ADULT INTAKE FORM

Doctor's Notes:

Patient Information

First Name: _____ MI:_____ Last Name:_____

DOB: _____ Sex: M F Street Address:_____

City:_____ State: _____ Zip:_____

Contact Numbers: Home:_____Cell_____ Work_____

Please circle Preferred Contact Number

Occupation:_____ Employer:_____

Marital Status: ▪Single ▪Married ▪Divorced ▪Widowed Spouse's Name:_____

Do you have children? Yes No If yes, please list ages: _____

How did you hear about our office? ▪Online Search ▪Social Media ▪Referral _____

Please list the health concerns that prompted your first visit:

Health Concern (list according to severity)	Rate Severity 0 = No Pain 10 =Unbearable	When did this problem begin?	Have you had this condition in the past?	Did it begin with injury?	Are problems Constant or Intermittent?
1.			▪ Yes ▪ No	▪ Yes ▪ No	▪ Constant ▪ Intermittent
2.			▪ Yes ▪ No	▪ Yes ▪ No	▪ Constant ▪ Intermittent
3.			▪ Yes ▪ No	▪ Yes ▪ No	▪ Constant ▪ Intermittent

Have you seen other doctors for these concerns? Yes No If so, type? Chiropractor Medical Doctor

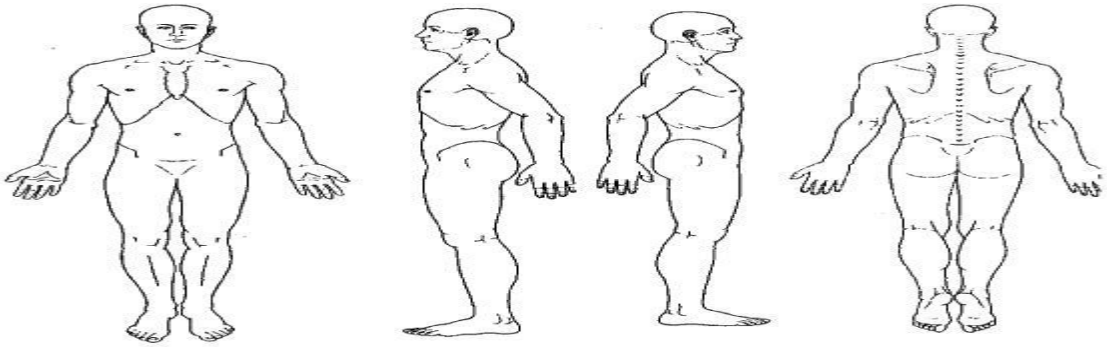
Are there any other concerns you would like the Doctor to address? Yes No _____

Please Mark "**C**" for **Current** Health Concerns or "**P**" for **Previous** Health Concerns

___ ADD/ADHD
___Allergies
___Anxiety
___Arm Pain
___ Asthma
___Back Pain - Low
___Back Pain – Mid
___Back Pain - Upper
___Bladder Disorders
___ Chest Pain
___Chronic Fatigue
___Constipation
___Depression
___Disc Problems
___Dizziness
___Ear Infections
___Epilepsy
___Fibromyalgia
___Food Sensitivities
___Gastric Reflux
___Headaches
___Heart Disease
___Hip Pain
___Infertility
___Irritable Bowel
___Kidney Problems
___Knee Pain
___Leg Pain
___Liver Disease
___Lupus
___Menstrual issues
___Migraines
___Neck Pain
___Nervousness
___Numbness in arm/hand
___Numbness in leg/feet
___Sciatica
___Shoulder Pain
___Sinus Issues
___Sleep Issues
___Skin Issues
___Stomach Disorders
___Throat Issues
___Thyroid Problems
___TMJ
___Ulcers
___Vertigo
___Arthritis
___Sexual Dysfunction
___Prostate Problems
___Blood Pressure H/L
Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms:

A = Ache	**N** = Numbness
B = Burning	**P** =Pins/Needles
S = Stabbing	**O** = Other



Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each.
** Score the pain **0 being no pain and 10 being the worst possible pain.**

Location of Pain (**AREA OF MAIN CONCERN**): _____

1. How would you rate your pain RIGHT NOW? 1 2 3 4 5 6 7 8 9 10
2. What is your TYPICAL or AVERAGE pain? 1 2 3 4 5 6 7 8 9 10
3. What is your pain level AT ITS BEST
   (How close to "0"does your pain get at its best? 1 2 3 4 5 6 7 8 9 10
4. What is your pain level AT ITS WORST?
   (How close to "10" does your pain get at its worst) 1 2 3 4 5 6 7 8 9 10

Have you ever been involved in an auto accident? ■ Yes ■ No If yes, when? _____

Please describe any other traumas you have undergone? _____

_____

Please check any condition you have currently, or have had in the past:

- ■ Stroke
- ■ Cancer
- ■ Heart Disease
- ■ Spinal Surgery
- ■ Seizures
- ■ Spinal Bone Fracture
- ■ Scoliosis
- ■ Diabetes: Type___

Please list all medications you are currently taking: _____

_____

How would a change in your health positively impact your life? *Please be specific with the goals you are hoping to achieve through care at our office. (i.e. "I could work out again, play with grandchildren, etc") _____

_____

Activities of Daily Living

Please identify how your current health concerns are affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Lifting/Carrying Objects	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sit to Stand	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Climbing Stairs	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Extended Computer Use	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Exercise	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Household Chores	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Lifting Children	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sexual Activity	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sleep	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sitting	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Standing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Work/Job Tasks	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Washing/Bathing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Yard Work	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Concentration (Reading)	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Other: _____	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Other: _____	No Effect	Painful (can do)	Painful (limits)	Unable to Perform

NOTES: _____

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