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ADULT INTAKE FORMS

ELMIRA FAMILY CHIROPRACTIC
est. 1964

Date: _____

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

Date of Birth: _____ Age: _____

Address: _____

City/Province: _____ Postal Code: _____

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

Best 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(s): _____

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:

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

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: _____

_____

_____

What position do you sleep in? ☐ Front ☐ Back ☐ Side How many hours per day do you sit? _____

In one week, how much time do you spend exercising? _____ hrs

What type of exercise do you do? _____

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? _____

_____