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

PERSONAL INFORMATION

Today's Date_____/_____/____

Name:
Birth date: _____/_____/_____ Age:
Address: City/State/ZIP:
Home Phone: Business Phone: Cell Phone:
E-mail address:
Employer: Occupation:
Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Widowed
Spouse's Name: Spouse'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 pursuing 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 prevent problems from recurring.
- ☐ I am interested in general wellness and natural health care for me and my family.
- ☐ I am continuing care from another chiropractor.

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ☐ Y ☐ N

If yes, Name of D.C. & Practice: _____

How long were you under care? ☐ _____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. McGovern permission contact my physician. ☐ Yes ☐ No

FOR WOMEN

Are you pregnant? ☐ Y ☐ N ☐ Possibly If pregnant, Due Date: ____/____/____

If x-rays are recommended, your signature is required (below) to verify that you are not pregnant.

Signature: _____ Date: _____/_____/_____

Where will you be birthing your baby? ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other_____

CURRENT HEALTH CONDITION

Describe what brings you into the office today:_____

_____

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.) _____

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: _____

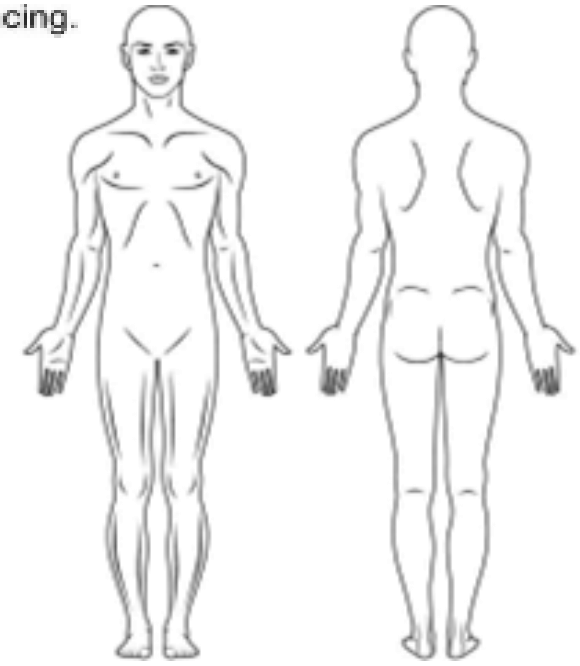
Medications you currently take: _____

Known Allergies: _____

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

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. Use the symbols provided below.

Numbness:	/ / / /
Burning:	x x x
Dull and aching:	+ + +
Pins and needles:	* * *
Sharp and stabbing	= = =
Stiff and tight	2 2 2



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
□ Irritability/impatience
□ Depression □ Excessive Thirst
□ Attention deficit
□ Stress
□ Dizziness
□ Forgetfulness
□ Confusion
□ Fainting
□ Convulsions
□ Cold Extremities

GENERAL
□ Hemorrhoids
□ Headaches
□ Migraines
□ Loss of Sleep
□ Allergies
□ Fatigue
□ Fibromyalgia

GENITO-URINARY
□ Bladder Trouble
□ Discolored Urine
□ Painful Urination
□ Excessive Urination

GASTROINTESTINAL
□ Poor Appetite
□ Excessive Appetite
□ Excessive Thirst
□ Excess Weight
□ Significant Weight Loss
□ Frequent Nausea
□ Gas or Bloating After Meals
□ Heartburn
□ Vomiting
□ Diarrhea
□ Constipation
□ Abdominal Cramps
□ Hemorrhoids
□ Liver Problems
□ Gall Bladder Problems
□ Diagnosed IBS, Crohn's, Diverticulitis, Colitis
□ Black/Bloody Stool

CARDIOVASCULAR/RESPIRATORY
□ Chest Pain
□ Asthma
□ High Blood Pressure
□ Irregular Heartbeat
□ Stroke
□ High Cholesterol

EENT (EYES,EARS,NOSE,THROAT)
□ Vision Problems
□ Sinus Infections
□ Earaches
□ Hearing Difficulty
□ Tinnitus

MALE/FEMALE
□ Menstrual Irregularity
□ Menstrual Cramps
□ Vaginal Pain/Infection
□ Breast Pain/Lumps
□ Prostate Dysfunction
□ Infertility Problems
□ Other: _____
_____

FAMILY HISTORY
The following family members have the same or similar problem(s) as I do:
□ Mother
□ Father
□ Sister
□ Brother
□ Spouse
□ Child

STRESS TEST

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

Physical/ Emotional/ Chemical Stress:	Child	Teen	Adult	Comments
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/ 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?

_____

_____

The above information is true and accurate to the best of my knowledge.

Signature: _____ Date: ____/_____/____