BLOSSOM
FAMILY CHIROPRACTIC

# Adult Intake Form

Date: _____

## PERSONAL INFORMATION

First Name: _____ M.I.:_____ Last Name:_____

Preferred Name: _____

Address:_____

City / State / Zip: _____

Home Phone: (  ) _____ Work Phone: (  ) _____

Cell Phone: (  ) _____ Email: _____

Birth Date: _____ Age:_____ Sex: ☐ M ☐ F

Occupation: _____ Employer's Name: _____

Marital Status: ○ S ○ M ☐ D ☐ W ☐ Other Spouse's Name:_____

# of Children: _____ Children's Names & Ages: _____

_____

Who can we thank for referring you or how did you hear about our office?_____

_____

## REASON FOR SEEKING CARE

What is your reason for seeking care at Blossom Family Chiropractic:_____

_____

When did this begin? (if applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your life? (ie sleep, work, energy, exercise, everyday life)

_____

Have you seen any other providers for this condition? (List all that apply)

_____

Have you seen a chiropractor before? ☐ Yes ☑ No

How long ago?_____ Clinic/Doctor Name: _____

What is your reason for the change? (if applicable) _____

What is your level of commitment to yourself and your health ( 10 most, 1 least) 1☑2☐3☐4☐5☐6☐7☐8☐9☐10☐

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

_____

Print Patient's Name: _____ Date: _____

## HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Digestive Troubles
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Hypertension
- ☐ Arthritis
- ☐ Loss of Balance
- ☐ Neck/Back Pain
- ☐ Pain in Arms/Legs
- ☐ Irritability
- ☐ Fatigue/Sleep Issues
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Sensitivity to Light
- ☐ Loss of Concentration
- ☐ Memory Problems
- ☐ Headaches
- ☐ Stiffness/Flexibility
- ☐ Sinus Troubles/Allergies
- ☐ Cold Hands/Feet
- ☐ Other_____

Explain any boxes checked above or add additional concerns:

_____

_____

_____

_____

_____

Is there anything else regarding your current condition you feel the doctor should know? _____

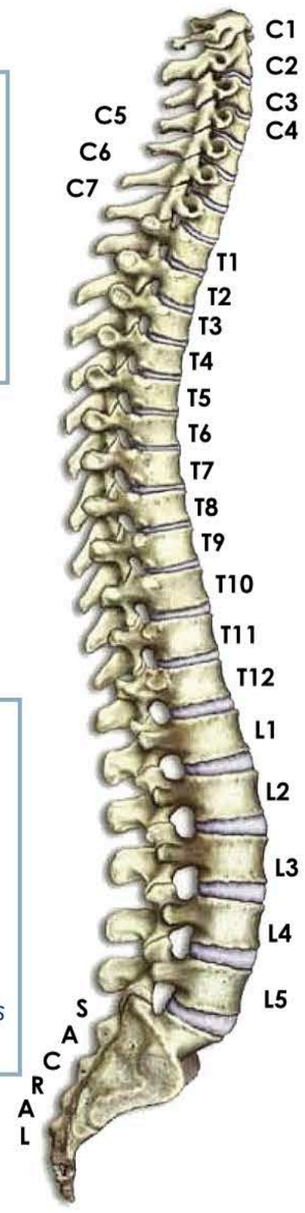
_____

_____

## DID YOU KNOW...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.

*Sore Throat*
*Stiff Neck*
*Radiating Arm Pain*
*Hand/Finger Numbness*
*Asthma*
*Allergies*
*High Blood Pressure*
*Heart Conditions*




*Headaches*
*Mirgrains*
*Dizziness*
*Sinus Problems*
*Allergies*
*Fatigue / Sleep Problems*
*Head Colds*
*Vision Problems*
*Difficulty Concentrating*
*Hearing Problems*

*Middle Back Pain*
*Congestion*
*Difficulty Breathing*
*Bronchitis*
*Pneumonia*
*Gallbladder Conditions*
*Stomach Problems*
*Ulcers*
*Gastritis*
*Kidney Problems*
*Indigestion*

*Constipation*
*Colitis*
*Diarrhea*
*Gas Pain*
*Irritable Bowel*
*Bladder Problems*
*Menstrual Problems*
*Low Back Pain*
*Pain or Numbness in Legs*
*Reproductive Problems*

## MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Blood Pressure
- ☐ Pain Narcotics
- ☐ Muscle Relaxers
- ☐ Migraine/Headache
- ☐ Cholesterol
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above: _____

_____

_____

_____

## VITAMINS / SUPPLEMENTS

- ☐ Multi-Vitamin
- ☐ Vitamin D3
- ☐ Prenatal Vitamin
- ☐ _____
- ☐ _____
- ☐ Fish Oil/Omega-3
- ☐ Probiotics
- ☐ _____
- ☐ _____

Explain any boxes checked above:

_____

_____

_____

## EMERGENCY CONTACT

First Name: _____ M. I.:_____

Last Name: _____

Preferred Name: _____

Address: _____

City / State / Zip: _____

Phone: (  ) _____ Relation: _____

Print Patient's Name: _____ Date: _____

## CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic adjustments and other procedures (diagnostic x-rays if necessary) by Dr. Savy Ford and staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with Blossom Family Chiropractic personnel and 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 allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Blossom Family Chiropractic 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 Blossom Family Chiropractic responsible for any errors or omissions that I may have made in the 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 abzout its content 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 employed staff.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

## X-RAY CONSENT FOR WOMEN OF CHILDBEARING AGE

X-ray examination of the abdomen and pelvis expose the uterus to radiation. The last ten days onset of the menstrual cycle are generally considered safe for x-ray examination.

Date of onset of last menstrual period: _____

I am pregnant: ◯Yes ◯No

I had a hysterectomy: ◯Yes ◯No

I use an IUD: ◯Yes ◯No

I recognize that if I am pregnant and have radiation to the abdomen, there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this examination is important to my health. I therefore wish to have this x-ray examination performed now.

Patient signature: _____

Guardian signature: _____

Witness signature: _____