Lifestyle & Health Intake Form

Name:______________________ Age:_____ City:_______________ Referred by:____________________ # of children:_____

The Purpose or reason for this appointment?____

Has this issue altered your Quality of Life?____________________How long have you had this issue?_____________________

Have you had Chiropractic ever?___________Who?________________________When was the last time?___________________

When was your last physical exam?___________Who is your primary care physician?___________________________________

Surgery History?____If so, when?_______________Any scars?_

Is this issue related to an auto or work accident?____

Occupation?____Do you work in front of a computer most days? ________

How is your typical diet/Food?_____________________Pop?___________Alcohol?______Coffee?_______Cigarettes?_______

How much pure water?____________Exercise?___________How often?____________Hours of Sleep?______

Are you happy with your overall health?_______Do you put much thought into your health/diet?____Do you eat breakfast?____

Do you crave certain foods?_______/What?___________________How much time do you commit to you and your health and mental well-being daily?___________ How long has it been since you really felt good?_______________

What your stress level? 1 (low)- 10 (maxed out)?_________ What is your main source of stress?_________________________

Medications List: Please name your prescription or over-the-counter medications/ vitamins:____
____
____

Conditions: Please circle any of the following symptoms which you now have or have had in the past.

Allergies
Anger/ rage problems
Anxiety
Arthritis
Bedwetting
Bladder control
Bloating or gas
Brain fog
Cancer
Chest pain
Cholesterol problems
Chronic cough
Constipation
Cramps/ muscle spasms
Depression
Diabetes
Dizziness
Ear problems
Eye conditions
Fatigue/ low energy levels
Gall bladder problems
Gastro-intestinal problems
Headaches
Heart problems
High/low blood pressure
Hormonal problems
Infertility
Kidney infections
Kidney stones
Knee pain
Low back pain
Lung conditions
Menopausal problems
Mid back pain
Neck pain
Numbness
Pacemaker
Prostate problems
Shoulder pain
Sinus infection
Skin conditions/ rashes
Sleeping difficulties
Stroke
Sweaty palms/ feet
Thyroid issues
Weight gain/loss
Yeast issues

In what ways are you wanting us to help you and your health concerns?____

Is there a **specific treatment** that you know you are looking for?_________ If so what?________________________________