Naturally Aligned Family Chiropractic, P.A.
Adult Health Intake Form

Patient Name _____ Age _____ Birth Date ____/____/_____

Address _____ City _____

State _____ Zip _____ Home phone _____ Cell _____

Email (print clearly)_____

Occupation _____ Employed by _____

Single/Married/Divorced/Widowed (circle one) Partner's Name/Occupation _____

No. of Children _____ ; Names/Ages _____

Who may we thank for referring you? _____

Addressing the issues that brought you to the office

Purpose for contacting us? _____

If you experience pain, is it…..

□ Sharp □ Dull □ Comes and goes □ Travels □ Constant

Since the problem started, is it: □ About the same □ Getting better □ Getting worse

What makes it worse? _____ better ? _____

Does it interfere with: □ Work □ Sleep □ Walking □ Sitting □ Hobbies □ Leisure

Check if you: □ Sit more than 4 hours per day □ Drive for more than 2 hours per day

□ Construction or physical labor □ Do repetitive motions throughout the day

Other doctors seen for this condition? (please list)

□ Chiropractor _____

Any previous chiropractic care? Y/N If yes, last adjustment? _____.

Why did you quit? _____

□ Medical Doctor _____

□ Other _____

Please check all of symptoms you have ever had, even if they are not related to your current problem:

□ Headaches	□ Back Pain	□ Fatigue	□ Dizziness
□ Neck Pain /Stiff neck	□ Constipation	□ Loss of Balance	□ Fainting
□ Ringing in Ears	□ Diarrhea	□ Tension	□ Sleeping problems
□ Numbness in limbs	□ Heartburn	□ Hot flashes	□ Problem urinating

Do you take any drugs/medications/supplements? If so, please list : _____

_____

Have you ever been hospitalized? If so, for what ?_____

Have you ever had surgery? If yes, please list: _____

Have you ever had a fall - accident - injury? (circle). Please explain _____

_____

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

Signature _____ Date _____