Adult Intake Form

Name: ____ **Today's Date:** ____________________

Nickname: ________________ **DOB:**________________ **Phone:** ____________________________

Email: _________________________________ **Marital Status:**______ **Spouse's Name**_________________

Address:____________________________________ **City:**__________________ **State:**_____ **Zip:**_______

Occupation: ________________________ **Employer:**______________________________

Referred by: _____________________________________

Emergency Contact:____________________________ **Contact:**_____________________

Relation:________________________

Have you been to a chiropractor before? Y N How recently? ___________

Primary reason for seeking care:____

When did it start and how?____

Is this related to an auto or work injury?_____________

What makes it better?__________________________ What makes it worse?___________________________

On a scale of 1 (mild pain) to 10 (incapacitating pain), at what level is your pain?___________

How frequent is your pain?(circle) Constant Frequent Intermittent Occasional

Do your symptoms interfere with daily life?______________________________________

Have you had this condition before?(circle) Yes No If so, when?__________________

Have you seen anyone else for this condition?____

Have you had x-rays or images taken?____

Current medications and supplements (vitamins, minerals, herbs) you are taking:

____

____

All surgeries with dates:____

All accidents/traumas with dates:____

Have you ever suffered from:

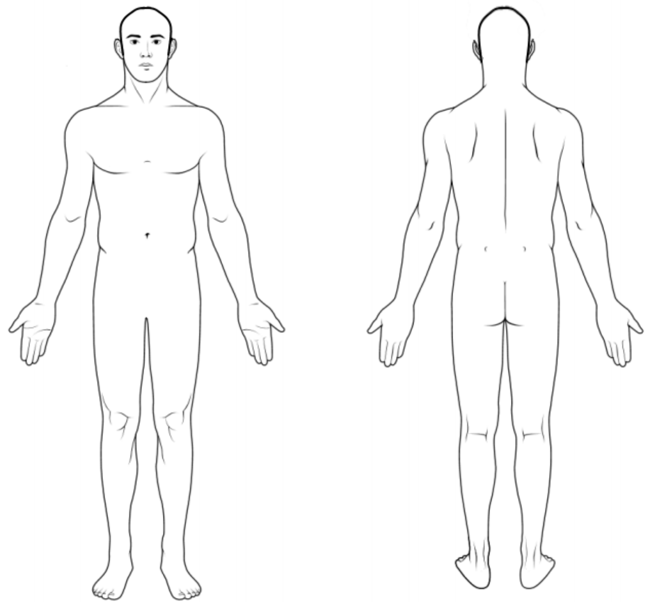
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back pain
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chest pain/conditions
- ☐ Cold extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion problems
- ☐ Dizziness
- ☐ Ears ring
- ☐ Excessive menstruation
- ☐ Eye pain or difficulties
- ☐ Fatigue
- ☐ Frequent urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High blood pressure
- ☐ Hot flashes
- ☐ Irregular heart beat
- ☐ Irregular cycle
- ☐ Kidney infection
- ☐ Kidney stone
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps in breast
- ☐ Neck pain or stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor posture
- ☐ Prostate trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus infection
- ☐ Sleep problems or insomnia
- ☐ Spinal curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen joints
- ☐ Thyroid condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose veins
- ☐ Venereal disease
- ☐ Other:_____________

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing:

A=Ache **O**=Other

B=Burning **P**=Pins & Needles

N=Numbness **S**=Stabbing



Are you interested in learning about therapeutic massage? YES NO

Are you interested in learning about nutritional supplementation counseling? YES NO

Consent to treatment: To the best of my knowledge, this form is accurate and complete. I have disclosed all known health conditions and will inform Dr. Lundy of any changes in my health status at the beginning of future appointments. I consent to treatment.

Signature____ Date:_________________________

Informed Consent to Join Manipulation/Mobilization and Care

Dr. April Lundy

1241 Canton St. Suite 100 Roswell, GA 30075

404-400-3332

I hereby request and consent to the performance of joint manipulations/mobilizations and other procedures including various modes of physiotherapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor/s named above and/or other licensed doctor/s who now or in the future treat me while employed by working or associated with serving as back up for the doctor/s or with the doctor/s named above, including those working at the clinic or office listed above.

I have had an opportunity to discuss with the doctor/s named above and/or with other office or clinic personnel the nature and purpose of joint manipulations/mobilization and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, chiropractic and physiotherapy there are some risks to the treatments including but not limited to reactions to modalities, fractures and strains. I do not expect the doctor/s to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/s to exercise judgement during the course of the procedures which the doctor/s feels at the time, based on fact then known, is in my best interests.

I have read, or have read to me above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT OR PATIENT'S REPRESENTATIVE, IF NECESSARY, e.g., IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED:

______________________	______________________	__________
Print Patient's Name	Signature	Date
______________________	______________________	__________
Representative	Relationship	Date

Witness:____