New Patient Intake Form

Personal Information Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Spouse or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Street, City, State, Zip): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status M☐ S☐ W☐ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No. of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to send health information Y/N

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (Name and Phone): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Health Information

Check the following conditions you may have had or have now:

☐Allergy ☐Diarrhea ☐Measles ☐Rheumatic Fever

☐Alcoholism ☐Eczema ☐Miscarriage ☐Stroke

☐Anemia ☐Emphysema ☐Multiple Sclerosis ☐Heart Attack

☐Arteriosclerosis ☐Gall Bladder ☐Mumps ☐Tuberculosis

☐Arthritis ☐Gout ☐Neuritis ☐Thyroid Problems

☐Backaches ☐High Blood Pressure ☐Nervousness ☐Ulcers

☐Cancer ☐Heart Disease ☐Depression ☐Venereal Disease

☐Convulsions ☐Malaria ☐Pleurisy ☐Whooping Cough

☐Constipation ☐Menstrual Cramps ☐Pneumonia ☐Low Blood Sugar

☐Cold Sores ☐Irregular Periods ☐Polio ☐Neck Pain

☐Diabetes ☐Migraine ☐Headaches ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Sinus ☐Epilepsy ☐Ringing in Ears ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check any of the conditions below that have affected anyone in your family (parents, grandparents, siblings, children, grandchildren):

☐Cancer ☐High Blood Pressure ☐Heart Attack ☐Stroke ☐Heart Disease

☐Asthma ☐Allergies ☐Mental Illness ☐Tuberculosis ☐Autoimmune Disease

☐Diabetes ☐Osteoporosis ☐Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all surgeries and hospitalizations:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List below your five greatest health concerns in order of significance to you:

1.

2.

3.

4.

5.

On a scale of 1-10 how strong is your resolve to do what it takes to correct these health problems? \_\_\_\_\_\_\_\_

There are three major components to great health. These three areas need ongoing attention. They are your structure (musculoskeletal system), chemical (your internal body chemistry) and your mental/emotional state (stress, emotions, and mental outlook). Please provide us information about these areas.

STRUCTURAL

Rate Your Posture: Poor ☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10 Excellent

What physical traumas have you had? ☐Birth Injury ☐Broken Bones ☐Concussion ☐Sports Injury

☐Auto Accident ☐Falls ☐Other

Aches and Pains? ☐Head ☐Neck ☐Shoulder ☐Elbow ☐Wrist/Hand ☐Mid Back ☐Lower Back

☐Hip ☐Knee ☐Ankle/Foot

What do you do to care for and maintain good structural health? ☐Chiropractic ☐Physical Therapy

☐Massage ☐Exercise ☐Stretching ☐Weight/Resistance Training ☐Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHEMICAL

What prescription drugs are you taking?

What supplements are you taking?

How would you rate your diet? Poor ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Excellent

☐Avoid Certain Foods, if so please list:

Have you had any abnormal lab findings? ☐Yes ☐No If Yes, describe:

Are you aware of any hormonal or endocrine problems? ☐Yes ☐No If Yes, describe:

MENTAL/EMOTIONAL

Rate Your Stress Level: None ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Extremely High

If it is high, what do you feel is the greatest source of your stress?

How many hours of sleep do you get?

Do you work long hours? ☐Yes ☐No If yes how many hours do you average per day?

Are you able to relax and unwind? ☐Yes ☐No

Do you feel that your relationships are unhealthy? ☐Yes ☐No If yes, explain:

What specific things are you doing to support your mental/emotional health? ☐Yoga ☐R&R ☐Breathing Exercises ☐Meditation ☐Spiritual Practice ☐Support Group ☐Counseling ☐Vacation☐ Other: