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**Practice Member Information** \_\_\_\_\_

File \_\_\_\_\_

Name: \_\_\_\_\_  
 Appointment Date M \_\_\_\_\_ D \_\_\_\_\_ 20 \_\_\_\_\_ Birth Date M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ May we leave a message? Yes No  
 Cell Phone: \_\_\_\_\_ May we leave a message? Yes No  
 Work Phone: \_\_\_\_\_ May we leave a message? Yes No  
 Email: \_\_\_\_\_  
 May we add you to our email newsletter and calendar of events? Yes No (Your email will not be shared)  
 Spouse's name? \_\_\_\_\_  
 Name(s) and age(s) of children: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Do you primarily: Sit Stand Perform repetitive tasks  
 How did you hear about us? \_\_\_\_\_

**Healthcare History**

Have you had previous chiropractic care? No Yes  
 Who was your previous Chiropractor? \_\_\_\_\_  
 Where? \_\_\_\_\_ When? \_\_\_\_\_  
 Were X-rays taken in the last 6 months? Yes No  
 What was the primary reason for consulting that office?  
 Relief Care - Symptom relief of pain or discomfort  
 Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues  
 Wellness Care - Maximizing the body's ability for optimal healing and function  
 Do you feel your previous chiropractic care was effective? No Yes  
 Please explain: \_\_\_\_\_  
 Are you wearing: Heel Lifts Custom Orthotics  
 Family Doctor: \_\_\_\_\_  
 Date and reason of last visit: \_\_\_\_\_  
 May we contact your family doctor regarding your care at our office if necessary? No Yes  
 Naturopathic Doctor: \_\_\_\_\_  
 Date and reason of last visit: \_\_\_\_\_  
**Other Specialists and healthcare professionals:**  
 Name: \_\_\_\_\_  
 Professional Designation: \_\_\_\_\_  
 Date and reason of last visit: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Professional Designation: \_\_\_\_\_  
 Date and reason of last visit: \_\_\_\_\_



## Pregnancy Profile

How far along in your pregnancy are you? \_\_\_\_\_ When is your baby's due date? D \_\_\_\_ M \_\_\_\_ Y \_\_\_\_

Have you taken any medications during this pregnancy? No Yes:

OTC and Reason: \_\_\_\_\_

Prescription and Reason: \_\_\_\_\_

Vaccines and Reason: \_\_\_\_\_

Have you experienced any physical trauma during this pregnancy? No Yes \_\_\_\_\_

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? No Yes

Dates and Reasons: \_\_\_\_\_

\_\_\_\_\_

Have there been any stressful events in your life during this pregnancy? No Yes \_\_\_\_\_

\_\_\_\_\_

What type of birth care provider are you planning on using? Midwife OB/Gyn Medical Doctor Other

Where do you plan on delivering? \_\_\_\_\_

Is this your first pregnancy? Yes No:

If not, how many pregnancies previously? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Miscarriages? No Yes: D&C Natural Miscarriage

How many vaginal deliveries? \_\_\_\_\_

How many caesarean sections? \_\_\_\_\_

Have there been any complications during your previous deliveries? No Yes \_\_\_\_\_

Was labor induced/use of Pitocin? No Yes Unknown

Did your care provider rupture your membranes? No Yes Unknown

Was there any back or hip pain during labor? No Yes

Was baby in a suboptimal position during the pushing phase of any labor? No Yes Unknown

Did you receive an epidural? No Yes

Were there any operative devices used? No Yes Forceps Vacuum

Any postpartum complications or long term consequences? No Yes \_\_\_\_\_

### Have you experienced any of the following symptoms during this pregnancy or a previous pregnancy?

CURRENT  
PREVIOUS

Headaches  
Facial Paralysis  
Chronic Fatigue  
Nausea/"Morning Sickness"  
Heartburn/Indigestion  
Preeclampsia  
Gestational Diabetes  
Constipation  
Hemorrhoids

CURRENT  
PREVIOUS

Carpal Tunnel (numbness in hands/fingers)  
Low/Mid Back Pain  
Breech or Sidelying Presentation  
Round Ligament Pain/Pulling (front of belly)  
Pain in your Pubic Bone  
Pins/Needles in the Front/Side of your Leg  
Pain in Posterior Leg (Sciatica)  
Leg Cramps  
Swelling of Ankles, Legs and Feet



## Wellness Profile

Do you have a specific concern that brings you in?

No, I'm interested in having my spinal and pelvic alignment assessed to help achieve optimal growth and delivery for my baby

Yes: \_\_\_\_\_

**If yes, please answer the following questions:**

What is your primary area of complaint today? \_\_\_\_\_

How long have you been aware of this? \_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

Where else does this pain go in your body? \_\_\_\_\_

How often do you experience this? daily weekly monthly comes and goes constantly

On a scale of 1 to 10 (10 being the worst), how does it feel when it's at its worst? \_\_\_\_\_

How would you describe the pain/discomfort?

Dull Achy Throbbing Stabbing Tight/Stiff Burning Sharp Other \_\_\_\_\_

What makes it feel worse? \_\_\_\_\_

What makes it feel better? \_\_\_\_\_

Do you notice any other problems in your body when you get this pain/discomfort? \_\_\_\_\_

Do you feel your condition getting progressively worse? No Yes

Do you feel your condition can be healed? No Yes

What have you tried that **has** helped? Ice Heat Medication Massage Physical Therapy Chiropractic

Other \_\_\_\_\_

What have you tried that **hasn't** helped? Ice Heat Medication Massage Physical Therapy Chiropractic

Other \_\_\_\_\_

See additional **Spinal Nerve Function Form** to provide further detail on your *Wellness Profile (Page 6)*

## Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called a **Vertebral Subluxation**. The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

## Physical

Height \_\_\_\_\_ Weight \_\_\_\_\_

Are you happy with your current physical appearance and abilities? Yes No

Frequency of exercise/week: Cardio? . . . . 0 1 2 3 4 5 6 7

Weight bearing? . 0 1 2 3 4 5 6 7

Do you stretch after exercise or after other activities of poor posture? Yes Sometimes No

Hours of sleep/night? <6 7-9 10+

Do you feel refreshed upon waking? Always Sometimes Rarely

Age of mattress? \_\_\_\_\_ Do you feel your mattress is appropriate for your sleeping style? No Yes

Which position do you sleep? Back Belly Side: Right Left Both

Number of hours spent commuting/week? 0-2 3-5 6-8 9-11 12+

Number of hours spent at a desk or computer/week? 0 1-5 6-10 11-20 21-40 41+

Number of hours spent on smart device/tablet/week? 0 1-5 6-10 11-20 21-40 41+

Do you perform any repetitive tasks at home or at work? No Yes

Have you ever been hospitalized or had surgery? No Yes If yes why and when? \_\_\_\_\_

Have you ever been in a motor vehicle accident (even if it was minor)? No Yes

If yes, what kind and when? \_\_\_\_\_

Were you evaluated and treated after each accident? No Yes

Have you had any non-vehicle accidents or falls? No Yes \_\_\_\_\_



## Early Years

To your knowledge, was your delivery difficult? No Yes  
 If yes: Forceps Vacuum Caesarean Breech Other \_\_\_\_\_  
 Were you breast fed? No Yes For how long? \_\_\_\_\_  
 Did you experience emotional trauma as a child? No Yes \_\_\_\_\_  
 Were you ever given antibiotics as a child? No Yes \_\_\_\_\_  
 Did you ever have ear infections as a child? No Yes \_\_\_\_\_  
 Any major childhood illness? No Yes \_\_\_\_\_

## Emotional

Rate your current level of **personal stress** in your life: . . . . . None Low Moderate High  
 Rate your current level of **relationship stress** in your life: . . . . . None Low Moderate High  
 Rate your current level of **financial stress** in your life: . . . . . None Low Moderate High  
 Rate your current level of **health stress** in your life: . . . . . None Low Moderate High  
 Rate your current level of **family stress** in your life: . . . . . None Low Moderate High  
 Rate your current level of **career stress** in your life: . . . . . None Low Moderate High  
 Do you feel you have a supportive network of friends and family? . . . Yes No  
 Do you feel you have healthy coping strategies for life stress? . . . . . Yes No

## Chemical

Were you vaccinated as a child? . . . . . No Yes  
 Any adverse reactions to vaccines? . . . . . No Yes \_\_\_\_\_  
 Do you choose to have annual flu shots? . . . . . No Yes  
 Do you take antibiotics? . . . . . No Yes, How often? \_\_\_\_\_  
 How many glasses of water/day: . . . . . 0 1-3 4-6 7-9 10+  
 How many glasses of caffeinated beverages/day: . . . . . 0 1-3 4-6 7-9 10+  
 How many glasses of cow's milk, juice and pop/day: . . . . . 0 1-3 4-6 7-9 10+  
 Do you eat gluten? . . . . . No Yes Trying to eliminate from diet  
 Do you eat dairy? . . . . . No Yes Trying to eliminate from diet  
 Do you eat refined sugars? (white sugar, white bread and pasta) . . . . . No Yes Trying to eliminate from diet  
 Do you eat boxed/frozen foods? . . . . . No Yes Trying to eliminate from diet  
 Do you choose organic foods? . . . . . No Yes, which: Veggies Fruits Meats Grains All  
 Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) . . . . . No Yes  
 Any food/drink allergies, sensitivities, intolerances? . . . . . No Yes \_\_\_\_\_  
 Do you smoke? . . . . . No Yes I used to for\_\_ years I wish I didn't  
 Are you or have you been exposed to second hand smoke? . . . . . No Yes  
 Do you drink alcohol? . . . . . No Yes 0-6/week 6-12/week 12+/week  
 Do you take a probiotic daily? . . . . . No Yes, \_\_\_\_\_ CFU's/day  
 Do you take vitamin D3 daily? . . . . . No Yes, \_\_\_\_\_ IU's/day  
 Do you take Omega 3 Fish Oils daily? . . . . . No Yes, \_\_\_\_\_ mg/day Capsule Liquid  
 Other supplements or homeopathics? \_\_\_\_\_  
 Any other daily medication and their purpose? \_\_\_\_\_

Do you have a plan in place with your medical doctor to wean yourself off of any long term medications? No Yes



## Family Health

At our clinic we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children: \_\_\_\_\_

Spouse: \_\_\_\_\_

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brothers/Sisters: \_\_\_\_\_

Are you seeking chiropractic care today for:

Relief Care - Symptom relief of pain or discomfort

Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues

Wellness Care - Maximizing the body's ability for optimal healing and function of the nervous system

Pregnancy Care: regular care throughout pregnancy to optimize the growth and development of my baby and prepare my body for a healthy delivery and fast recovery.

Do you have other concerns we should know about? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Goals & Consent

What is your primary goal for consulting our clinic? \_\_\_\_\_

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential to this is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your health through a chiropractic evaluation!

### Consent to Evaluation

I \_\_\_\_\_ hereby grant permission to receive a chiropractic evaluation including history, spinal scan and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

\_\_\_\_\_  
Consenting Adult's Signature

\_\_\_\_\_  
Date

