Anchor Family Chiropractic

Adult Intake Form

Patient Information

First Name _____ Last Name _____

Street Address _____

Town/City _____ State _____ Zipcode _____

Home Phone _____ Cell _____

Email _____

Birth Date _____ Age _____ Sex _____

Height _____ Weight _____

How did you hear about our office? _____

Were you referred to this office? YES NO

If, yes by whom? _____

Who is your primary care physician? _____

Date and reason for last doctor visit? _____

Are you also receiving care from any other health professionals? __ Yes __ No

If yes, please name them _____

Current Health Conditions

What health condition(s) bring you into our office?

1. _____
2. _____
3. _____
4. _____
5. _____

Have you received care for these problems before? __ Yes __ No

Health Goals

Your top three health goals.

1. _____
2. _____
3. _____

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Chiropractic History

What would you like to gain from chiropractic care?

__ Resolve existing condition(s) __ Overall wellness __ Both

Have you ever seen a chiropractor? __ Yes __ No

If so, who and when? _____

What is their specialty? __ Pain relief __ Physical Therapy & Rehab __ Nutrition __ Other

Do you have any health concerns for other family members today?

Traumas: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? __ Yes __ No

If yes, please explain _____

Notable childhood injuries? __ Yes __ No If yes, explain: _____

Youth or college sports? __ Yes __ No If yes, list injuries: _____

Any auto accidents? __ Yes __ No If yes, explain: _____

Exercise frequency: __ None __ 1-2x/week __ 3-5x/week __ Daily

What types of exercise? _____

How do you sleep? __ Back __ Side __ Stomach

Do you wake up? __ Refreshed and ready __ Stiff and tired

Do you commute to work? __ Yes __ No If yes, how many minutes per day?

_____

List any problems with flexibility (putting socks/shocks on, etc.) _____

_____

How many hours per day do you typically spend sitting at a desk on a computer, tablet, phone?

_____

Toxins: Chemical & Environmental Exposure

Please circle/rate your CONSUMPTION of each: (1=None, 3=Moderate, 5=High)

Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweeteners	1	2	3	4	5
Sugar	1	2	3	4	5	Sugary Drinks	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5	Recreational Drugs	1	2	3	4	5

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Please **list** any medications/vitamins/herbs/others that you are taking and **why**:

Thoughts: Emotional Stress & Challenges

Please rate your STRESS for each: (1=None, 3=Moderate, 5=High)

Home	1	2	3	4	5	Money	1	2	3	4	5
Work	1	2	3	4	5	Health	1	2	3	4	5
Life	1	2	3	4	5	Family	1	2	3	4	5

Acknowledgement & Consent

Patient Name: _____ Date: _____

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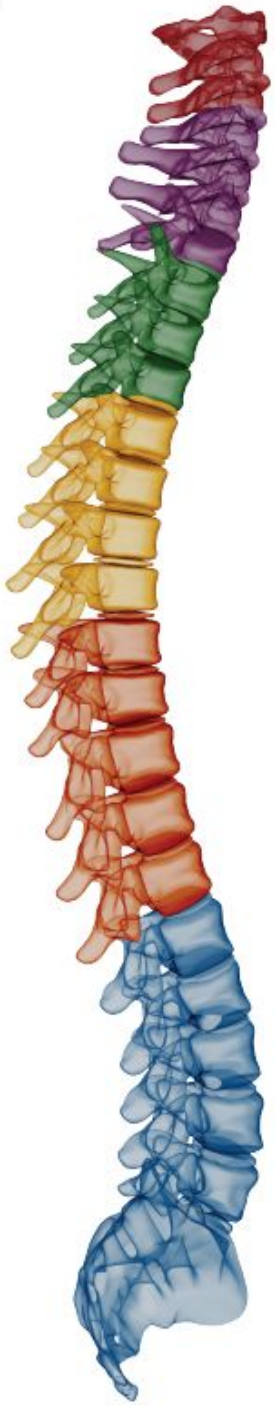
Please mark all that you have had in the past or are currently having issues with:



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT		
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐	Colic & Excessive Crying	
		☐	☐	Ear & Sinus Infections	
		☐	☐	Allergies & Congestion	
		☐	☐	Immune Deficiency	
		☐	☐	Headaches & Migraines	
		☐	☐	Vertigo & Dizziness	
		☐	☐	Sore Throat & Strep	
		☐	☐	Swollen Tonsils & Adenoids	
		☐	☐	Vision & Hearing Issues	
		☐	☐	Low Energy & Fatigue	
		☐	☐	Difficulty Sleeping	
		☐	☐	Pain, Numbness & Tingling in Arms to Hands	
		☐	☐	Epilepsy & Seizures	
		☐	☐	Sensory & Spectrum	
		☐	☐	ADD / ADHD	
		☐	☐	Focus & Memory Issues	
		☐	☐	Anxiety & Stress	
		☐	☐	Balance & Coordination	
		☐	☐	Speech Issues	
		☐	☐	TMJ / Jaw Pain	
		☐	☐	Stiff Neck & Shoulders	
		☐	☐	Depression	
		☐	☐	High Blood Pressure	
		☐	☐	Poor Metabolism & Weight Control	
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐	Reflux / GERD	
		☐	☐	Chronic Colds & Cough	
		☐	☐	Asthma	
		☐	☐	Bronchitis & Pneumonia	
		☐	☐	Functional Heart Conditions	
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐	Gallbladder Pain / Issues	
		☐	☐	Jaundice	
		☐	☐	Fever	
		☐	☐	Indigestion & Heartburn	
		☐	☐	Stomach Pains & Ulcers	
		☐	☐	Blood Sugar Problems	
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐	Behavior Issues	
		☐	☐	Hyperactivity	
		☐	☐	Chronic Fatigue	
		☐	☐	Chronic Stress	
		☐	☐	Allergies & Eczema	
		☐	☐	Skin Conditions / Rash	
		☐	☐	Kidney Problems	
		☐	☐	Gas Pain & Bloating	
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐	Constipation	
		☐	☐	Chrohn's, Colitis & IBS	
		☐	☐	Diarrhea	
		☐	☐	Bed-wetting	
		☐	☐	Bladder & Urination Issues	
		☐	☐	Cramps & Menstrual Issues	
		☐	☐	Cysts & Endometriosis	
		☐	☐	Infertility	
		☐	☐	Impotency	
		☐	☐	Hemorrhoids	
		☐	☐	Sciatica & Radiating Pain	
		☐	☐	Lumbopelvic / SI Joint Pain	
		☐	☐	Hamstring Tightness	
		☐	☐	Disc Degeneration	
		☐	☐	Leg Weakness & Cramps	
		☐	☐	Poor Circulation & Cold Feet	
		☐	☐	Knee, Ankle & Foot Pain	
		☐	☐	Weak Ankles & Arches	
		☐	☐	Lower Back Pain	
		☐	☐	Gluten & Casein Intolerance	

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