Wildflower
FAMILY CHIROPRACTIC

NPM INTAKE FORM: ADULT

INFORMATION:

Name:	Age:	Date:
Address:		City/State/Zip:
Home Phone No.:	Work Phone No:	Cell Phone:
Email Address:	Gender:	Date of Birth:
Occupation:	Employer Name and Address:	
Best Time to Contact:	Marital Status:	
Number of Children :	Names and Ages:	

PERSONAL INFORMATION:

As a society we are 50th in the world in health care. We take pride in helping people to reach their optimum health and wellness. With that being said, we need an honest assessment of where you believe your current level of health is. So please place an "X" on the scale below marking where you believe your level of health and wellness is at this time. Then place a star (*) on the diagram indicating where you would like your health and wellness to be.

YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or concerns and are here for Chiropractic Wellness Services, please skip to the "General History" page.

Health Concerns:	Severity 1 = mid 10 = worst imaginable	When did this start?	Are symptoms constant or intermittent?	Did the problem begin with an injury?

Since the challenge started, it is ____The Same _____Getting Better _____Getting Worse

What makes it worse? _____

What, if anything makes it feel better? _____

Does this interfere with your: ____Work ____Leisure ____Sleep ____Sports ____Other: ____

It's common for people to have multiple doctors on their health care team. Which of the following have you seen for your challenges? ___Chiropractor ___ Medical ___Other
(Please List):
_____

During the above visits, was the cause of your health challenge identified? Yes or No

If yes, what was the diagnosis? _____

What was the recommended solution? _____

GENERAL HISTORY:

Given that prescription medications are in the top 5 leading causes of preventable death in the United States we are interested in knowing what, if any medications you are currently taking and why:
_____
_____

It is becoming more popular for people to take charge of their own health and wellbeing. Supplementation is a major trend in this movement, please list any supplements or vitamins that you are taking and why:
_____
_____
_____

Have you had any surgeries or hospitalizations? (Please include all surgeries)
_____
_____

Have you ever had any work related injuries?
_____
_____

Slips and falls, although common have a direct impact on your health and wellbeing. Even MINOR falls or accidents cause stress, strain and damage to the spine that take up to 18 months to heal. If you have had any slips, falls or auto accidents (even minor) please list them here:
_____
_____

Because the Nervous system controls everything in your body, it is common that current health challenges can be related to the problems you are seeking care for in our office. Please check (✓) the following symptoms you have had, whether CURRENT (C) or PAST (P):

	Past	Current		Past	Current
Headaches	☐	☐	Neck stiff/pain	☐	☐
Loss of smell	☐	☐	Loss balance	☐	☐
Loss of taste	☐	☐	Tension	☐	☐
Ulcers	☐	☐	Dizziness	☐	☐
Fatigue	☐	☐	Irritability	☐	☐
Cold Hands	☐	☐	Constipation	☐	☐
Migraines	☐	☐	Hot flashes	☐	☐
Diarrhea	☐	☐	Urinary issues	☐	☐
Cold Sweats	☐	☐	Asthma	☐	☐
Fainting	☐	☐	Arm tingling	☐	☐
Back pain	☐	☐	Buzz/ring in ears	☐	☐
Nervousness	☐	☐	Numbness in fingers	☐	☐
Stomach upset	☐	☐	Numbness in toes	☐	☐
Depression	☐	☐	Sleeping problems	☐	☐
Cold feet	☐	☐	Lights bother eyes	☐	☐
Fever	☐	☐	Menstrual irregularity	☐	☐
Menstrual Pain	☐	☐	Tingling in legs	☐	☐
Heartburn	☐	☐	Allergies	☐	☐

If we have not listed current health challenges on the list above, please list additional health concerns in the lines below:

_____

_____

_____

THANKS FOR PROVIDING US WITH PIVOTAL INFORMATION THAT CAN LITERALLY CHANGE YOUR LIFE!
ON TO THE NEXT PAGE!!!

It has been shown that daily lifestyle stress significantly impacts your overall health and wellbeing. As a family wellness office we specialize in not only removing the cause of your health challenges, but we also focus on teaching you how to manage the lifestyle stresses that are keeping you from reaching your optimum health and wellness.

Please rate the following and circle ALL answers that apply to your habits:
(1 being very poor and 10 being excellent)

Eating habits: _____
a. I eat 3-5x's a day
b. I eat fruits and vegetables daily.
c. I eat out 2-3 times weekly (min)
d. I drink 3-5 sodas weekly
e. I crave sweets.
f. I don't watch what I eat.

Exercise habits: _____
a. I exercise 3-5 times a week.
b. I walk daily.
c. I don't exercise.
d. I want to exercise.
e. I sit at computer 6-8 hours/day

Sleep: _____
a. I sleep 7-9 hours/night
b. I wake up well rested
c. I wake up tired.
d. I toss and turn.
e. I stay up late.

Mind Set: _____
a. I have a positive outlook.
b. I have a negative outlook.
c. I am always in a bad mood.
d. I am always in a good mood.
e. I trap things inside.
f. I share easily.

General Health: ____
a. I am not on medications.
b. I take care of myself.
c. I watch what I eat.
d. I base my health on how everyone around me is doing.
e. I think I am healthy but know I could make some changes.

On a scale of 1-10 describe your psychological/emotional stress levels:
(1= none/ 10=extreme)
Occupational: _____
Personal: _____

YOU ARE ALMOST THERE!

THANKS FOR PROVIDING US WITH INFORMATION THAT COULD HELP US TO BETTER SERVE YOU AND HELP YOU TO BE THE BEST YOU CAN BE!

YOUR GOALS

At our office we pride ourselves in helping you to achieve phenomenal results with your health and wellness. In order for us to truly help you to be as healthy as possibly, it is important that we understand your goals for your overall health and wellbeing.
Please list your goals for your health and wellness in the spaces provided.

Physical Goals	Nutritional/Biochemical Goals	Psychological Goals

If there is a need for dietary changes would you like to know? ☐ Yes ☐ No

If there is a need for specific exercises would you like to know? ☐ Yes ☐ No

If there is a need for support in the psychological, mind body, stress management dimension of health would you like assistance? ☐ Yes ☐ No

YOU ARE ALMOST THERE! HAVE YOU EVER:

Bought bottled water: ☐ Yes ☐ No
Belonged to a health club: ☐ Yes ☐ No
Consumed vitamins or supplements ☐ Yes ☐ No
Eaten organic? ☐ Yes ☐ No
Started a diet program? ☐ Yes ☐ No
Gotten more than 6 massages in a year? ☐ Yes ☐ No

Now we just need your permission to continue through our process!

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature_____ Date: _____

THANK YOU FOR FILLING OUT THIS FORM.
IT IS YOUR FIRST STEP TO CREATING WELLNESS!
Present this to our staff and in a moment we will be starting our journey together!