Fairbanks Family Wellness
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FairbanksFamilyWellness.com

Chiropractic Intake Form

Practice Member Information

Name: _____ Appointment Date: _____
Birth Date: _____

Home Address: _____
Home phone: _____ May we leave a message ☐Yes ☐No
Cell phone: _____ May we leave a message ☐Yes ☐No
Work phone: _____ May we leave a message ☐Yes ☐No
Email: _____

May we add you to our email newsletter and calendar of events? (Your email will not be shared.) ☐Yes ☐No
Spouse's name? _____
Name(s) and age(s) of children: _____
Occupation: _____
Do you primarily ☐Sit ☐Stand ☐Perform repetitive tasks
How did you hear about us? _____

Healthcare History

Have you had previous chiropractic care? ☐No ☐Yes
Who was your previous Chiropractor? _____
Where? _____
Were X-rays taken in the last 6 months? ☐Yes ☐No
What was the primary reason for consulting that office?

☐ Relief Care- Symptom relief of pain or discomfort
☐ Corrective Care- Correcting, relieving and stabilizing spinal, joint and postural issues
☐ Wellness Care- Maximizing the body's ability for optimal healing and function

Do you feel your previous chiropractic care was effective? ☐No ☐Yes
Please explain: _____
Are you wearing ☐Heel ☐Lifts ☐Custom orthotics
Family Doctor: _____
Date and reason of last visit: _____
May we contact your family doctor regarding your care at our office if necessary? ☐No ☐Yes
Naturopathic Doctor: _____
Date and reason of last visit: _____

Other Specialists and healthcare professionals:

1) Name: _____
Professional Designation: _____
Date and reason of last visit: _____
2) Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Wellness Profile

Do you have a specific concern that brings you in? _____

☐No I'm interested in having my nervous system assessed to achieve optimal health and functioning.

☐Yes: _____

If yes, please answer the following questions:

What is your primary area of complaint today? _____

How long have you been aware of this? _____ days _____ weeks _____ months _____ years

Where else does this pain go in your body? _____

How often do you experience this? ☐daily ☐weekly ☐monthly ☐comes and goes ☐constantly

On a scale of 1 to 10 (10 being the worst), how does it feel when it's at its worst? _____

How would you describe the pain/discomfort?

☐Dull ☐Achy ☐Throbbing ☐Stabbing ☐Tight/Stiff ☐Burning ☐Sharp ☐Other: _____

What makes it feel worse? _____

What makes it feel better? _____

Do you notice any other problems in your body when you get this pain/discomfort? _____

Do you feel your condition getting progressively worse? ☐No ☐Yes

Do you feel you condition can be healed? ☐No ☐Yes

What have you tried that **has** helped? ☐Ice ☐Heat ☐Medication ☐Massage ☐Physical Therapy

☐Chiropractic ☐Other: _____

What have you tried that **hasn't** helped? ☐Ice ☐Heat ☐Medication ☐Massage ☐Physical Therapy

☐Chiropractic ☐Other: _____

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called a *Vertebral Subluxation*. The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine, which may be impeding your body's ability to heal.

Physical

Height_____ Weight_____

Are you happy with your current physical appearance and abilities? ☐Yes ☐No

Frequency of exercise/week: Cardio? . . . . . .☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

Weight bearing? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

Do you stretch after exercise or after other activities of poor posture? ☐Yes ☐Sometimes ☐No

Hours of sleep/night ☐>6 ☐7-9 ☐10+

Do you feel refreshed upon waking? ☐Always ☐Sometimes ☐Rarely

Age of mattress? _____ Do you feel your mattress is appropriate for your sleeping style? ☐No ☐Yes

Which position do you sleep? ☐Back ☐Belly ☐Side: ☐Right ☐Left ☐Both

Number of hours spent commuting/week? . . . . . ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+

Number of hours spent at a desk or computer/week? . . . . . ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+

Number of hours spent on smart device/tablet/week? . . . . . ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+

Do you perform any repetitive tasks at home or at work? ☐No ☐Yes _____

Have you ever been hospitalized or had surgery? ☐No ☐Yes If yes, why and when? _____

_____

_____

Have you ever been in a motor vehicle accident (even if it was minor)? ☐No ☐Yes

If yes, what kind and when? _____

Were you evaluated and treated after each accident? ☐No ☐Yes _____

Have you had any non-vehicle accidents or falls? ☐No ☐Yes _____

Early Years

To your knowledge, was your delivery difficult? ☐No ☐Yes

If yes: ☐Forceps ☐Vacuum ☐Cesarean ☐Breech ☐Other: _____

Were you breast fed? ☐No ☐Yes For how long? _____

Did you experience emotional trauma as a child? ☐No ☐Yes _____

Were you ever given antibiotics as a child? ☐No ☐Yes _____

Did you ever have ear infections as a child? ☐No ☐Yes _____

Any major childhood illness? ☐No ☐Yes _____

Emotional

Rate your current level of **personal stress** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High

Rate your current level of **relationship stress** in your life: . . . . ☐None ☐Low ☐Moderate ☐High

Rate your current level of **financial stress** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High

Rate your current level of **health stress** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High

Rate your current level of **family stress** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High

Rate your current level of **career stress** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High

Do you feel you have a supportive network of friends and family? . . . . .☐Yes ☐No

Do you feel you have healthy coping strategies for life stress? . . . . . .☐Yes ☐No

Chemical

Were you vaccinated as a child? . . . . . ☐No ☐Yes

Any adverse reactions to vaccines? . . . . . ☐No ☐Yes _____

Do you choose to have annual flu shots? . . . . . ☐No ☐Yes _____

Do you take antibiotics? . . . . . .☐No ☐Yes, How often?_____

How many glasses of water/day? . . . . . ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of caffeinated beverages/day? . . . . . ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of cow's milk, juice and pop/day? . . . . . ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Do you eat gluten? . . . . . ☐ No ☐ Yes ☐ Trying to eliminate from diet

Do you eat dairy? . . . . . .☐ No ☐ Yes ☐ Trying to eliminate from diet

Do you eat refined sugars? (white sugar, white bread and pasta) . . . ☐ No ☐ Yes ☐ Trying to eliminate from diet

Do you eat boxed/frozen dinners? . . . . . ☐ No ☐ Yes ☐ Trying to eliminate from diet

Do you choose organic foods? . . . . . ☐ No ☐ Yes, which: ☐ Vegetables ☐ Fruits ☐ Meats ☐ Grains ☐ All

Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) . . ☐ No ☐ Yes ☐ Trying to eliminate from diet

Any food/drink allergies, sensitivities, intolerances? . . . . . ☐ No ☐ Yes

Do you smoke? . . . . . ☐ No ☐ I used to for ___ years ☐I wish I didn't

Are you or have you been exposed to second hand smoke? . . . . . ☐ No ☐ Yes _____

Do you drink alcohol? . . . . . ☐ No ☐ Yes ☐ 0-6/week ☐ 6-12/week ☐ 12+/week

Do you take a probiotic daily? . . . . . ☐ No ☐Yes, _____ CFU's/day

Do you take vitamin D daily? . . . . . ☐ No ☐ Yes _____ IU's/day

Do you take Omega 3 Fish Oils daily? . . . . . ☐ No ☐ Yes _____ mg/day Capsule Liquid

Other supplements or homeopathics? _____

_____

Any other daily medication and their purpose? _____

Do you have a plan in place with your medical doctor to wean yourself off any long term medications? ☐ No ☐ Yes

Family Health

At our clinic, we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers/Sister: _____

Other: _____

Are you seeking chiropractic care today for:

- ☐ Relief Care- Symptom relief of pain or discomfort
- ☐ Corrective Care- Correcting, relieving and stabilizing spinal, joint and postural issues
- ☐ Wellness Care- Maximizing the body's ability for optimal healing and function

Do you have other concerns we should know about? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Goals and Consent

What is your primary goal for consulting our clinic? _____

Our goals are to provide a detailed assessment of your current health status and provide to you resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your health through a chiropractic evaluation!

Consent to Evaluation

I _____ hereby grant permission to receive a chiropractic evaluation, including history, spinal scan and examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

_____ _____

Consenting Adult's Signature Date

_____ _____

Parent/Guardian's Name if Under 18 Years Old Date