



2 Park Ave East
Elmira, Ontario
N3B 2G8
www.elmiraafc.com
team@elmiraafc.com
ADULT INTAKE FORMS

Date: _____

Name (first and last): _____ Gender: FEMALE or MALE

Date of Birth: _____ Age: _____

Address: _____

City/Province: _____ Postal Code: _____

Phone Number – Home: (____) _____ Mobile Phone: (____) _____

Email: _____

Check if you **don't** want us to communicate with you by email

Marital Status: SINGLE PARTNERED MARRIED WIDOWED DIVORCED

Name of spouse/partner (if applicable): _____

Children: YES or NO If yes, names and ages: _____

Occupation: _____ Current employer: _____

Whom may we thank for referring you to Elmira Family Chiropractic? _____

Have you ever had chiropractic care before? YES NO

If yes, please tell us the doctor's name: _____

If yes, dates from: _____ to _____

Briefly describe your previous chiropractic experience: _____

Family Doctor: _____ Phone Number: (____) _____

Do you have any present complaints or persistent health challenges? _____

How is this affecting your life? _____

If you are experiencing pain, is it: Sharp Dull Comes & Goes Travels Constant

Since the problem started it is: About the Same Getting better Getting Worse

What makes it worse: _____

It Interferes with: Work Sleep Walking Sitting Hobbies Leisure

Names of other Doctors seen for this problem:

Chiropractor _____

Medical Doctor _____

Other _____

Please rate your level of commitment to resolving this/these problem(s) (10 being the highest)

1 2 3 4 5 6 7 8 9 10

If you have no specific problems but are here to become healthier, check here:

Have you ever injured your nervous system or spine? YES NO If yes, describe: _____

Are you healthy? YES NO What makes you think this is the case? _____

Why is your health important to you? _____

Please check **ALL** of the following you might have **EVER** had even if you don't think they are related to the current problem:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Pinched nerve | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Liver/gall bladder problems |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Chronic infections | <input type="checkbox"/> Chest pains/heart disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low back/hip pain | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Bladder trouble/painful urination |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Walking problems | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Confusion/Forgetfulness | <input type="checkbox"/> Decreased immunity/frequent colds | <input type="checkbox"/> Frequent nausea | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Imbalance | <input type="checkbox"/> Asthma/allergies | <input type="checkbox"/> Ulcers/heartburn | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood pressure trouble |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Heart/vascular problems | <input type="checkbox"/> Pain/stiff in mornings | <input type="checkbox"/> Ankle swelling |
| <input type="checkbox"/> Neck/arm/shoulder Pain | <input type="checkbox"/> Buzzying/ringing in ears | <input type="checkbox"/> Diarrhea/constipation | <input type="checkbox"/> Pain between shoulders |
| <input type="checkbox"/> Leg/knee/foot pain | | <input type="checkbox"/> Thyroid problems | |
| <input type="checkbox"/> Arthritis | | <input type="checkbox"/> Upset stomach | |
| <input type="checkbox"/> Herniated Disc | | <input type="checkbox"/> Mood swings | |
| <input type="checkbox"/> Numbness | | | |
| <input type="checkbox"/> Depression | | | |

Physical Stress or Challenges

Childhood: please describe any childhood illnesses, surgeries, serious falls, car accidents, prolonged use of medication (antibiotics or inhalers), and birth trauma: _____

Adulthood: Please list any previous surgeries, traumas, falls, injuries: _____

Chemical Stress or Challenges

Are you currently taking any medications (over the counter and/or prescriptions) or supplements? _____

Allergies? _____

Previous medications: _____

Do you consume daily? Sugar Caffeine Cigarette Toxins Alcohol

Emotional Stress or Challenges

List any emotional/mental stressors presently in your life and any previous major stressors: _____

Current emotional/mental state: excellent good poor Other _____

Goals

What are the top three priorities in your life? _____

What would you like to gain from chiropractic care? _____
