Family First Chiropractic Intake Form

Date_____/_____/_____

Name_____Referred By_____

Address_____City_____State____Zip_____

Date of Birth_____/_____/_____Age_____Gender_____Marital Status_____

Home Phone_____Cell_____Work_____

Spouse's Name_____Number of Children_____

Occupation_____Social Security #_____-_____-_____

E-mail _____Check yes to receive our monthly newsletter: yes □ no □

Health Survey

Please draw a "O" for previously experiencing or a "✓" for currently experiencing

Musculoskeletal:
- ❑ Headaches
- ❑ Jaw pain
- ❑ Neck stiff
- ❑ Neck pain
- ❑ Pins and needles in arms
- ❑ Numbness in arms/hand
- ❑ Cold hands
- ❑ Mid-back pain
- ❑ Low-back pain
- ❑ Pins and needles in legs
- ❑ Cold feet
- ❑ Numbness in legs/feet
- ❑ Ankle swelling
- ❑ Paralysis
- ❑ Cold extremities
- ❑ Lights bother eyes
- ❑ Cold sweats

Visceral:
- ❑ Allergies
- ❑ Chest pain
- ❑ Heart conditions
- ❑ High blood pressure
- ❑ Asthma
- ❑ Difficulty breathing
- ❑ Lung problems
- ❑ Acid reflux/heartburn
- ❑ Loss of appetite
- ❑ Excessive appetite
- ❑ Weight loss
- ❑ Diarrhea
- ❑ Stomach upset
- ❑ Ulcers
- ❑ Colitis
- ❑ Irritable bowel
- ❑ Diabetes
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Constipation
- ❑ Prostate problems
- ❑ Hemorrhoids
- ❑ Fever
- ❑ Problem urinating
- ❑ Excessive thirst

Special Senses:
- ❑ Blurred vision
- ❑ Ringing in ears
- ❑ Loss of balance
- ❑ Dizziness
- ❑ Fainting
- ❑ Loss of hearing
- ❑ Loss of taste
- ❑ Loss of smell

Other:
- ❑ Sleeping problems
- ❑ Mood swings
- ❑ Confusion
- ❑ Tension
- ❑ Depression
- ❑ Irritability
- ❑ Nervousness
- ❑ Loss of sleep
- ❑ Low energy
- ❑ ADD/ADHD
- ❑ Ear infections

Female:
- ❑ Pregnancy
- ❑ Menstrual pain
- ❑ Menstrual irregularity
- ❑ Hot flashes

Please Fill in the Appropriate Spaces

Major Complaint_____

_____

- ➢How long have you had this problem?_____
- ➢Have you lost work days? □Yes □ No How many days?_____
- ➢Have you had a similar problem before? □*Yes* □ *No* When?_____
- ➢Was the injury related to a work accident? □*Yes* □ *No* Auto Accident? □*Yes* □ *No*
- ➢When did you last see a chiropractor?_____Dr._____
- ➢Why did you see this chiropractor?_____Were you helped?_____
- ➢What spinal maintenance programs were you given to maximize stability of your spine?_____
- ➢Did you follow it?_____If not why?_____
- ➢Why are you changing chiropractors?_____

What surgeries have you had?_____
List any drugs that you are currently taking (prescription or over the counter)?_____

_____

_____

What is your health philosophy? (What should you do to be healthy?)_____

_____

_____

How do you want us to handle your problem? Please "✓"

___Temporary Relief (Help the symptom but do not correct the cause of the problem)

___Maximum Correction (Correct the cause of the problem for maximum stability in the future)

If the cause of your problem was corrected, how would it change your life?_____

_____

_____

What are your favorite hobbies or activities?_____

Are your current problems affecting these activities or hobbies?_____

What activities are you looking forward to doing in the future?_____

On a scale of 1-10 (1 being the least and 10 being the most)

_____How committed are you to being at your maximum health potential?

_____How important is it for your family to be at their maximum health potential?

The 4 Essentials of Life

1. It is essential to maintain a well balanced diet for optimal health. Rate your current diet.
   Poor *Average* *Good*

2. Proper hydration is essential for optimal health. What is your main source of fluid intake?
   (i.e. Tap water, Bottled water, Juice, Coffee, Soda, etc…)

_____

3. Proper oxygenation of tissues is essential for optimal health.
   Do you smoke? □*Yes* □ *No*
   Rate you exercise routine. *Poor* *Average* *Good*

4. Your nervous system controls every function in your body. Proper nerve function is essential for life as well as optimal health. Are you currently doing anything to maximize your nervous system function? □*Yes* □ *No* If Yes, what?

_____

_____

The statements made on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation.

Signature_____ Date_____/_____/_____