Adult Intake Form

Thank you for taking the time to fill out this form. Your responses are important and will help us assist you in achieving the best possible heath and well being outcomes.

Date:		
Title: (e.g. Mr, Mrs, Miss, Dr)	Surname:	
First name:	Middle Name:	
Preferred name:	Date of Birth:	
Email:	Mobile:	
Address:		
Occupation:		Children:
Emergency Contact Name:		
Emergency contact Phone:		
Who may we thank for referring you?		
Previous chiropractic care? ❑ (please tick for yes)	Who?	
Recent X-Rays? ❑ (please tick for yes)	Details of X-Ray provider: (e.g. Qld Xray, Darling Downs Radiology)	

What is the main reason for your visit today? _____

_____

How long have you experienced this? _____

What do you think brought this on? _____

Have you experienced this before? _____

Is it limiting your life in any way? (e.g. sleep) _____

Does anything make it worse? _____

Does anything make it better? _____

Have you seen anyone else for this? _____

_____

Have you had any accidents / injuries or falls? (please provide details) _____

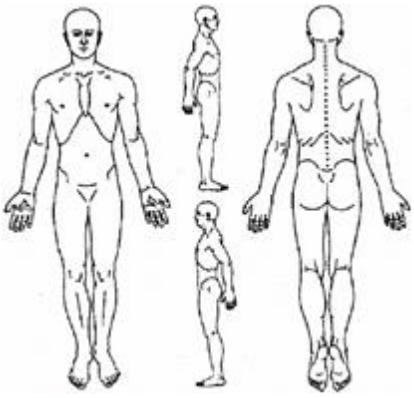
_____

Have you had any surgeries? (please provide details) _____

_____

Current medications / supplements: _____

Exercise / Sport ❑ (please tick for yes)	How much water do you drink per day?
Do you wear orthotics? ❑ (please tick for yes)	How many cups of tea/coffee per day?
How would you describe your diet?	
Do you drink alcohol? ❑ (please tick for yes)	If so how many per week?
Do you smoke ❑ (please tick for yes)	If so how many per day?
If you have quite smoking, how long ago?	



Right now, what is the intensity of your issue.
None 0....1....2....3....4....5....6....7....8....9....10 Severe

Please mark the least intense & the most intense if has been.
None 0....1....2....3....4....5....6....7....8....9....10 Severe

Please mark the diagram above to show your areas of concern.
Please use the following symbols, if relevant.

Numbness	Pins & Needles	Burning	Aching	Stabbing
*	O	^	X	□

ADDITIONAL HEALTH INFORMATION ✓= recently / X = previously

Allergies	Epilepsy / seizures	Knee problems	Snoring
Appetite (excessive / poor)	Fainting	Low back pain	Spinal Curve
Asthma	Feet problems	Low immune system	Stroke
Anxiety / Depression	Fevers / sweats	Lung issues	Swelling
Arthritis	Fibromyalgia	Nausea or vomiting	Tailbone pain
Balance	Gall bladder / liver issues	Neck pain	Tinnitus
Blood disorders	Gout	Numbness	Thyroid
Bruise easily	Hay Fever	Osteoporosis	Tonsillitis
Cancer	Headaches / Migraines	Pain between shoulders	Tremors
Circulation	Hearing problems	Pins and needles	Ulcers
Chronic Cough	Heart disease / problems	Reflux / Indigestion	Unexplained weight loss
Chronic Fatigue	Hernia	Sciatica	Visual problems
Dental appliances	High/low blood pressure	Shoulder / elbow / hand problems	Whiplash
Diabetes	Insomnia	Sinus	
Diarrhoea or constipation	Jaw problems	Skin issues	
MALES	Fertility	Genitals	Prostate
FEMALES	Breasts	Fertility	Menopause
	Ovaries / uterus	Menstrual problems	

Is there anything else about your health history we should know?

_____

The statements and answers on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation.

..... **.....**

Signature **Date**