Rochester Chiropractic & Wellness

# ADULT INTAKE FORM

## PATIENT INFORMATION

Date _____/_____/_____

Patient Name _____

LAST FIRST MI

Address _____

City _____ State _____ Zip _____

Email _____

Cell Phone (_____) _____ Work Phone (_____) _____

Home Phone (_____) _____ Best time to reach you _____

Date of Birth _____/_____/_____ Age _____ Sex ☐ Male ☐ Female

☐ Married ☐ Single ☐ Dating ☐ Divorced ☐ Widowed

Occupation _____ Employer/School _____

IN CASE OF EMERGNCY, CONTACT

Name _____ Relationship _____

Primary Phone (_____) _____ Secondary Phone (_____) _____

## REFERRAL INFORMATION

How did you hear about us? ☐ Facebook ☐ Family /Friend (Whom may we thank for referring you? _____)

☐ Internet Search ☐ Insurance ☐ Staff ☐ Other: _____

## PATIENT CONDITION

Current Health Concern: _____ When did this condition start? _____ /_____ /_____

Mark an X on the picture where you have symptoms.

Rate your pain on a severity scale from 1 (least) to 10 (severe) _____

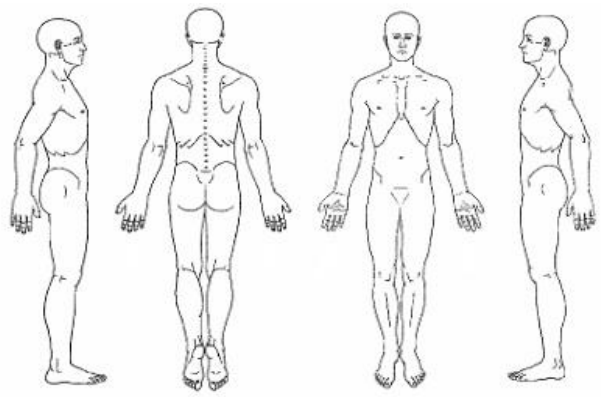
Describe your symptoms: ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Burning ☐ Numbness ☐ Tingling ☐ Stiffness

☐ Stabbing ☐ Swelling ☐ Other _____

How often do you have this pain? ☐ Constant ☐ Frequently ☐ Intermittent ☐ Occasionally

Does this condition interfere with: ☐ Work ☐ Family ☐ Sleep ☐ Daily Activities

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



Have you experienced this problem before? ☐ No ☐ Yes

Please Explain: _____

Have you sought treatment for this condition before? ☐ No ☐ Yes

Please Explain: _____

**What is your sense of urgency to relieve your pain and/or improve your performance? 0 1 2 3 4 5 6 7 8 9 10**

## PREVIOUS TREATMENT

Family Medical Doctor: _____ Date of last visit: _____/_____ /_____

Previous Chiropractic Care: ☐ No ☐ Yes Name: _____ Date of last visit: _____/_____ /_____

What treatment have you already received for your condition? ☐ Acupuncture ☐ Chiropractic ☐ Massage

☐ Medications ☐ Physical Therapy ☐ Surgery ☐ None ☐ Other _____

Previous Diagnosis: _____ Last X-Rays Taken: _____/_____ /_____

## HEALTH HISTORY

Please mark any of the following conditions that you have been diagnosed with or experience.

☐ AIDS/HIV
☐ Alcoholism
☐ Allergies (List: _____)
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Breast Lump (s)
☐ Blood Pressure High Low
☐ Cancer
☐ Circulatory Problems
☐ Cholesterol High
☐ Congenital Disease (List: _____)
☐ Depression
☐ Diabetes Type I Type II
☐ Diarrhea
☐ Digestive Problems
☐ Dizziness
☐ Eating Disorder
☐ Epilepsy
☐ Excessive Thirst
☐ Fainting
☐ Fatigue
☐ Fever
☐ Prostate Problems
☐ Fractures
☐ Headaches
☐ Heartburn
☐ Heart Problems
☐ Hernia
☐ Herniated Disc (List:)
☐ Hypertension
☐ Kidney Disease
☐ Liver Disease
☐ Miscarriage
☐ Mononucleosis
☐ Nausea
☐ Night Sweats
☐ Numbness
☐ Osteoporosis
☐ Pacemaker
☐ Pinched Nerve
☐ Pneumonia
☐ Ringing in the ears
☐ Sleep problems Too little Too much
☐ Shortness of breath
☐ Stroke
☐ Thyroid Problems (Explain: _____)
☐ Tuberculosis
☐ Tumor(s) (List: _____)
☐ Unexplained weight loss
☐ Visual Problems
☐ Vomiting

☐ OTHER: _____

Are you taking any medications or drugs? ☐ No ☐ Yes
Please List: _____

Are you taking any vitamins/herbs/minerals? ☐ No ☐ Yes
Please List: _____

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor
☐ Other: _____

HABITS
☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Caffeine Cups/Day _____
☐ High Stress Level Reason _____

Please describe any injuries or surgeries (e.g. slips/falls, head injuries, broken bones, dislocations, surgeries, auto accidents): _____
_____
_____
_____