live well
CHIROPRACTIC AND ACUPUNCTURE

Adult Intake Form

Form can be filled digitally or printed. You may email completed form to info@livewelltwincities.com.

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 the body) _____

Secondary complaint (if applicable) _____

When did you first notice this problem? _____

How did it originally occur? _____

How has it progressed recently?

☐ Same ☐ Improved ☐ 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? ☐ No ☐ Yes, explain: _____

Does anything make the problem worse? ☐ No ☐ Yes, explain: _____

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

Please place a check 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
- ☐ Circulatory problems
- ☐ Rheumatoid arthritis
- ☐ Seizures/Convulsions
- ☐ Any congenital disease
- ☐ Excessive bleeding
- ☐ High/low blood pressure
- ☐ Osteoarthritis
- ☐ Epilepsy
- ☐ Pace maker
- ☐ Stroke
- ☐ Cancer
- ☐ Ruptures
- ☐ Coughing blood
- ☐ Eating disorders
- ☐ Alcoholism
- ☐ Drug addiction
- ☐ HIV positive
- ☐ Gall bladder problems
- ☐ Depression
- ☐ Ulcers

Please list any major illnesses, injuries, falls, auto accidents or surgeries including dates. Women include information about 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 for each that apply.

- ☐ 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 mark all conditions that run in your family and indicate your relationship to the family member.

Grandparent, **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** _____