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ADULT PATIENT INTAKE FORM

Patient Information

Name_____ Preferred Name_____
Social Security Number _____ Address_____
City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
Email_____
Can we leave a voicemail □ No □ Yes Would you like to receive emails (special offers, upcoming events, newsletter) □ No □ Yes
Birth Date_____ Age_____ Gender_____ Marital Status_____
Spouse's Name_____ Number of children_____
Occupation_____ Employer_____
How did you hear about us? _____

Other Health Care Professionals

Have you previously been under chiropractic care? □ No □ Yes
If yes, please tell us the doctor's name_____
Who is your primary care physician? _____
Date and reason for last visit_____
Are you under the care of any other health care professionals? □ No □ Yes
If yes, please list the provider's name, specialty, and date of last visit _____
_____
_____

Your Current Health

My overall health is: □ Excellent □ Good □ Fair □ Poor
Reason you are seeking care at Awaken Family Chiropractic_____
_____

Many individuals begin chiropractic care as a form of "wellness" or "preventative" care and to increase their body's ability to function and heal. If this is the case for you, skip to the next section of questions, "Your Health Habits". Continue with this section if you are seeking care for a specific condition.

When did this condition begin? _____
What symptoms are you experiencing? _____
Since the onset, symptoms seem to be: □ Getting better □ Getting worse □ Staying the same
Is this condition the result of an injury or accident? □ No □ Yes
If yes, please explain _____
This condition began: □ Suddenly □ Gradually
Have you had this condition in the past? □ No □ Yes
If yes, please explain_____
What (if anything) increases these symptoms? _____
What (if anything) decreases these symptoms? _____
Are you under care with another healthcare provider for this condition? □ No □ Yes
If yes, who is the provider? _____
What treatment do/did they use? _____
What were the results? _____

How is this condition affecting your daily activities (bathing, dressing, eating, walking, driving, etc)? _____
_____
_____

Rate of pain/discomfort with this condition on scale of 0 to 10 (0 is no symptoms, 10 is worst possible):
At rest_____ With activity_____ In the morning_____ In the evening_____
Is there anything else about this condition you feel the doctor should know about? _____
_____

Your Health Habits

Do you smoke? □ No □ Yes If yes, how much per day? _____
Do you drink alcohol? □ No □ Yes If yes, how much per week? _____
Do you drink caffeinated beverages? □ No □ Yes If yes, how much per day? _____
Do you eat dairy products? □ No □ Yes
Do you eat gluten? □ No □ Yes
Are you on a restricted diet? □ No □ Yes If yes, please explain_____
Do you exercise? □ No □ Rarely □ Weekly □ Daily (What type of exercise? _____)
Do you watch TV? □ No □ Rarely □ Weekly □ Daily
How many hours of sleep do you get per night, on average? _____
Have you ever been hospitalized? □ No □ Yes
If yes, please list reason and year_____
_____
_____
Please list all surgeries, including year_____
_____
_____
Have you been in a motor vehicle accident? □ No □ Yes (please describe) _____
_____
Have you broken any bones? □ No □ Yes (please describe) _____
_____
Have you had any major falls or other accidents? □ No □ Yes (please describe) _____
_____
Do you play contact sports? □ No □ Yes, seasonally □ Yes, year round
Are you vaccinated? □ No □ Yes, some vaccinations are current □ Yes, up to date on all vaccinations
Reaction(s) to vaccinations: □ None □ I am unsure □ Fever □ Rash □ Pain at injection site □ Diarrhea □ Vomiting
□ Fatigue □ Excessive crying □ Seizures □ Developmental regression
□ Other (please describe) _____
Have you been prescribed antibiotics in the last 2 years? □ No □ Yes
If yes, how many times and list reason_____
_____
Please list current medications/supplements you are taking and reason for taking_____
_____
_____
_____

For Women Only

Are you currently pregnant? □ No □ Yes
If yes, when is your due date? _____
Please describe any symptoms you may be experiencing associated with this pregnancy_____
_____
Have you been pregnant in the past? _____
If yes, how many times? _____
How many children do you have? _____

Have you ever experienced: □ Miscarriage □ Abortion □ Preeclampsia □ Ectopic pregnancy □ Anemia
□ Gestational diabetes □ Hyperemesis gravidarum □ Placenta previa
□ Other complications (please describe) _____

Are you nursing? □ No □ Yes

Do you have breast implants? □ No □ Yes

Do you experience irregular menstrual cycles? □ No □ Yes

Chiropractic Care

Has anyone you know been under chiropractic care? □ No □ Yes

Did you know that Doctors of Chiropractic work with the nervous system? □ No □ Yes

Did you know that chiropractic is the most utilized natural, drug-free healthcare profession in the world? □ No □ Yes

Do you know what a **subluxation** is? □ No □ Yes

What is your health goal while under care in our office? _____

_____

Do you have any other concerns you would like to address with us (health-related or not)? _____

_____

_____

Any immediate family members (mother, father, sibling, grandparent, child) diagnosed with the following:

□ Cancer_____

□ Heart Disease _____

□ Stroke _____

□ Aneurysm _____

□ Diabetes _____

□ Seizures _____

□ Dementia _____

□ Liver disease _____

□ High blood pressure _____

□ High cholesterol _____

□ Depression _____

□ Other major medical condition _____

_____

AWAKEN FAMILY CHIROPRACTIC

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REVIEW OF SYSTEMS

EYES/EARS/NOSE/THROAT ☐ None

Past	Present	
☐	☐	Glaucoma
☐	☐	Cataracts
☐	☐	Double vision
☐	☐	Blurred vision
☐	☐	Ear infections
☐	☐	Sinus congestion
☐	☐	Sinus infections
☐	☐	Nosebleeds
☐	☐	Toothache
☐	☐	Dizziness
☐	☐	Tinnitus (ringing in ears)
☐	☐	Tonsillitis
☐	☐	Hearing loss
☐	☐	Frequent colds

RESPIRATORY ☐ None

Past	Present	
☐	☐	Asthma
☐	☐	Seasonal allergies
☐	☐	Chronic allergies
☐	☐	Respiratory tract infections
☐	☐	Shortness of breath
☐	☐	Pneumonia
☐	☐	Coughing/wheezing
☐	☐	RSV

GASTROINTESTINAL ☐ None

Past	Present	
☐	☐	Food sensitivities/allergies
☐	☐	Acid reflux
☐	☐	Difficulty swallowing
☐	☐	Constipation
☐	☐	Excessive gas
☐	☐	Diarrhea
☐	☐	Nausea/vomiting
☐	☐	Ulcers
☐	☐	Poor appetite
☐	☐	Crohn's Disease
☐	☐	Digestive problems
☐	☐	Liver problems
☐	☐	Gallbladder problems

GENITOURINARY ☐ None

Past	Present	
☐	☐	Frequent urination
☐	☐	Burning urination
☐	☐	Blood in urine
☐	☐	Bedwetting (enuresis)
☐	☐	Kidney stone
☐	☐	Kidney disease
☐	☐	Prostate problems

MUSCULOSKELETAL ☐ None

Past	Present	
☐	☐	Neck pain
☐	☐	Back pain
☐	☐	Growing pains
☐	☐	Scoliosis
☐	☐	Poor posture
☐	☐	Arthritis
☐	☐	Rheumatoid arthritis
☐	☐	Joint stiffness
☐	☐	Muscle weakness
☐	☐	Osteoporosis
☐	☐	Joint replacement
☐	☐	Hip Dysplasia

IMMUNE/SKIN ☐ None

Past	Present	
☐	☐	Autoimmune disorder
☐	☐	Eczema
☐	☐	Rashes
☐	☐	Cortisone use
☐	☐	Weak immune system
☐	☐	Recurrent fevers

CARDIOVASCULAR/LYMPHATIC ☐ None

Past	Present	
☐	☐	Poor circulation
☐	☐	Anemia
☐	☐	Swollen glands
☐	☐	High blood pressure
☐	☐	Heart disease
☐	☐	Heart attack
☐	☐	Jaw pain
☐	☐	Irregular heartbeat
☐	☐	Pacemaker
☐	☐	Leg cramping/swelling
☐	☐	High cholesterol
☐	☐	Aneurysm
☐	☐	HIV/AIDS
☐	☐	Stroke
☐	☐	Abnormal bruising

ENDOCRINE ☐ None

Past	Present	
☐	☐	Thyroid problems
☐	☐	Type 1 diabetes
☐	☐	Type 2 diabetes
☐	☐	Hair loss
☐	☐	Menstrual problems
☐	☐	Hair loss
☐	☐	Endometriosis
☐	☐	Fertility issues
☐	☐	Hashimotos

NEUROLOGICAL ☐ None

Past	Present	
☐	☐	Asymmetric gait
☐	☐	Sleep disturbances
☐	☐	Seizures
☐	☐	Tics/tremors/shaking
☐	☐	Autism/Spectrum disorder
☐	☐	ADD/ADHD
☐	☐	Sensory processing disorder
☐	☐	Toe walking
☐	☐	Headaches/migraines
☐	☐	Numbness/tingling
☐	☐	Radiating pain
☐	☐	Parkinson's disease
☐	☐	Sciatica
☐	☐	Carpal tunnel syndrome
☐	☐	Balance/coordination issues
☐	☐	Trigeminal neuralgia
☐	☐	Fine motor problems
☐	☐	Gross motor problems

PSYCHIATRIC ☐ None

Past	Present	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	OCD
☐	☐	Bipolar disorder
☐	☐	Difficulty sleeping
☐	☐	Seasonal affective disorder
☐	☐	Memory loss
☐	☐	Mood swings

GENERAL ☐ None

Past	Present	
☐	☐	Weight loss
☐	☐	Weight gain
☐	☐	Low energy
☐	☐	Learning disabilities
☐	☐	Behavior issues
☐	☐	Speech delays
☐	☐	Chronic fatigue
☐	☐	Obesity
☐	☐	Fibromyalgia
☐	☐	Cancer