ChiroLife
Family Wellness
By A Adams Chiropractic Corp

Adult Patient Intake Form

To help us serve you better, please complete the following: Date:_____

Name:_____ D.O.B.: _____ Age:_____
SSN _____ Gender: M___ F___ Height_____ Weight_____
Address:_____City/State/Zip:_____
Home phone:_____ Cell #: _____ Work:_____
Where do you prefer we call?:_____
Occupation:_____ Employer:_____
Email:_____
Emergency Contact:_____Relation_____Phone#:_____
Marital Status: M S D W Spouse Name:_____
Children/ages:_____

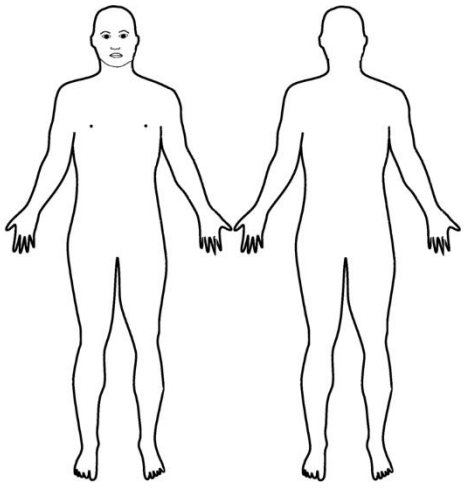
Who is your Primary Care Physician? _____
Clinic Name_____ Date & Reason for last visit _____
May we communicate with your Primary Care Physician regarding your care if necessary? □ Yes □ No

Have you ever received Chiropractic Care? □ Yes □ No
If yes, who is your previous Doctor of Chiropractic? _____
What was the date and reason for previous visit? _____
Were you pleased with your care? □ Yes □ No

How did you find out about our office?_____
Whom may we thank for referring you to our office?_____

What is the purpose of your visit today?
□I have no complaints. I am here for a wellness checkup.
□Current health concerns: _____

Please circle on the diagram the area of your discomfort.



Please describe your present complaints_____
_____
_____
_____
_____
_____
Please circle one of the numbers below to describe your current level of pain.

Is this a work related injury? □ Yes □ No
When did your present complaints first occur?_____
Does anything make it better:_____
Does anything make it worse:_____

Who has treated you for this condition (if anyone)? _____
Is this condition interfering with your: □ Work □ Sleep □ Recreation □Days missed:_____
Have you had this condition or similar conditions in the past? □ Yes □ No
If so, when?_____
What treatment did you receive_____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto accidents:
Motorcycle accidents:
Falls or other injuries:
Spinal or neck injuries:
Broken bones:
Knocked unconscious:
Surgeries:
Health problems of parents:

Check appropriate squares (x) past or (✓) present condition:

CARDIOVASCULAR □ N/A
___Stroke
___High Blood Pressure
___Aortic Aneurysm
___Brain Aneurysm
___Heart Disease
___Heart Attack
___Chest Pain
___High Cholesterol
___Pacemaker
___Jaw Pain
___Irregular Heartbeat
___Swelling of Leg

RESPIRATORY □ N/A
___Asthma
___Shortness of Breath
___Upper Resp. Infection
___Cold/Flu
___Pneumonia
___Cough/Wheezing
___Emphysema

EYES □ N/A
___Double/Blurred Vision
___ Glaucoma

GENITOURINARY □ N/A
___Kidney Stone
___Kidney Disease
___Lower Side Pain
___Burning Urination
___Blood in Urine
___Bed Wetting/Enuresis
___Prostate Problems

EAR/NOSE/THROAT □ N/A
___Hearing Loss
___Dizziness
___Sinus Congestion
___Sinus Infection
___Nosebleed
___Sore Throat
___Difficulty Swallowing
___Ear Ache
___ Ear Infections
___Ear Ringing/Tinnitus

GASTROINTESTINAL □ N/A
___Pancreatitis
___Acid Reflux
___Bowel Problems
___Constipation
___Upset Stomach
___Gas Pains
___Ulcers
___Gallbladder Problems
___Liver Problems
___Diarrhea
___Nausea/Vomiting
___Poor Appetite
___Bloody Stool
___Crohn's Disease
___Hiatal Hernia
___Frequent Urination

OTHER □ N/A
_____
_____
_____

MUSCULOSKELETAL □ N/A
___Chronic Hip Dislocation
___Torticollis
___Poor Posture
___Neck Pain
___Back Pain
___Arthritis
___Rheumatoid Arthritis
___Joint Stiffness
___Muscle Weakness
___Osteoporosis
___Broken Bones
___Joint Replacement

ENDOCRINE □ N/A
___Hyperthyroid Issues
___Hypothyroid Issues
___Hashimoto
___Graves
___Type 1 Diabetes
___ Type 2 Diabetes
___Hair Loss
___Menstrual Problems
___Hot Flashes
___Endometriosis
___Polycystic Ovarian Syndrome
___Cushing's Disease
___Gout

ALLERGIC/IMMUNOLOGICAL □ N/A
___HIV/AIDS
___Autoimmune Disorder
___Inflammation
___Environmental Allergies
___Food Allergies
___Cortisone Use
___Allergy Shots
___Chronic Allergies
___Seasonal Allergies

CONSTITUTIONAL □ N/A
___ Pregnancy/Fertility Issues
___Speech Delays
___Obesity
___Weight Loss/Gain
___Energy Level Low
___Energy Level High
___Difficulty Sleeping
___Chronic Fatigue
___General Malaise
___Compulsive Behavior
___Behavior Issues
___Social Anxieties
___Depression
___Anxiety Disorder

NEUROLOGICAL □ N/A
___Radiating Pain
___Numbness/Tingling
___Sciatica
___Parkinson's Disease
___Carpal Tunnel
___Balance/Coordination
___ADHD/ADD/Sensory Processing Disorder
___Autism/Spectrum Disorder
___Migraine Headaches
___Tension Headaches
___Bell's Palsy
___Poor Fine/Gross Motor Skills
___Seizures
___Head Injury
___Tic Disorder
___Trigeminal Neuralgia
___Auditory Processing
___Toe Walking
___Vertigo/Dizziness
___Sensory Integration

Current List of MEDICATIONS: _____
_____
Any SURGERIES or HOSPITALIZATONS:_____
Any ACCIDENTS or INJURIES:_____
Methods you have tested:
___Exercise ___Physical therapy ___Prescription drugs ___Massage ___Acupuncture ____Nothing
My conditions interrupt the following:
___Career ___Social life ___Ability to exercise ___Sleep ___Family life
What results would you want for yourself?
___Reduce symptoms ___Restore health ___Maintain health

_____ I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, fees for professional services rendered will be immediately due and payable. I have been advised and concur, past due accounts will bear interest at 5% per month on the past due balance. I am responsible for costs required to enforce collection of my account including, but not limited to, collection fees, attorney fees and court costs. There is a $35.00 charge for returned checks.

_____ I understand that I am responsible for any fees and account balances that my insurance company does not cover. All account balances must be paid within 60 days of insurance

_____ **Cancelation Policy**: Any time you are unable to keep your appointment, we would appreciate a call in advance from you so that we may cancel your appointment and use the appointment time for another patient. Please call the office and we will be happy to schedule another appointment for you. A $40.00 charge will be made for broken appointments unless **24 hours**' notice is given. No Show visits will result in a full visit fee.

CC Holder name _____
Billing Address: _____ **Zip Code**:_____

CC # _____ **Exp:**_____ **CVV**:_____

_____ _____
Signature of Patient or Guardian Date