sup> hand smoke Amount:	Career Stress				
Quick Tempered  Smoker/ 2 <sup>nd</sup> hand smoke Amount:	Relationship Stress				
Smoker/ 2 <sup>nd</sup> hand smoke Amount:  Poor Nutrition Habits  Excessive Sugar Consumption:  Caffeine Consumption  Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  information is true and accurate to the best of my knowledge.	Concealed Feelings				
Amount:  Poor Nutrition Habits - Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.	Quick Tempered				
- Excessive Sugar Consumption: - Caffeine Consumption - Artificial Sweeteners  Over The Counter Drugs  What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.					
Over The Counter Drugs  What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.	- Excessive Sugar Consumption:				
What do you feel are your primary stressors?  e information is true and accurate to the best of my knowledge.					
e information is true and accurate to the best of my knowledge.	Over The Counter Drugs		•		
	What do you feel are your primary stre	essors?			
: Date:/			of my knov	vledge.	
	·				Date:/