RĀDIX
— CHIROPRACTIC —

ADULT INTAKE FORM

PERSONAL INFORMATION

Today's Date_____
Name: (*First MI Last*) _____ **Preferred Name**:_____
Address: _____ **City**: _____ **State**: _____ **Zip**: _____
Phone: **Cell**_____ **Home**_____ **Work**_____
Text Reminders ❑Y ❑N **Before Visit:** ❑ 1 Hr ❑ 4 Hrs ❑ 1 Day **Cell Provider:**_____
Email:_____ **Gender**: ❑M ❑F **Marital Status**: ❑S ❑M ❑D ❑W
Social Security #:_____ **Date of Birth**:_____ **Age**:_____
Occupation: _____ **Employer**: _____
Spouse Name: _____ **Number of Children**: _____
Have you received chiropractic care before: ❑Y ❑N **When:** _____**Where:**_____
Referred By: (*Name*)_____ Family / Friend / Co-Worker / Internet / Other Source

EMERGENCY CONTACT

Name: (*First MI Last*) _____ **Contact #**: _____ **Relationship**: _____
Primary Care Physician: _____ **Contact #:**_____

FINANCIAL INFORMATION / RESPONSIBLE PARTY

❑Insurance ❑Time-of-Service (*Cash*) ❑Personal Injury/Auto ❑Worker's Comp ❑Other_____
Primary Insurance Name: _____ **Relationship to Insured**: Self / Spouse / Parent / Child
If Other than Self: **Insured Name**: _____ **Date of Birth**: (MM/DD/YYYY) _____
I Have Medicare:_____ The Reason for this Visit is from a Recent Auto Accident:_____

REASON FOR SEEKING CARE

Describe Major Complaint: _____
Describe any Secondary Complaints: _____
Describe WHEN and HOW this began: _____
_____
Severity of Complaint: ❑None (0) ❑Mild (1-2) ❑Mild-Mod (2-4) ❑Moderate (4-6) ❑Mod-Severe (6-8) ❑Severe (8-10)

Quality of the Complaint/Pain: ❑Sharp ❑Stabbing ❑Burning ❑Achy ❑Dull ❑Stiff & Sore ❑Other_____

Frequency of Complaint: ❑Intermittent ❑Constant **Condition Worse in the:** ❑Morning ❑Mid-day ❑Evening

Does this complaint radiate/shoot to any areas of your body? ❑No ❑Yes (*Describe*) _____

Does anything make the complaint better? ❑Ice ❑Heat ❑Rest ❑Movement ❑Stretching ❑Other_____

Does anything make the complaint worse? ❑Sit ❑Stand ❑Walk ❑Lying ❑Sleeping ❑Overuse ❑Other_____

Have you seen any other Doctor(s) for current condition: ❑Yes ❑No

If Yes, describe treatment rendered: _____

Doctor's Comments:

PATIENT SIGNATURE:_____ **DATE:**_____ **DOCTORS INITIALS**_____

HEALTH HISTORY

Medications and Supplements: ❑Yes. List below ❑None

Name	Dosage	Frequency	Method

PAST HEALTH HISTORY

Number of falls in the last 24 months:____ Injuries from fall(s): _____

Surgeries: ❑Yes. List below ❑None

Date	Area of the Body	Reason

Major Injuries / Traumas / Hospitalizations: ❑Yes. List below ❑None

Date	Describe

FAMILY HEALTH HISTORY

List *relevant* major health problems of first-degree relatives: or ❑N/A

Problem	Parent (M or F)	Sibling (B or S)	Child (M or F)

LIFESTYLE AND SOCIAL HISTORY

Lifestyle: Please previous and present lifestyle choices:

Lifestyle	Previously (1+ years ago)	Presently (within past 12 months)	
Hobbies			
Exercise			
Recreation			
Diet			
Work			
Other_____			

Smoking/Tobacco Use: ❑Every Day ❑Some Days ❑Former ❑Never

Habit	Frequency (daily, weekly, monthly, occasionally, etc.)
Smoking	
Tobacco	
Alcohol	
Caffeine	
Rec. Drugs	
Other_____	

PATIENT SIGNATURE:_____ DATE:_____ DOCTORS INITIALS_____

REVIEW OF SYSTEMS

Check "P" for Past, "C" for Current – if past and current, check both boxes.
If it does not apply, please check *None in this Category*.

General: *(constitutional)*
❑P ❑C Recent Weight Change
❑P ❑C Fever
❑P ❑C Fatigue
❑P ❑C *None in this Category*

Musculoskeletal
❑P ❑C Low Back Pain
❑P ❑C Mid Back Pain
❑P ❑C Neck Pain
❑P ❑C Arm Problems_____
❑P ❑C Leg Problems_____
❑P ❑C Painful Joins
❑P ❑C Stiff/Swollen Joints
❑P ❑C Sore/Weak Muscle/Joints
❑P ❑C Muscle Spasms/Cramps
❑P ❑C Broken Bones_____
❑P ❑C Other:_____
❑P ❑C *None in this Category*

Neurological
❑P ❑C Numbness/Tingling
❑P ❑C Loss of Feeling
❑P ❑C Dizziness/light headed
❑P ❑C Frequent/Recurrent Headaches
❑P ❑C Convulsions/seizures
❑P ❑C Tremors
❑P ❑C Stroke
❑P ❑C Other:_____
❑P ❑C *None in this Category*

Mind/Stress
❑P ❑C Nervousness
❑P ❑C Depression
❑P ❑C Sleep Problems
❑P ❑C Memory loss/Confusion
❑P ❑C Other:_____
❑P ❑C *None in this Category*

Genitourinary
❑P ❑C Sexual Difficulty
❑P ❑C Kidney Stones
❑P ❑C Burning/Painful Urination
❑P ❑C Frequent Urination
❑P ❑C Incontinence or Bed Wetting
❑P ❑C Other:_____
❑P ❑C *None in this Category*

Gastrointestinal
❑P ❑C Loss of Appetite
❑P ❑C Blood in stool
❑P ❑C Change in bowel movements
❑P ❑C Nausea or Vomiting
❑P ❑C Abdominal pain
❑P ❑C Frequent diarrhea
❑P ❑C Constipation
❑P ❑C Other:_____
❑P ❑C *None in this Category*

Cardiovascular & Heart
❑P ❑C Chest Pains
❑P ❑C Rapid or heartbeat changes
❑P ❑C Blood Pressure Problems
❑P ❑C Swelling of hands, ankles, or feet
❑P ❑C Heart problems
❑P ❑C Other:_____
❑P ❑C *None in this Category*

Respiratory
❑P ❑C Difficulty breathing
❑P ❑C Persistent Cough
❑P ❑C Coughing blood
❑P ❑C Asthma or Wheezing
❑P ❑C Lung problems
❑P ❑C Other:_____
❑P ❑C *None in this Category*

Eyes & Vision
❑P ❑C Wear contacts/glasses
❑P ❑C Blurred/Double vision
❑P ❑C Glaucoma
❑P ❑C Eye disease or injury
❑P ❑C Other:_____
❑P ❑C *None in this Category*

Ears, Nose, & Throat
❑P ❑C Bleeding gums
❑P ❑C Bad breath or bad taste
❑P ❑C Dental problems
❑P ❑C Swollen throat or voice change
❑P ❑C Swollen glands in neck
❑P ❑C Ringing in ears
*Continued on top of next column

❑P ❑C Ear – ache or drainage
❑P ❑C Sinus/Allergy problems
❑P ❑C Nose Bleeds
❑P ❑C Hearing problems
❑P ❑C Other:_____
❑P ❑C *None in this Category*

Endocrine, Hematologic, & Lymphatic
❑P ❑C Thyroid problems
❑P ❑C Diabetes
❑P ❑C Excessive thirst or Urination
❑P ❑C Cold extremities
❑P ❑C Heat or Cold intolerance
❑P ❑C Dry skin
❑P ❑C Glandular or hormone problem
❑P ❑C Swollen glands
❑P ❑C Anemia
❑P ❑C Easily bruise/bleed
❑P ❑C Immune system disorder
❑P ❑C Other:_____
❑P ❑C *None in this Category*

Skin & Breasts
❑P ❑C Rash or Itching
❑P ❑C Change in skin color
❑P ❑C Change in hair/nails
❑P ❑C Non-healing sores
❑P ❑C Breast Pain
❑P ❑C Breast Lump
❑P ❑C Breast Discharge
❑P ❑C Other:_____
❑P ❑C *None in this Category*

Women Only:
❑P ❑C Pregnancy
❑P ❑C Infertility
❑P ❑C Painful or Irregular periods
❑P ❑C Vaginal Discharge
❑P ❑C Other:_____
❑P ❑C *None in this Category*

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care in accordance with this state's statues.

PATIENT OR GUARDIAN SIGNATURE_____**DATE**_____

Doctor Signature_____**Date**_____ **Initials**_____