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:

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 makes the problem **worse**?	What makes the problem **better**?

Have you received care for this problem before? ○ Y ○ N

If yes, please explain:

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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:

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

Please explain or list any complications or unusual events when your mom was pregnant with **you** or during **your** own birth:

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 disorders
- ☐ Numbness/Tingling
- ☐ Dental/Jaw issues
- ☐ Headaches
- ☐ Diabetes (Type:_____)
- ☐ Urinary tract infections
- ☐ Bowel/Bladder changes
- ☐ Dizziness/Vertigo
- ☐ Cold hands/Feet
- ☐ Stiffness/Flexibility
- ☐ Concentration
- ☐ Arthritis (Type? _____)
- ☐ 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 _____ Genetic Disorder _____

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

Explain any boxes checked above:

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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/fatique)
- Tightness/Stiffness
- Difficulty performing daily activities
- History of Accidents/Falls
- Inability to Exercise/Perform Physical Activities
- Surgeries/organs removed
- Dislocation/fractures
- Sports injuries
- Abuse
- Other _____

Explain any boxes checked above:

Do you exercise regularly? If yes, how often?

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
- Sugar
- Tobacco
- Amalgam Fillings
- Makeup /Other
- Dairy
- Gluten
- Recreational Drugs
- Vaccinations
- Other _____

Explain any boxes checked above:

Do you follow a special diet? Explain:

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

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

Explain any boxes checked above:

CHIROPRACTIC HISTORY

Have you been to a chiropractor before?

- Y
- N

Who was your most recent chiropractor?

Reason for visit:

When was your last adjustment?

Result & reason for change?

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

Are there any particular factors or elements about your life, experiences, family, work, recreation, genetics, dietary programs, exercises, outlook, etc. that you feel **improves** 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:

Signature

Date