Modern Health
CHIROPRACTIC & WELLNESS

File # _____

NEW PATIENT INTAKE FORM

Who can we thank for referring you to our clinic? _____

INFORMATION:

Name:	**Age:**	**Date:**
Address:		**City/Postal Code:**
Home Phone No.:	**Work Phone No:**	**Cell Phone:**
Email Address:	**Gender:**	**Date of Birth:**
Occupation:	**Employer Name and Address:**	
Marital Status:	**Name of Spouse:**	
Number of Children:	**Names and Ages:**	
Name of Emergency Contact:	**Number of Emergency Contact:**	
Best Way to Contact You:	**Best Time to Contact You:**	
Do you have insurance coverage? ☐Yes ☐No	**If yes, what is the name of your insurance company?**	
This plan covers _____% of chiropractic services rendered up to $_____ per year.		

PERSONAL INFORMATION:

As a society we are 50th in the world in health care. We take pride in helping people attain their optimum health and wellness. With that being said we need an honest assessment of your current level of health. Please place an "**X**" on the scale below, indicating your current level of health and wellness. Then place a star (*) on the diagram, showing us the desired location of your health and wellness.

Very challenged	Challenged	Transition	Good	Excellent
0-50	50-75	75-100	100-125	125+

YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or concerns right now and you are here for Chiropractic Wellness Services please skip to the "General History" page.

Health Concerns	Severity 1 = mild 10 = worst imaginable	When did this start?	Are symptoms constant or intermittent?	Did the problem begin with an injury?

Since the challenge started, it is: _____Same _____Getting Better ____Getting Worse

When is the problem at its worst? _____AM _____PM _____Mid-day

Does the problem radiate? ____No ____Yes, into: _____

What, if anything makes it feel worse? _____

What, if anything makes it feel better? _____

This interferes with your: ____Work ____Leisure ____Sleep ____Sports ____Other:
_____

It's common for people to have multiple doctors on their health care team. Which doctors have you seen for your challenges? ___Chiropractor ___ Medical ___Other
(Please List):
_____

During the above visits was the cause of your health challenge identified?

___Yes ____No

What was the recommended solution? Did you see results?
_____

GENERAL HISTORY:

Given that prescription medications are in the top 5 leading causes of preventable death in the United States we are interested in knowing what, if any, medications you take and why:

_____

_____

It is becoming more popular for people to take charge of their own health and wellbeing. Supplementation is a major trend in this movement. Please list any supplements or vitamins that you are taking and why:

_____

_____

_____

Have you had any surgeries or hospitalizations? (Please include all surgeries)

_____

_____

_____

Have you ever had any work related injuries?

_____

_____

_____

Slips and falls, although common have a direct impact on your health and wellbeing. Even MINOR falls or accidents cause stress, strain and damage to the spine that take up to 18 months to heal. If you have had any slips, falls or auto accidents (even minor) please list them here with approximate dates:

_____

_____

_____

Since the Nervous System controls everything in your body it is quite likely that your current health challenges are related to the problems you are seeking care for in our office. Please check (✓) the following symptoms you have had, whether CURRENT or PAST:

	Past	Current		Past	Current
Headaches	☐	☐	Epilepsy	☐	☐
Loss of smell	☐	☐	Neck stiff/pain	☐	☐
Loss of taste	☐	☐	Loss balance	☐	☐
Ulcers	☐	☐	Tension	☐	☐
Fatigue	☐	☐	Dizziness	☐	☐
Cold Hands	☐	☐	Irritability	☐	☐
Migraines	☐	☐	Constipation	☐	☐
Diarrhea	☐	☐	Hot flashes	☐	☐
Cold Sweats	☐	☐	Urinary issues	☐	☐
Fainting	☐	☐	Asthma	☐	☐
Low Back pain	☐	☐	Arm tingling	☐	☐
Nervousness	☐	☐	Buzz/ring in ears	☐	☐
Stomach upset	☐	☐	Numbness in fingers	☐	☐
Depression	☐	☐	Numbness in toes	☐	☐
Cold feet	☐	☐	Sleeping problems	☐	☐
Fever	☐	☐	Vision Problems	☐	☐
Menstrual Pain	☐	☐	Menstrual irregularity	☐	☐
Heartburn	☐	☐	Tingling in legs	☐	☐
Mid Back Pain	☐	☐	Allergies	☐	☐
Knee Problems	☐	☐	Sinus Problems	☐	☐
Jaw Pain	☐	☐	Skin Problems	☐	☐
ADD/ ADHD	☐	☐	Prostate Problems	☐	☐
Heart Issues	☐	☐	Liver Problems	☐	☐
Blood Pressure Issues	☐	☐	Gallbladder Issues	☐	☐

If we have not listed current health challenges on the list above please now list additional health concerns in the lines below:

_____

_____

_____

_____

Thanks for providing us with pivotal information that can literally change your life!
On to the next page!

It has been shown that daily lifestyle stress significantly impacts overall health and wellbeing. As a family wellness office we specialize in removing the cause of your health challenges. We also focus on teaching you how to manage the lifestyle stresses that prevent you from realizing your optimum health and wellness.

Please rate the following and circle ALL answers that apply to your habits:
(1 being very poor and 10 being excellent)

Eating habits: _____
a. I eat 3-5x's a day
b. I eat fruits and vegetables daily.
c. I eat out 2-3 times weekly (min)
d. I drink 3-5 sodas weekly
e. I crave sweets.
f. I don't watch what I eat.

Exercise habits:_____
a. I exercise 3-5 times a week.
b. I walk daily.
c. I don't exercise.
d. I want to exercise.
e. I sit at computer 6-8 hours/day

Sleep: _____
a. I sleep 7-9 hours/night
b. I wake up well rested
c. I wake up tired.
d. I toss and turn.
e. I stay up late.

Mind Set: _____
a. I have a positive outlook.
b. I have a negative outlook.
c. I am always in a bad mood.
d. I am always in a good mood.
e. I trap things inside.
f. I share easily.

General Health: ____
a. I am not on medications.
b. I take care of myself.
c. I watch what I eat.
d. I base my health on how everyone around me is doing.
e. I think I am healthy but know I could make some changes.

On a scale of 1-10 describe your psychological/emotional stress levels:
(1= none/ 10=extreme)
Occupational: _____
Personal: _____

You are almost there!

Thanks for providing us with information that helps us to better serve you and help you to be the best you can be!

YOUR GOALS

At our office we pride ourselves in helping you to achieve phenomenal results with your health and wellness. So we can help you achieve your optimum health, it is important that we understand your goals for your overall health and wellbeing.
Please list your goals for your health and wellness in the spaces provided.

Physical Goals	Nutritional/Biochemical Goals	Psychological Goals

If there is a need for dietary changes would you like to know? ☐ Yes ☐ No

If there is a need for specific exercises would you like to know? ☐ Yes ☐ No

If there is a need for support in the psychological, mind-body or stress management dimensions of health would you like assistance? ☐ Yes ☐ No

DO YOU REGULARILY:

Buy bottled water: ☐ Yes ☐ No
Exercise at a health club: ☐ Yes ☐ No
Consume vitamins or supplements ☐ Yes ☐ No
Eat organic foods? ☐ Yes ☐ No
Start a diet program? ☐ Yes ☐ No
Gotten more than 6 massages in a year? ☐ Yes ☐ No
Do a cleanse/detox? ☐ Yes ☐ No
Meditate? ☐ Yes ☐ No
Smoke cigarettes? ☐ Yes ☐ No
Drink Alcohol? ☐ Yes ☐ No
Drink Soda? ☐ Yes ☐ No
Expose yourself to harsh chemicals? ☐ Yes ☐ No
Get the flu shot? ☐ Yes ☐ No

Now we just need your permission to continue through our process!

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature: _____ Date: _____

Present this to our staff so we can begin our journey together!