

**Adult Chiropractic Intake Form**

**Confidential Patient Information**

**Dr. Michael Evans & Dr. Brittney Knowlton**| Lake Country Family Chiropractic

112 Harmony Crossing Suite 1, Eatonton | 706-991-5348 |[**www.lakecountryfamilychiro.com**](http://www.lakecountryfamilychiro.com)

|  |
| --- |
| Name: SSN: Date: |
| Street Address: City: State: Zip: |
| Home Phone: Cell Phone: Work Phone: |
| Email: Date of Birth: Age |
| Height: Weight: Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed |
| Emergency Contact: Phone Number: Relationship: |
| Whom may we thank for referring you? |

**Current Health Condition**

|  |
| --- |
| Present complaint: |
| Location of complaint: Does the pain radiate? |
| When did this begin? Was there an accident or injury involved? [ ] Yes [ ] No |
| Have you had any past treatment for this complaint? [ ] Yes [ ] NoIf yes – Please Explain |
| Is this condition: [ ] Getting worse [ ] Improving [ ] Intermittent [ ] Constant [ ] Unsure |
| Type of Pain: [ ] Achy [ ] Tight [ ] Tense [ ] Sharp [ ] Stiff [ ] Stabbing [ ] Throbbing [ ] Burning  [ ] Tingling [ ] Numb [ ] Dull |
| What makes the pain better? Worse? |

**Past Health History**

|  |
| --- |
| Have you ever received chiropractic care? [ ] Yes [ ] No Doctor: |
| How long were you under care? Date of last visit: |
| Why did you stop? |
| List any surgeries or hospitalizations you have had: |
| List all medications you are currently taking and how often: |
| List any accidents/injuries/broken bones: |
| Family History: [ ] Cancer [ ] High Blood Pressure [ ] Diabetes [ ] Heart Attack [ ] Stroke [ ] Arthritis [ ] Other – Please explain: |

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**Social History**

|  |
| --- |
| Do you drink alcohol? [ ] Yes [ ] No If yes, how much & how often? |
| Do you smoke? [ ] Yes [ ] No [ ] FormerIf yes, how much, how often, & how long? |
| Do you think your appetite is: [ ] Heavy [ ] Moderate [ ] Light |
| Do you participate in a regular exercise program? [ ] Yes [ ] NoIf yes, how often and what? |
| Are you currently employed? [ ] Yes [ ] NoIf yes, what is your occupation? |
| Who is your current employer? How long have you been at this job? |

Using the symbols given below, mark the area on your body where you feel the described pain sensations. Include all affected areas.



**Review of Systems**

The following items may relate to your current condition. Please place a “P” if you PRESENTLY have the problem and an “H” if you HAD the problem in the past. Leave the space blank if you NEVER had the problem.

GENERAL

\_\_\_\_\_Anemia

\_\_\_\_\_Allergies

\_\_\_\_\_Arthritis

\_\_\_\_\_Bleeding Problem

\_\_\_\_\_Cancer/Tumors

\_\_\_\_\_Diabetes

\_\_\_\_\_Epilepsy

\_\_\_\_\_Fainting or Seizures

\_\_\_\_\_Fibromyalgia

\_\_\_\_\_Gout

\_\_\_\_\_Hepatitis

\_\_\_\_\_High Cholesterol

\_\_\_\_\_Loss of Sleep

\_\_\_\_\_Multiple Sclerosis

\_\_\_\_\_Night Sweats

\_\_\_\_\_Osteoporosis

\_\_\_\_\_Tiredness

\_\_\_\_\_Thyroid Problems

CARDIOVASCULAR

\_\_\_\_\_Chest Pain

\_\_\_\_\_Heart Disease

\_\_\_\_\_High Blood Pressure

\_\_\_\_\_Irregular Heartbeat

\_\_\_\_\_Low Blood Pressure

\_\_\_\_\_Pacemaker

\_\_\_\_\_Poor Circulation

\_\_\_\_\_Stroke

\_\_\_\_\_Swelling of Ankles

\_\_\_\_\_Varicose Veins

\_\_\_\_\_Heart/Lung Defect

RESPIRATORY

\_\_\_\_\_Asthma

\_\_\_\_\_Difficulty Breathing

\_\_\_\_\_Chronic Cough

\_\_\_\_\_COPD

\_\_\_\_\_Emphysema

\_\_\_\_\_Pneumonia

\_\_\_\_\_Tuberculosis

\_\_\_\_\_Wheezing

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GENITOURINARY

\_\_\_\_\_Difficulty Starting/Stopping Flow

\_\_\_\_\_Frequent Urination

\_\_\_\_\_Painful Urination

GASTROINTESTINAL

\_\_\_\_\_Poor Appetite

\_\_\_\_\_Black or Bloody Stools

\_\_\_\_\_Bloating/Gas

\_\_\_\_\_Colitis/IBS

\_\_\_\_\_Constipation

\_\_\_\_\_Diarrhea

\_\_\_\_\_Excessive Hunger or Thirst

\_\_\_\_\_Hemorrhoids

\_\_\_\_\_Hernia

\_\_\_\_\_Indigestion

\_\_\_\_\_Liver Disease

\_\_\_\_\_Loss of Bowel Control

\_\_\_\_\_Nausea

\_\_\_\_\_Reflux

\_\_\_\_\_Stomach Pain

\_\_\_\_\_Ulcers

\_\_\_\_\_Vomiting

GYNECOLOGICAL

\_\_\_\_\_Abnormal Periods

\_\_\_\_\_Dysmenorrhea

\_\_\_\_\_Endometriosis

\_\_\_\_\_Hot Flashes

\_\_\_\_\_Oral Contraceptive Use

\_\_\_\_\_PCOS

Date of last period\_\_\_\_\_\_\_\_\_\_

Last Mammogram \_\_\_\_\_\_\_\_\_\_

Last Pap Smear \_\_\_\_\_\_\_\_Abnormal? [ ] Yes [ ] No

NEUROLOGICAL/MENTAL

\_\_\_\_\_Anxiety

\_\_\_\_\_Anger/Aggression

\_\_\_\_\_Attention Deficit

\_\_\_\_\_Psychotic Episodes

\_\_\_\_\_Tremors

\_\_\_\_\_Mental Disorder