ADULT INTAKE

TREE OF LIFE chiropractic

Personal Information:

First name: _____ **Last name:** _____ **Goes by:** _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone number: _____ **Email:** _____

Which type of reminders would you like (circle): TEXT | EMAIL

↳ **If text reminders, who is your cell phone provider?** _____

Gender: Male | Female **DOB:** _____ **Age:** _____

Marital Status: Single / Married / Widowed Spouses name: _____

# of children: _____ Names/ages: _____

Emergency contact: _____ Emergency contact phone number: _____

↳ Relation? _____

Whom may we thank for referring you? _____

Reason for Seeking Care:

What is your reason for seeking care at Tree of Life Chiropractic: _____

_____

When did it start (if applicable): _____

Are there any major injuries, surgeries or accidents we should know about? _____

_____

What is this affecting most in your life (list all that apply)? _____

List other providers you have seen for it: _____

Have you seen a chiropractor before? ☐ yes ☐ no How long ago? _____

Reason you are no longer seeing them (If applicable)? _____

What is your level of commitment to yourself and your health? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What health goal if completed or accomplished would have the biggest impact on your life?

_____

Health Concerns(check all that apply):

- ☐ Anxiety
- ☐ Depression
- ☐ Digestive trouble
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Fatigue/Sleep issues
- ☐ Arthritis
- ☐ Loss of balance
- ☐ Neck pain
- ☐ Back pain
- ☐ Sciatica
- ☐ Pain in arms or legs
- ☐ Irritability
- ☐ Memory problems
- ☐ Headaches / Migraines
- ☐ Stiffness
- ☐ Cancer
- ☐ Cold hands/feet
- ☐ Dizziness
- ☐ Inability to concentrate
- ☐ Postpartum concerns
- ☐ Allergies or Sinus issues
- ☐ Concussion
- ☐ Sports Injury
- ☐ Infertility
- ☐ Other: _____
- ☐ High Blood Pressure
- ☐ Knee pain / Ankle pain
- ☐ Shoulder pain
- ☐ ADD/ADHD
- ☐ Nervousness
- ☐ TMJ dysfunction
- ☐ Menstrual Issues
- ☐ Vertigo
- ☐ Epilepsy
- ☐ Scoliosis
- ☐ Poor Posture

ADULT INTAKE

Are you working currently (circle one) YES / NO

Occupation: _____ Employer: _____

Job duties: _____

_____

Medications currently taking: _____

Vitamins/supplements currently taking: _____

_____

How many hours of sleep do you get per night? _____ Quality of sleep (circle): POOR | MODERATE | GREAT

Hobbies: _____

Current Exercise Regimen: _____

Anything else you want the Doctors to know? _____

_____

Consent to Chiropractic Services:

I hereby request and consent to chiropractic adjustments and other procedures by Doctors Moe and their staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with TOLC personnel the nature and purpose of treatment indicated. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to anticipate and explain all risks and complications, and wish to rely on the Doctors to exercise judgement during the course of any procedure which the Doctors feel at that time is in my best interest. I understand that TOLC will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of TOLC responsible for any errors or omissions that I may have made in completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its consent and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or empoloyed staff.

Patient signature: _____ Date: _____

Pregnancy consent:

By signing the below line I am confirming to the best of my knowledge I am NOT pregnant

Patient signature: _____ Date: _____