ADULT INTAKE

Personal History:

Patient's Name: _____
First Middle Last

Gender: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ - _____ - _____ (This line must be filled out)

Home Phone: _____ Cell Phone: _____

Do you want to opt in for text message appt reminders: Yes No

Email Address: _____

Marital Status: Single Married Divorced Other: _____

Spouse's Name: _____

Children's Names and Ages: _____

_____

Occupation: _____ Employer: _____

Military Service: Current Veteran Branch: _____

Emergency Contact: _____ Phone: _____

Referred to our office by: _____

Previous Chiropractor: _____ City: _____

When was the last visit to this chiropractor: _____

Reason for leaving: _____

I understand and agree that all services rendered for the above patient are charged directly to me and that I am personally responsible for payment.

Signature: _____ Date: _____

FLOW CHIROPRACTIC

What are your health objectives or goals: _____

_____

Your main complaints: _____

How long have you suffered with this problem? _____

What have you tried to get rid of this problem that DID NOT work? _____

_____

Have you become discouraged about handling this problem? _____

When the problem is at its worst, how does it make you feel? _____

_____

How does this problem affect the following areas of life?

Work: _____

Family: _____

Hobbies: _____

Life: _____

Does handling this problem cause stress for you? _____

What do you do that makes the problem worse? _____

How much older does this problem make you feel? _____

Are you healthier today than you were 5 years ago? _____

If so, what did you do to improve your health? _____

_____

Have you experienced any extremely stressful life events (divorce, serious illness, loss of a loved one, etc.) and if so, when? _____

_____

Our goal with our new patient procedure is to determine the underlying, root cause of your health issue(s). Once we figure out the cause, we will recommend a course of care aimed at correcting the problem.

On a scale of 1-10, with 10 being the highest, rate your commitment in helping us help you achieve optimal wellness: _____

Do you take any vitamins / supplements?

Supplement	Dosage and Frequency (ie: 100mg, 1x/day)

Are you on any type of medication? Please list all medication (including regularly used over the counter medication.)

Medication Name	Dosage and Frequency (ie: 5mg, 1x/day)

Do you have any medication allergies?

Medication	Reaction	Onset Date	Additional Comments

Standard Authorization of Use and Disclosure of Protected Health Information

The information covered by this authorization includes Appointments, Account and Billing Information, Personal Health Information, and Care Recommendations. I authorize Flow Chiropractic to give my information to the following people:

Primary Care Doctor:		Ob / Midwife:	
Pediatrician:		Doula:	
Pt or OT:		Lactation Consultant:	
Dentist:		CST / Massage:	
Body Worker:		Other:	

I acknowledge that I have been informed and given the opportunity to review the Notice of Privacy Practices for Flow Chiropractic. I also acknowledge that I have been given the option to receive a copy of this Notice.

Signature: _____ Date: _____

Past Medical History and Review of Systems

Review of Systems

Heart Attack……	No	Yes	Emphysema…….	No	Yes	Asthma……..	No	Yes
Heart Failure……...	No	Yes	Coughing Up Blood	No	Yes	Unplanned Weight Loss.	No	Yes
Heart Disease…….	No	Yes	Tuberculosis……	No	Yes	Enlarged Lymph Nodes..	No	Yes
Osteoporosis……..	No	Yes	Pneumonia……..	No	Yes	Celiac / Crohn's / Colitis.	No	Yes
Multiple Sclerosis…...	No	Yes	Severe Heart Burn.	No	Yes	Anesthesia Problems…..	No	Yes
Parkinson's…….	No	Yes	Hiatal Hernia……	No	Yes	Depression / Anxiety…...	No	Yes
High Blood Pressure.	No	Yes	Stomach Ulcers…..	No	Yes	Auto-Immune Disorders.	No	Yes
Poor Circulation…….	No	Yes	Hepatitis……..	No	Yes	Eye Disorders……..	No	Yes
High Cholesterol……	No	Yes	Jaundice……..	No	Yes	Hearing Loss……	No	Yes
Stroke……..	No	Yes	Kidney Infection…..	No	Yes	Menstrual Problems……	No	Yes
Paralysis……..	No	Yes	Irritable Bowel…….	No	Yes	Prostate Problems……..	No	Yes
Severe Headaches…	No	Yes	Thyroid Problems…	No	Yes	Pacemaker……	No	Yes
Seizures……..	No	Yes	Diabetes……...	No	Yes	Urinary Problems…….	No	Yes
Blackout Spells……..	No	Yes	Arthritis / Joint Pain	No	Yes	Cancer _____		
Head Injury…….	No	Yes	Skin Disorders…….	No	Yes	Other _____		
Meningitis……	No	Yes	Acid Reflux……..	No	Yes	Other _____		

Past History

Please list any other medical problems not listed above:

_____

_____

_____

Please list any previous **Surgeries:**

_____

_____

_____

Allergies

Are you allergic to (circle):

Wheat / Gluten	Lotions
Dairy	Laundry Detergent
Essential Oils	Medicine / Vitamins: _____
Latex	Other: _____

Health Choices

- Do you SMOKE / use tobacco? Daily Weekly Occasionally Never
- Do you drink ALCOHOL? Daily Weekly Occasionally Never
- Do you drink COFFEE / CAFFEINE? Daily Weekly Occasionally Never
- Do you drink SODA? Daily Weekly Occasionally Never
- Do you eat FAST FOOD? Daily Weekly Occasionally Never
- Do you eat SUGAR Daily Weekly Occasionally Never
- Do you EXERCISE? Daily Weekly Occasionally Never
- WORK Activity: Sitting Standing Light Labor Heavy Labor
- Daily ENERGY Level: Low Moderate High
- Cups of WATER per day: 0 1 2 3 4 5 6 7 8 9
- Do you eat FRUIT? Daily Weekly Occasionally Never
- Do you eat VEGGIES? Daily Weekly Occasionally Never
- Stress Level: Low Moderate High
- Do you sleep well? N Y I sleep on: Back Side Stomach How many hours? _____

Goals For Your Care

People see chiropractors for a variety of reasons, and our office offers different types of care. Please select the type of care that you are looking for as you begin your health journey with us.

___ Crisis Care / Symptom-based Care: Short-term, symptomatic relief of pain or discomfort

___ Corrective Care: Correct the underlying cause of your health problems, including symptom relief

___ Wellness Care: Once you are truly well, maintain the highest state of health possible

___ *I want the doctor to select the type of care appropriate for my condition.*

Family Health History

Circle those involving family members: M=Mother F=Father S=Sibling G=Grandparent			
Cancer, Type: _____ M / F / S / G	Depression M / F / S / G	Diabetes M / F / S / G	Back Problems M / F / S / G
Heart Disease M / F / S / G	Liver Disease M / F / S / G	High Blood Pressure M / F / S / G	High Cholesterol M / F / S / G
Lung Problems M / F / S / G	Scoliosis M / F / S / G	Neck Problems M / F / S / G	Osteoporosis M / F / S / G
Seizures M / F / S / G	Osteoarthritis M / F / S / G	Rheumatoid Arthritis M / F / S / G	Other: _____ M / F / S / G