Adult Intake Form

Last Name:	First Name:	Date:

Please check the type of care desired:

- ○ Family Health/Prevention
- ○ Stabilization
- ○ Temporary Relief
- ○ Doctor's Advice

Is this appointment related to an: (if yes, please call before continuing)

- ○ Auto Accident
- ○ Injury on the Job?

How did you hear about Shine?

PERSONAL INFORMATION

First Name:	M.I.	Last Name:

Preferred Name:	Address:

City:	State:	Zip:

Cell Phone:	Alternate Phone:	Email:

Birth Date:	Age:	Sex: ○ M ○ F	Occupation:	Employer's Name:

Work Phone:	Married/Life Partner: ○ Y ○ N	Partner's Name:	Number of Children:

Children's Names & Ages:

Emergency Contact:	Phone:	Relationship:

REASON FOR SEEKING CARE

What is your reason for seeking care at Shine Chiropractic?

When/how did this first begin?

What aggravates your concern?	What alleviates your concern?

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Is the condition worse during certain times of the day? If yes, when?

○ Y ○ N

Does it affect your:

☐ Work ☐ Relationships ☐ Decision Making ☐ Exercise or Play

☐ Mood, Patience ☐ Ability to Relax or Sleep ☐ Day-to-Day Activities ☐ Other _____

Explain any of the above:

On a scale of 1-10 (1 least & 10 most), please circle the severity of your symptoms:

1 2 3 4 5 6 7 8 9 10

Do you have:

☐ Pain ☐ Numbness

☐ Tingling ☐ Aches

Explain:

Is your pain:

○ Sharp ○ Dull ○ Throbbing ○ Constant ○ Intermittent

Explain:

Do you feel:

☐ Swelling ☐ Cramping ☐ Stiffness ☐ Burning

Explain:

Have you seen any other providers for this condition? (list all providers & any treatments or diagnosis)

Is there anything else about your current condition you feel the doctor should know?

Do you have any other health concerns?

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DEVELOPMENTAL HISTORY

Your Mom's Pregnancy with You: (check all that apply)

- ☐ Tobacco
- ☐ Alcohol
- ☐ Medications
- ☐ Recreational drugs
- ☐ Falls/Injuries
- ☐ Abuse (any type)

Notes:

Your Birth: (check all that apply)

- ☐ Hospital
- ☐ Home
- ☐ Vaginal
- ☐ Cesarean (emergency or scheduled?)
- ☐ Vacuum
- ☐ Forceps
- ☐ Medications
- ☐ Epidural
- ☐ Complications

Explain any boxes checked above:

Childhood – Age 0-18: (check all that apply)

- ☐ Breast fed
- ☐ Formula fed (dairy or soy?)
- ☐ Abuse
- ☐ Surgeries
- ☐ Accidents
- ☐ Falls/Injuries
- ☐ Dislocations/Fractures
- ☐ Scoliosis
- ☐ Braces/Retainer
- ☐ Nightmares
- ☐ Played in a bouncy swing
- ☐ Crawled before walking
- ☐ Special diet/Food allergies
- ☐ Vaccinations
- ☐ Medications
- ☐ Allergies/Eczema
- ☐ Asthma
- ☐ Ear infections

Explain any boxes checked above:

ADULT HISTORY (18 to present)

Mark all that apply with (N) for Now, (P) for Past

- ☐ Weight changes
- ☐ Frequent colds/Flu
- ☐ Respiratory problems
- ☐ Sinus problems/Allergies
- ☐ Anemia
- ☐ Skin conditions
- ☐ Neck/Back pain
- ☐ High cholesterol
- ☐ Stroke
- ☐ High blood pressure
- ☐ Anxiety/Depression
- ☐ Bipolar disorder
- ☐ OCD
- ☐ ADD/ADHD
- ☐ SAD
- ☐ Concussion/Head injury
- ☐ Digestive problems
- ☐ Cancer
- ☐ Menstrual problems
- ☐ Reproductive organ disorders
- ☐ Numbness/Tingling
- ☐ Dental/Jaw issues
- ☐ Headaches
- ☐ Diabetes (Type:_____)
- ☐ Urinary tract infections
- ☐ Arthritis (Type? _____)
- ☐ Cold hands/Feet
- ☐ Stiffness/Flexibility
- ☐ Concentration
- ☐ Bowel/Bladder changes
- ☐ Dizziness/Vertigo
- ☐ Ear/Hearing Issues
- ☐ Eye/Vision
- ☐ Thyroid disorder
- ☐ Other: _____

Explain any boxes checked above:

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FAMILY HISTORY

Please indicate family members who have had any of the following conditions:

Osteoporosis_____ Cancer (Type:)_____ Bleeding Disorder _____Diabetes (Type:) _____

High Blood Pessure _____ Stroke _____ Heart Attack_____Generic Disorder _____

Please list, multiple family members with the same disease:

Please list disease related deaths if applicable:

Mother's Age_____ Cause of Death _____ Grandfather's Age _____ Cause of Death _____

Father's Age _____ Cause of Death _____ Grandmother's Age _____ Cause of Death _____

MEDICATIONS

Check all that apply:

- ☐ Anxiety/Depression
- ☐ Migraine/Headache
- ☐ Blood Pressure
- ☐ Cholesterol
- ☐ Pain Medication
- ☐ ADD/ADHD
- ☐ Muscle Relaxers
- ☐ Diabetes
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain:

VITAMINS & SUPPLEMENTS

Check all that apply:

- ☐ Multi/Prenatal
- ☐ Vitamin D3
- ☐ B-Vitamin
- ☐ Fish Oil/Omega-3
- ☐ Probiotic
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain:

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STRESS QUESTIONNAIRE

Physical Stress (please check any of the following stresses you have experienced with (N) for Now, (P) for Past)

- ☐ Physical pain
- ☐ Low energy/fatigue
- ☐ Tightness/Stiffness
- ☐ Difficulty performing daily activities
- ☐ History of accidents/Falls
- ☐ Inability to perform physical activities
- ☐ Surgeries/Organs removed
- ☐ Dislocation/Fractures
- ☐ Sports injuries
- ☐ Abuse
- ☐ Other _____

Explain any boxes checked above:

Chemical Stress (please check any of the following stresses you have experienced with (N) for Now, (P) for Past)

- ☐ Fast food/Processed food
- ☐ Medications (Prescription or OTC)
- ☐ Alcohol
- ☐ Tobacco
- ☐ Amalgam fillings
- ☐ Makeup /Other cosmetic products
- ☐ Recreational drugs
- ☐ Vaccinations
- ☐ Other _____

Explain any boxes checked above:

Emotional Stress (please check any of the following stresses you have experienced with (N) for Now, (P) for Past)

- ☐ School
- ☐ Health
- ☐ Finances
- ☐ Family/Relationships
- ☐ Abuse
- ☐ Daily Schedule/Time
- ☐ Other _____

Explain any boxes checked above:

QUALITY OF LIFE QUESTIONNAIRE

Please rate your GENERAL stress level AT **WORK/SCHOOL**, 0-10

0 1 2 3 4 5 6 7 8 9 10

Please rate your GENERAL stress level **AT HOME**, 0-10

0 1 2 3 4 5 6 7 8 9 10

How do you think you handle your stress?	○ excellent	○ good	○ fair	○ poor
How do you grade your physical health?	○ excellent	○ good	○ fair	○ poor
How do you grade your emotional/mental health?	○ excellent	○ good	○ fair	○ poor
How do you rate your overall quality of life?	○ excellent	○ good	○ fair	○ poor

Do you exercise regularly? If yes, how often?

Do you follow a special diet? Explain:

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FOR FEMALES ONLY

How many pregnancies have you had?

How many births have you had?

Please explain if applicable:

MOST RECENT BIRTH

Please check the following for your most recent birth

- Third Trimester Presentation: ☐ Vertex ☐ Breech ☐ Transverse ☐ Face/Brow ☐ Posterior
- Type of Birth: ☐ Vaginal ☐ Forceps ☐ Vacuum ☐ Cesarean (ER or planned?)
- Interventions: ☐ Medication ☐ Epidural ☐ Ruptured Membranes

Delivery Location:

OB/Midwife Name:

BIRTH STORIES

Please include all births, listed in chronological order from your most recent birth:

CURRENT PREGNANCY

How many weeks are you?

Guess Date:

Do you plan on birthing at:
◯ Home ◯ Birthing Center ◯ Hospital

If not birthing at home, please name birthing location:

Have you experienced any spotting this pregnancy? If yes please explain:

Do you plan on using a: (check all that apply)
☐ Doula ☐ Midwife ☐ Nurse Midwife ☐ OB

List practitioners:

Do you plan on breastfeeding?
◯ Y ◯ N

Do you plan on vaccinating this child?
◯ Y ◯ N ◯ Undecided

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CHIROPRACTIC HISTORY

Have you been to a chiropractor before?
Y N

How old were you the 1st time you were adjusted?

Who was your most recent chiropractor?

When was your last adjustment?

Reason for visit:

Result & reason for change?

In your own words, what do chiropractors do?

SELF EVALUATION

What is your level of commitment to yourself and your health?

1 2 3 4 5 6 7 8 9 10

Explain:

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

Are there any particular factors about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel impair your opportunity for full, unimpeded health?

Are there any particular factors or elements about your life, experiences, family, work, recreation, genetics, dietary programs, exercises, outlook, etc. that you feel give you an edge or adds to your health?

Is there anything else which may help us to understand you, your history, or your needs that have not been discussed on this survey? Please explain:

Patient Signature

Date