Adult Intake Form

ALIGN
HEALTH & WELLNESS

Name: First _____ MI_____ Last_____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell: _____ Cellular Provider:_____Work:_____
E-Mail Address: _____
Preferred form of contact: ❑ Email ❑ Text ❑ Call
DOB: _____ Marital Status: M W D S Spouse's Name: _____
Children's Name(s) & Age(s): _____
Occupation: _____ Employer: _____
Most patients are referred to our office by a caring family member or friend. Who may we thank for referring you to our office? _____
Research shows that a spine should be checked regularly. Have you seen a chiropractor in the past? Yes / No
Date of Last Visit: _____ Location: _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO ALIGN

Briefly describe the main problem that has brought you to our office: _____
_____
_____
Since the problem started, is it: ❑ About the same ❑ Getting better ❑ Getting worse
What makes it worse? _____
Does it interfere with: ❑ Work ❑ Sleep ❑ Walking ❑ Sitting ❑ Hobbies ❑ Leisure
When did your problem first appear? _____ Have you experienced this in the past? Yes / No
Has anyone in your family experienced similar problems? Yes / No. If so, who? _____
Doctors seen for this problem: Chiropractor: Yes / No Medical Doctor: Yes / No Other: _____
Do you suffer from any condition other than that which you are now consulting us? Yes / No
Please explain: _____

BODY SIGNALS

Please check ALL symptoms you are currently suffering from or have struggled with in the past:

❑ Headaches	❑ Anxiety	❑ Fainting	❑ Neck pain
❑ Poor posture	❑ Heartburn	❑ Back pain	❑ Loss of balance
❑ Dizziness	❑ Mood swings	❑ Ringing in the ears	❑ Nervousness
❑ Numbness in fingers	❑ Numbness in toes	❑ Menstrual irregularity/pain	❑ Upset stomach
❑ Fatigue	❑ Depression	❑ Irritability	❑ Tension
❑ Sleeping problems	❑ Neck stiffness	❑ Cold hands	❑ Lack of mobility
❑ Tight neck & shoulders	❑ Constipation	❑ Ulcers	❑ Hot flashes
❑ Cold sweats	❑ Trouble sleeping	❑ Problem urinating	

Stress can cause or accelerate spinal damage. Rate your stress level over the past 90 days (circle):
Low – 1 2 3 4 5 6 7 8 9 10 – High
Poor posture leads to poor health and often indicates a spinal condition. How would you rate your posture?
Poor – 1 2 3 4 5 6 7 8 9 10 – Excellent
Prescription medications may cause various side effects, hide the severity of health conditions and/or hinder the body's ability to heal. What medications are you currently taking? _____
_____
_____

FAMILY HISTORY (Indicate if mom (M), dad (D) or both (B) have or had the following)

___ High blood pressure	___ Heart attack	___ Emphysema	___ Asthma
___ Diabetes	___ Kidney disease	___ Mental illness	___ Cancer
___ HIV positive	___ Thyroid disease	___ Circulation problem	___ Ulcer/digestive issues
___ Arthritis/rheumatoid	___ Seizures/convulsions	___ Stroke (Indicate age at 1st stroke: M ___ F ___)	

ACTIVITIES OF DAILY LIVING

Check each of the activities which you have difficulty performing or causes pain when performing...

General:	❑ Walking	❑ Standing	❑ Running	❑ Sitting
	❑ Lifting children	❑ Bending	❑ Climbing stairs	❑ Reading
	❑ Laying in bed	❑ Chewing	❑ Swimming	❑ Getting in/out of car
	❑ Playing piano	❑ Using computer	❑ Kneeling	❑ Sexual intercourse
	❑ Sports: _____	❑ Sleeping	❑ Using telephone	❑ Other: _____
House/Yard Work:	❑ Laundry	❑ Making beds	❑ Vacuuming	❑ Doing dishes
	❑ Cooking	❑ Carrying groceries	❑ Caring for pets	❑ Shoveling snow
	❑ Mowing lawn	❑ Raking leaves	❑ Gardening	❑ Other: _____
Personal Grooming:	❑ Combing hair	❑ Shaving	❑ In/out bathtub	❑ Brush teeth
	❑ Dressing yourself	❑ Other: _____		
Travel:	❑ Driving	❑ Riding (Passenger), minutes per day spent in ___Car ___ Bus or Other: _____		

REVIEW OF SYMPTOMS (Check ones that you have now or have had in the past)

Now / Past	Now / Past	Now / Past
❑ ❑ Incoordination	❑ ❑ Weight gain	❑ ❑ Weight loss
❑ ❑ Weak grip	❑ ❑ Heat intolerance	❑ ❑ Cold intolerance
❑ ❑ Seizures	❑ ❑ Insecurity	❑ ❑ Depression
❑ ❑ Troubled sleep	❑ ❑ Irritable	❑ ❑ Undecidedness
❑ ❑ Timid	❑ ❑ Vertigo	❑ ❑ Loss of sensation
❑ ❑ Suicidal thoughts	❑ ❑ Extreme worry	❑ ❑ Sexual problems
❑ ❑ Muscle pain	❑ ❑ Muscle weakness	❑ ❑ Muscle cramps
❑ ❑ Muscle twitching	❑ ❑ Joint stiffness	❑ ❑ Joint pain
❑ ❑ Loss of memory	❑ ❑ Concussion(s)	❑ ❑ Infertility

PAST MEDICAL HISTORY (Check ones that you have had in the past)

❑ Hay fever	❑ Mumps	❑ Rheumatic fever	❑ Allergies	❑ Sexual problems
❑ Cancer	❑ Tumor	❑ Blood disease	❑ Leukemia	❑ Heart trouble
❑ Depression	❑ Phlebitis	❑ Hypertension	❑ Stroke	❑ Mental illness
❑ Jaundice	❑ Polio	❑ Skin trouble	❑ Gallstones	❑ Liver trouble
❑ Hepatitis	❑ Parasites	❑ Epilepsy	❑ Paralysis	❑ Prostate problem
❑ Alcoholism	❑ Dysentery	❑ Varicose veins	❑ Diabetes	❑ Gout
❑ Syphilis	❑ Migraine	❑ Hemorrhoids	❑ Nervous breakdown	❑ Gonorrhea
❑ Ulcers	❑ Angina	❑ Bladder trouble	❑ Kidney stones	❑ Kidney infections
❑ Other_____				

THE REAL REASON I AM HERE

My lack of optimal health and wellness affects: ❑ My work ❑ My leisure ❑ My family ❑ My life

I have been living this way for: ❑ Weeks ❑ Months ❑ Years

The positive things that will be added to my life when I regain optimal health and wellness are:

_____

The greatest asset in my life is: _____

Print Name:_____

Signature:_____ Date:_____