DR. MARGIE SMITH CHIROPRACTOR

Welcome to my practice! I appreciate your trust in me and look forward to help support your health goals. Please complete the following information so I can get to know a bit more about you. ~Dr. Margie

INITIAL INTAKE - ADULT

Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Cell Phone (____) _____ Date of Birth _____ (Age _____) Gender M / F
Email _____
Occupation _____
Employer_____ Marital Status: S M D W
Spouses Name _____
Number of Children & Ages _____
Have you ever received Chiropractic Care? Y / N If yes, please describe your previous experience:
_____
Who may we thank for your referral today? _____
_____

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. The following information will uncover the layers of damage, especially to your spine and nervous system, that resulted in poor health. Following your exam, Dr. Margie will outline a course of care to begin to correct these layers of damage and recover your innate health potential in accordance with your health goals.

Let's begin with **YOUR** birth and childhood history:

1. Birth Process - please describe any details you may know about your own birth/delivery (such as - hospital/home birth? Natural birth? C-Section?) _____
_____
_____

2. Growth and Development

Were you taught how to care for your spine? _____
Any significant falls/injuries/broken bones? _____
Were you breastfed? _____ Any food sensitivities as a child? _____
Childhood sicknesses? _____
Accidents?_____
Surgery or hospitalizations? _____
Regular medications? _____
Any emotional abuse? _____
Did you have other traumas? What? When? _____

3. Adolescence

What type of sports or activities were you involved in? Describe the number of years and level of involvement: _____
_____
_____
_____

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Any significant emotional trauma? _____
_____
_____
_____

Past/Current Health Choices

Past and current health choices play a part in our body's overall wellness and ability to heal. The following information will help Dr. Margie assess this portion of your body's health ability by fully assessing and examining all of the systems of the body.

1. Current Health Habits - please list any applicable details

Did/do you smoke? _____
Did/do you drink any alcohol? _____
Did/do you use any recreational drugs? _____
Please describe your typical meals? _____
How much do you drink in a day? Water: _____ (ounces) Caffeine: _____ (ounces) Soda: _____ (ounces)
What type of exercise do you do? _____ How often? _____
What are your favorite hobbies? _____
Sleeping posture: side back stomach Quality/Quantity of sleep: _____
Please describe your stress levels in the following:
Occupational: _____
Home/family: _____
Any other emotional, physical, or chemical stresses? _____

2. Past Health History

Have you been in accidents? _____
Surgeries/Hospitalizations? _____
Any falls or injuries? _____
Have you ever lost consciousness in your life? If so, please describe: _____
Number of bowel movements per/day? _____ Quality (mark all that apply): well-formed loose hard with pain
Any issues with oral health? _____
Visions issues (glasses or contacts?) _____
Hearing issues? _____

Current Symptoms/concerns

Now the important part...what has motivated you to seek out chiropractic care in our office today and how can we best help you?

PRESENT HEALTH CONCERN: _____
_____
_____

When did this first begin? _____ How often are you experiencing this? _____
If pain is present, would you describe as: (circle all that apply) dull achy sharp shooting throbbing burning
What makes this condition worse? _____
Anything improve the condition? _____
Is this condition better/worse in the morning/evening? _____
Does this interfere with: Sleep? Daily routine? Work? Other?
Is this condition getting worse? _____
Any other providers you have seen for this condition? _____
Have you tried any at-home remedies? _____
Any other details related to this concern? _____
_____
_____

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REVIEW OF SYSTEMS: (please circle any symptoms that apply to your current or past health history)

Headaches	Pins & Needles in Legs	Cold Feet	Neck Pain/Stiffness	Loss of Smell
Migraines	Pins & Needles in Arms	Cold Hands	Midback Pain	Loss of Taste
Insomnia	Numbness in fingers	Chest Pains	Low Back Pain	Stomach Upset
Diarrhea	Nervousness (anxiety)	Fatigue	Dizziness	Light Sensitivity
Depression	Shortness of Breath	Irritability	Fever	Buzzing in Ears

Please describe any medical care you are under: _____
_____
_____

Current medications? How long? _____
_____
_____

Current supplements? How long? _____
_____
_____

Any significant family history? _____
_____
_____

Future Health Outlook

With proper course of care and support, ANYONE can change their health future!

What are all of your goals for your overall health and wellness?

1. _____ 2._____
3. _____ 4._____
5. _____ 6._____
7. _____ 8._____
9. _____ 10._____

WHAT TO EXPECT IN OUR OFFICE:

Chiropractic care provides different levels of health and healing. Once Dr. Margie has conducted an examination and thorough consultation, a Report of Findings will be reviewed with you at your next visit. Your customized recommendations will be based on your current state of health, our clinical experience, and your health goals.

Consent for Evaluation:

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

_____ _____

Signature Date