ARCHEUS Chiropractic and Wellness

New Patient Intake

Your Information Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Date:______________________

First Name: ______________________________ Middle Initial: ________ Last Name:______________________________

Address: ____

City: ____ State:__________________________ Zip Code:________________

Home Phone: (______)_______-_________ Cell Phone: (______)_______-_________ Ethnicity:_______________________

Date of Birth: ________/________/________ Sex: Male / Female Marital Status: ☐ Single ☐ Married ☐ Other

Family Medical Doctor: ____ Location:________________________________

Employer/School Data Employment Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Other

Name: ____ Work Phone: (_________)________-____________

Address:____

City: ____ State: ___________________ Zip Code: ______________________

Please describe your occupation(s):____

Spouse/Partner Data Is your spouse/partner a patient in this clinic? ☐ Yes ☐ No

First Name: _________________________________ Middle Initial: ________ Last Name: ____________________________

Cell Phone: (______)______-_________ Work Phone: (______)______-_________

Emergency Contact

Contact Name: ____Contact Phone: (______)_______-__________

Chiropractic Health History

Have you received chiropractic care in the past? Y / N When? ____

Why?____________________________________ Chiropractors Name:____

Primary reason(s) for seeking chiropractic care today:____

Have you seen anyone else for this condition? Y/N Who?____

How did you hear about Archeus Chiropractic?____

Health Goals

I would like to improve my health beyond my current state Y/N. I am interested in nutrition and lifestyle changes Y/N.

If offered I would attend nutrition/lifestyle and health improvement activities Y/N.

Past Health History

Please list any health conditions you have experienced in the last 6 months:___________________________________

____

____

Please list all current medications:

Medication	Dosage	Reason	How long

Please list all current supplements:

Supplement	Dosage	Reason	How long

Explanation for Medications and supplements:____

____

____

Review of Systems: Have you ever had any of the following?

Cardiovascular ☐ **No to all**

☐ Poor Circulation ☐ High Blood Pressure ☐ Aortic Aneurysm ☐ Heart Disease ☐ Vascular Disease ☐ Heart Attack

☐ Chest Pain ☐ High Cholesterol ☐ Pace Maker ☐ Jaw Pain ☐ Irregular Heartbeat ☐ Swelling of Legs ☐ Other

Explanation:____

Respiratory ☐ **No to all**

☐ Asthma ☐ Tuberculosis ☐ Shortness of Breath ☐ Emphysema ☐ Cold/Flu ☐ Cough/Wheezing ☐ Sputum

☐ Coughing Blood ☐ Other

Explanation:____

Genitounrinary ☐ **No to all**

☐ Kidney Disease ☐ Lower Side Pain ☐ Burning Urination ☐ Frequent Urination ☐ Blood in Urine ☐ Kidney Stones

☐ Other

Explanation:____

Neurological ☐ **No to all**

☐ Stroke ☐ Seizures ☐ Head Injury ☐ Brain Aneurysm ☐ Numbness ☐ Pinched Nerves ☐ Carpal Tunnel

☐ Balance Problems ☐ Other

Explanation:____

Musculoskeletal ☐ **No to all**

☐ Gout ☐ Arthritis ☐ Joint Stiffness ☐ Muscle Weakness ☐ Osteoporosis ☐ Broken Bones ☐ Joints Replaced

☐ Other

Explanation:____

Skin ☐ **No to all**

☐ Skin Lesions ☐ Skin Ulcers ☐ Skin Disease/Cancer ☐ Eczema ☐ Psoriasis ☐ Other

Explanation:____

Allergic/Immunologic ☐ **No to all**

☐ Hives ☐ Immune Disorder ☐ HIV/AIDS ☐ Allergy Shots ☐ Cortisone Use ☐ Other

Explanation:____

☐ Food Intolerance ☐ Medication intolerance ☐ Other

Please list all known allergies:____

____

Have you received any vaccinations? Y/N If yes please list any and all that you can remember:________________

____

Gastrointestinal ☐ **No to all**

☐ Gallbladder Problems ☐ Bowel Problems ☐ Constipation ☐ Liver Problems ☐ Ulcers ☐ Diarrhea ☐ Nausea/Vomiting

☐ Bloody Stools ☐ Poor Appetite ☐ Other

Explanation:____

Hematologic/Lymphatic ☐ **No to all**

☐ Hepatitis ☐ Blood Clots ☐ Cancer ☐ Easy Bruising ☐ Easy Bleeding ☐ Fevers/Chills/Sweats ☐ Other

Explanation:____

Endocrine ☐ **No to all**

☐ Thyroid Disease ☐ Diabetes ☐ Hair Loss ☐ Excessive appetite/thirst ☐ Frequent Urination ☐ Other

Explanation:____

Psychiatric ☐ **No to all**

☐ Depression ☐ Anxiety Disorder ☐ Unusual Stress ☐ Confusion/Memory loss ☐ Mood Change ☐ Other

Explanation:____

Eyes ☐ **No to all** ☐ **Glasses/Contacts**

☐ Glaucoma ☐ Double Vision ☐ Blurred Vision ☐ Other

Explanation:____

Head ☐ **No to all**

☐ Headaches ☐ Severe Headaches ☐ Migraines ☐ Head Injury ☐ Other

Explanation:____

Ears/Nose/Throat ☐ **No to all**

☐ Hearing Loss ☐ Sinus Infection ☐ Nosebleed ☐ Sore Throat ☐ Difficulty Swallowing ☐ Bleeding Gums

☐ TMJ problems ☐ Ringing in Ears ☐ Other

Explanation:____

General ☐ **No to all**

☐ Weight Loss ☐ Weight Gain ☐ Energy Level Problem ☐ Difficulty Sleeping ☐ Other

Explanation:____

Female ☐ **No to all** ☐**Currently Pregnant**

☐Birth Control ☐Cramps ☐Irregular menstruation ☐Breast lumps/pain ☐ Vaginal discharge ☐ Other

Number of pregnancies:___________ Number of Children:___________ Complicated Births: Y/N.

Explanation:____

Male ☐ **No to all**

☐Prostate problems ☐ Hesitancy/Dribbling ☐ Erectile dysfunction ☐ Other

Explanation:____

Surgeries/Injuries

Please give a complete list of surgeries and severe injuries you have undergone including month/year:____

____

Other problems not elsewhere listed:

____

____

____

Family History

Has anyone in your family had any of the following problems? □ Arthritis □ Cholesterol □ Heart Problems □ Psychiatric Problems □ Thyroid □ Cancer □ Diabetes□ High Blood Pressure □ Stroke □Other

Explanation:____

____

Do you have children? Y/N If yes how many? Female__________ Male__________

Child health concerns/conditions?____

____

Do you have siblings? Y/N If yes how many? Female__________ Male_________

Sibling health concerns/conditions?____

____

Current Lifestyle

Physical

How often do you exercise? □ Daily □ 3x week □ Occasionally □ Rarely □ Never Hours per week?:__________

Do you stretch daily? Y/N Do you pay attention to your posture? Y/N

Please list your hobbies or activities: ____

____

Bio-Chemical

Do you smoke or have you in the past? Y/N If yes how often and how much?____________________________

Do you use / consume? □ Tobacco □ Alcohol □ Caffeine How often day/week?________________________

Do you eat prepared, processed or fast foods? Y/N How often?____

Do you consume carbonated or drinks high in sugar daily? Y/N How often do you drink water?__________________

Are you on any special diet? Y/N If yes for what reason?____

Your diet emphasizes fruits, vegetables, whole grains, lean meats and other protein sources and is low in sugar and artificial sweeteners? Y/N please rate your diet 10 being healthy: 1 2 3 4 5 6 7 8 9 10.

Do you feel stressed out regularly? Y/N Do you handle stress in a positive way? Y/N

Do you practice meditation or relaxation methods daily? Y/N Lack of time and Energy stresses you? Y/N

Please list your specific current goals for health and this office:_____________________________________

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It is important that our patients and we have the same health objectives concerning chiropractic and wellness care. Regardless of what a disease or condition is called our practice objective is to eliminate a major interference to the expression of the body's internal ability to heal and thrive. By adjusting the spine, removing subluxations, we help restore the neurological communication of the brain to the body and improve the biomechanical supports of this system. With the addition of lifestyle, nutrition and exercise recommendations we support the healing of this system and therefore maximize the bodies inborn abilities, bringing you beyond the comfort zone of no symptoms and constantly challenge you to reach for optimal health! Your signature here verifies that the information provided on this form is complete and correct and that you are willing to begin your journey with chiropractic care!

Patient Signature: ____ Date: ________________________