Adult New Patient In-Take Form

Personal Profile

Name:_____ DOB:_____ Age:___ Male □ Female □

Address:_____ City:_____ Prov:____ PC:_____

Telephone: Home:_____ Work:_____ Cell:_____

Which phone numbers may I leave messages at?_____

E-mail address_____ Status: Single □ Married □ Divorced □

Occupation:_____ Name of employer:_____

Number of Children:____ Names and ages:_____

Have you seen a chiropractor before? Yes □ No□ if yes, who did you see:_____

What techniques were used?_____ Name of Medical doctor:_____

Have you ever seen a wellness chiropractor before? Yes □ No□

How did you hear about me?_____

Current health concern _____

Do you have a current health issue? Please explain_____

When did it first begin?_____

What makes it worse?_____

Have you seen anyone about this?_____

If you have, what was done about it?_____

Did it work?_____

What is your greatest concern; What do you hope I can do for you and how long do you think it will take?

_____

Please describe how your current health issue has affected your life:_____

_____

What would be different about your life if you did not have this issue?_____

_____

We don't want this, but how would it affect your life it got worse?_____

_____

If you got better, how would it affect your life? (ie are there things you would like to do if you were better?)

_____

_____

Your Health Profile

My goal is to first address the issues that brought you here and second, to offer you the opportunity of improved heath, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most of the time the effects are gradual and may not even be felt until they become serious. Answering the following questions will give me a profile of the specific stresses past and present that you face and allow me to better assess the challenges to your health potential.

Please reflect on all the stages in your life and circle as many as apply; **C** for Childhood, **T** for Teenager, **A** for Adult and **N** for Not applicable. If you circle a category other than "N", please take a moment on to provide a brief explanation of your experience.

I.EMOTIONAL STRESSES:		**Explanation:**
Relationships	C T A N	
Career	C T A N	
Children	C T A N	
Money	C T A N	
Fast-Paced Life	C T A N	
Held in Feelings	C T A N	
Quick Temper	C T A N	
Verbal Abuse	C T A N	
Perfectionism	C T A N	
Procrastination	C T A N	
The Sickness or Loss of Loved One	C T A N	

II. CHEMICAL STRESS:		**Explanation:**
Environmental	C T A N	
Smoking or second hand	C T A N	
Poor Diet	C T A N	
Caffeine - Amount?	C T A N	
Excessive Sugar	C T A N	
Alcohol Consumption	C T A N	
Artificial Sweeteners	C T A N	
Prescription Drugs	C T A N	
Over the Counter Drugs	C T A N	
Allergies	C T A N	
Work with chemicals	C T A N	

III. PHYSICAL STRESS **Explanation:**

Birth Traumas(mother or child)	C T A N	
Slips/ Falls	C T A N	
Car accidents	C T A N	
Sports Injuries	C T A N	
Broken Bones	C T A N	
Hospitalizations	C T A N	
Physical Abuse	C T A N	
Work Injuries	C T A N	
Poor Posture	C T A N	
Sitting on your wallet	C T A N	
Sleeping Position/Stomach	C T A N	
Extensive Computer Work	C T A N	
Carrying Heavy Back Pack/Purse	C T A N	
Repetitive Lifting/Bending	C T A N	
Driving For Many Hours	C T A N	
Continuous Sitting/Standing	C T A N	

Please check all symptoms even if it does not apply to what brought you into see me.

☐Headaches	☐Menstrual pain	☐Depression	☐Frequent colds
☐Pins and needles in arms	☐Menstrual irregularity	☐Mood Swings	☐Sinus infection
☐Pins and needles in legs	☐Hot flashes	☐Loss of smell	☐Enlarged glands
☐Numbness in fingers	☐Nervousness / Anxiety	☐Loss of taste	☐Thyroid problems
☐Numbness in toes	☐Irritability	☐Speech problem	☐Cardiovascular issues
☐Dizziness	☐Cold sweats	☐Head injuries	☐Poor circulation
☐Loss of balance	☐Fever	☐Back pain	☐Cold hands / feet
☐Fatigue	☐Fainting	☐Neck pain	☐Respiratory problems
☐Sleeping problems	☐Urinary problems	☐Stiff neck	☐Chronic cough
☐Tension	☐Eyes bothered by light	☐Joint pain	☐Diabetes
☐Ear / Eye pain	☐Blurred / Double vision	☐Swollen joints	☐Stroke
☐Deafness	☐Stomach upset	☐Skin rashes	☐Kidney infection
☐Buzzing / Ringing in ears	☐Heart burn	☐Bruise easily	☐Tenderness in breasts
☐Constipation / Diarrhea	☐Ulcers	☐Asthma	☐Prostate problems

Is there a family history of:

Mother: ☐Arthritis ☐Heart Disease ☐Cancer ☐Diabetes Other_____

Father: ☐Arthritis ☐Heart Disease ☐Cancer ☐Diabetes Other:_____

Please indicate if there are any other family illnesses (sisters, brothers, grandparents)

_____

Your Goals

On a scale of 1 to 10 (1 = none, 10 = extreme), please rate and describe your emotional/psychological/ lifestyle stress levels:

Rating = _____ Occupational stress: _____

Rating = _____ Personal stress: _____

On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and condition as it relates to:

Eating _____ Exercise _____ Sleep _____ Energy Levels _____ General Health _____

Wellness lifestyle _____

To successfully succeed on your healing journey it is important that you have a plan to begin to counter balance the stress in your life. Please list 3 goals you would like to achieve in each category. This will help facilitate your wellness plan.

Wellness Goals

Be Fit. (Physical)	**Eat Right. (Bio Chemical)**	**Think Well. (Psychological)**
1._____	**1.**_____	**1.**_____
2._____	**2.**_____	**2.**_____
3._____	**3.**_____	**3.**_____

I consent to a professional and complete chiropractic examination, and radiographic examination if necessary with Dr. Biljana Durickovic. I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date.

Signature_____ Date:_____