Live Well
Chiropractic Spa & Acupuncture Center

Adult Intake Form

Name: _____ Date: _____

Address: _____ City:_____ State:____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____ May we contact you via email? __ Yes __ No

Age: _____ Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____ Work Phone: _____

Spouse's Name: _____ Phone: _____

Name of Nearest Relative:_____ Phone: _____

Names and Ages of any Children: _____

Family Medical Doctor: _____

History of Present Illness

Purpose of this appointment:

___ Wellness Check-Up ___ Auto Accident Related ___Work Injury Related

Primary Complaint (area of body):_____

Secondary Complaint (if applicable):_____

When did you first notice this problem: _____

How did it originally occur? _____

How has it progressed recently? ___Same ___ Improving ___Getting Worse

How frequent is the condition? ___Constant ___Frequently ___Intermittent ___Occasionally

Describe the pain: ___Sharp ___Dull ___Numbness ___Tingling ___Aching ___Burning

___ Stabbing __ Throbbing ___Other:_____

Does anything relieve the problem? If so please list. ___ No ___Yes:_____

Does anything make the problem worse? If so please list. ___No ___Yes:_____

What does this problem prevent you from doing or enjoying? _____

Please place an "X" on the line below to indicate the level of your problem.

No Symptoms ←——————————————→ Extreme Symptoms

Past Medical History

Please check any of the following conditions that you have been diagnosed with or experienced.

___Broken or Fractured Bones	___Osteoarthritis	___Eating Disorders
___Circulatory Problems	___Epilepsy	___Alcoholism
___Rheumatoid Arthritis	___Pace Maker	___Drug Addiction
___Seizures/Convulsions	___Strokes	___HIV Positive
___Any Congenital Diseases	___Cancer	___Gall Bladder Problems
___Excessive Bleeding	___Ruptures	___Depression
___High/Low Blood Pressure	___Coughing Blood	___Ulcers

Please list any major illnesses, injuries, falls, auto accidents or surgeries including dates. Women provide information including childbirth. _____
_____

Have you been treated for any health condition by a physician within the last year? ___No ___Yes
If yes, describe: _____

Are you taking any medications or drugs? Please list_____
_____

Women: Is there any chance you may be pregnant? ___Yes ___No ___Not Sure

Please list any additional health problems you have, no matter how significant they may be._____
_____

Social History

Please check the following that apply to your lifestyle.

	Please describe the frequency and type
___ Alcohol	_____
___ Tobacco Products	_____
___ Caffeine	_____
___ Vitamin supplements	_____
___ Exercise	_____
___Hobbies	_____

What percentage of the day are you: ___lifting ___sitting ___bending ___working at a computer

Family History

Please check any conditions that run in your family and indicate whether the family member is your **G**randparent, **F**ather, **M**other, **S**ister, or **B**rother:

___Diabetes	___Cancer	___Mental Illness	___Arthritis
___Stroke	___Asthma	___Kidney Disease	___Liver Disease
___Heart Disease	___Lung Disease	___Other_____	

Patient (or Guardian) Signature:_____ Date:_____