NEW LIFE
HEALTH & WELLNESS

Adult Intake Form

Date: / /

Personal Information

First Name: Last Name: DOB: / /

Preferred to be called: Occupation:

Home Address: City: State: Zip:

Cell: Home:

Email: Gender identity:

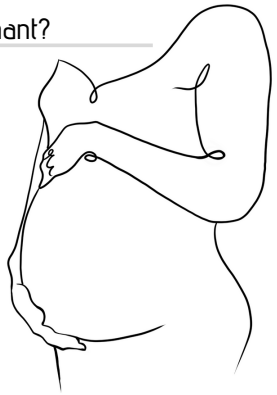
Marital Status: M / S / W / D / P Name of Spouse:

Who can we thank for referring you:?

Have you ever recieved chiropractic care? ☐ No ☐ Yes (Please list the City, State, & Doctor):

Women (if pregnant)

☐ Weeks Estimated Due Date: / / How many times have you been pregnant?



Who is your OB/Midwife?

May we contact them about your care in our office? ☐ Yes ☐ No

What are your plans for birth? Natural / Vaginal with epidural / Cesarean

Planned location? Home / Birthing Center / Hospital

Have you had any ultrasounds? How many?

Health concerns for you or baby?

Emergency Contact

Name: Number: Relationship:

Insurance/ Medicare Information

(Please give your insurance card and driver's license to the front desk)

Primary Insurance Carrier: Subscriber's Name:

Occupation: Employer: Subscriber's DOB: / /

Subscriber's address: Group #:

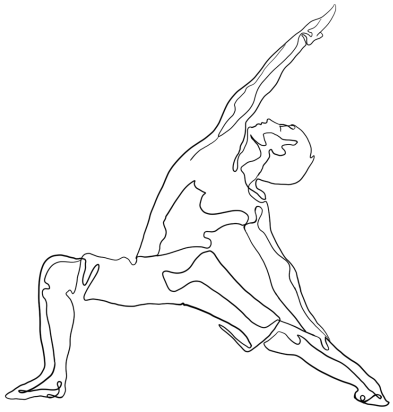
Policy Number #: Drivers Licence Number #: State:

NEW LIFE
HEALTH & WELLNESS

Name: Date: / /

Current Health & Lifestyle Goals

- ☐ Relieve Pain/ Discomfort
- ☐ Relieve Muscle Tension
- ☐ Restore Proper Function
- ☐ Improve Flexibility/ Mobility
- ☐ Improve Posture
- ☐ Increase Energy
- ☐ Get Adequate Sleep
- ☐ Pregnancy Care
- ☐ Reduce Medication(s)
- ☐ Improve Diet/ Nutrition
- ☐ Maintain Health Body Weight
- ☐ Improve Work/ Life Balance
- ☐ Improve Focus/ Concentration
- ☐ Strengthen Immune System
- ☐ Restore Emotional Health
- ☐ Improve Athletic Performance
- ☐ Quit Unhealthy Habit:_____
- ☐ Other:_____



Health History

Do you have any genetic disorders or disabilities? ☐ No ☐ Yes (Explain):

Have you ever had a serious illness or health emergency? ☐ No ☐ Yes (List condition(s) and year):

Have you ever had an operation? ☐ No ☐ Yes (List operation(s) and year):

Have you ever been in an auto accident? ☐ No ☐ Yes (Explain):

Have you ever been unconscious? ☐ No ☐ Yes (Explain):

Have you ever fractured a bone? ☐ No ☐ Yes (Explain):

How often do you smoke? ☐ Never ☐ In the past ☐ Occaisonally ☐ Daily ☐ Other:

How often do you drink alcohol? ☐ Never ☐ In the past ☐ Occaisonally ☐ Daily ☐ Other:

How often do you exercise? ☐ Never ☐ In the past ☐ Occaisonally ☐ Daily ☐ Other:

My typical day includes: ☐ Light Lifting ☐ Heavy Lifting ☐ Physical Repetition ☐ Excessive Sitting ☐ Excessive Standing ☐ Low Stress ☐ High Stress ☐ Other:_____

Do you currently take any over-the-counter or prescription drug, vitamn. supplement, or natural remedy?

☐ No ☐ Yes (Please list the names & reason for taking):

NEW LIFE
HEALTH & WELLNESS

Name: Date: / /

Current Symptoms

☐ No compllaints, I'm here to use chiropractic care for my overall well-being.

#1 Health concern: Severity (0-10)?

When did your symptom(s) begin? What percentage of the day do you feel it?

Did your symptom(s) begin as a result of an injury? ☐ No ☐ Yes (Explain):

Does your symptom(s) move or travel from one area of your body to another? ☐ No ☐ Yes (Explain):

Words to decribe it?

What makes it better? What makes it worse?

#2 Health concern: Severity (0-10)?

When did your symptom(s) begin? What percentage of the day do you feel it?

Did your symptom(s) begin as a result of an injury? ☐ No ☐ Yes (Explain):

Does your symptom(s) move or travel from one area of your body to another? ☐ No ☐ Yes (Explain):

Words to decribe it?

What makes it better? What makes it worse?

#3 Health concern: Severity (0-10)?

When did your symptom(s) begin? What percentage of the day do you feel it?

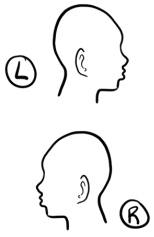
Did your symptom(s) begin as a result of an injury? ☐ No ☐ Yes (Explain):

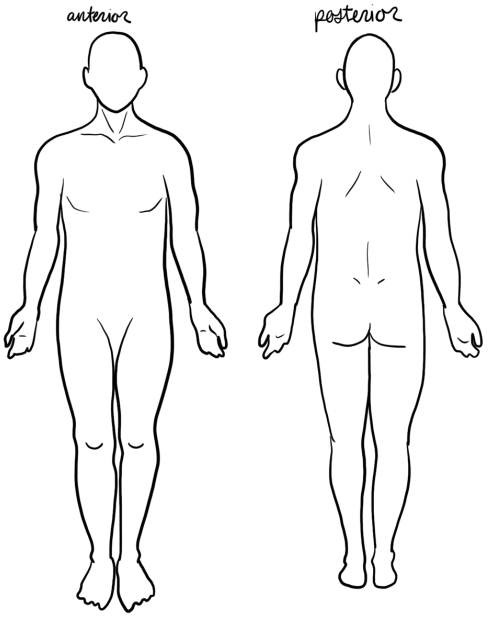
Does your symptom(s) move or travel from one area of your body to another? ☐ No ☐ Yes (Explain):

Words to decribe it?

What makes it better? What makes it worse?

In the diagram to mark the figures in relation to where you experience symptoms on your body.





NEW LIFE
HEALTH & WELLNESS

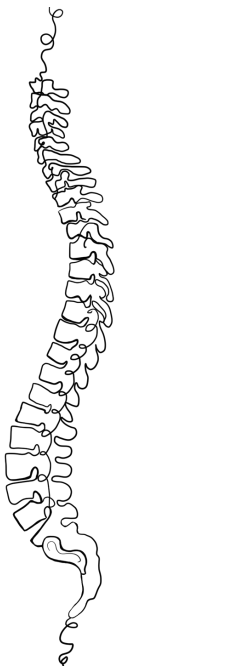
Name: Date: / /

Check any of the following that apply

	Present	Past
Acid Reflux		
ADD/ ADHD		
Allergies		
Anxiety		
Arthritis		
Asthma		
Autoimmune problems		
Bed Wetting		
Cancer		
Depression		
Digestive Problems		
Diabetes		
Dizziness		
Ear Problems		
Eczema		
Fatigue		
Flu		
Headaches		
Heart Problems		
Immune Problems		
Indigestion		
Infertility		
Kidney Problems		
Liver Problems		
Menstrual Problems		
Migraines		
Muscle spasms		
Nausea		
Numbness		

	Present	Past
Sciatica		
Scoliosis		
Seizures		
Sinus Problems		
Sleeping Problems		
Stiffness		
Stomach Trouble		
Thyroid Problems		
TMJ Pain		
Ulcers		
Vertigo		
Weight Gain / Loss		

Other (Please explain)



NEW LIFE
HEALTH & WELLNESS

Pediatric Intake Form

Date: / /

Child Information

First Name: Last Name: DOB: / /

Preferred to be called: Gender: M / F Age:

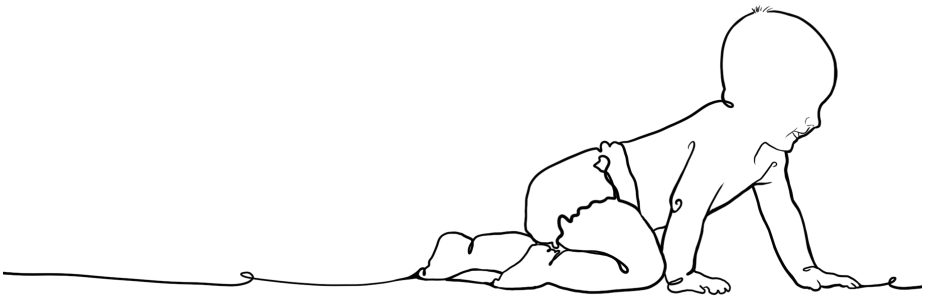
Pediatrician: Can we contact them regarding our child's care? ☐ Yes ☐ No

Have you ever recieved chiropractic care? ☐ No ☐ Yes ,(As an): ☐ Infant ☐ Child ☐ Adolescent

(If yes, please list the City, State, & Doctor):

Who can we thank for referring you:?

Current Weight	Current Height
lb.	ft.
oz.	in.



Parent(s) / Guardian(s) Information

Parent(s)/ Guardians(s) #1

Home Address: City: State: Zip:

Cell: Home: Email:

Have you ever recieved chiropractic care? ☐ No ☐ Yes (Please list the City, State, & Doctor):

Parent(s)/ Guardians(s) #2

Home Address: City: State: Zip:

Cell: Home: Email:

Have you ever recieved chiropractic care? ☐ No ☐ Yes (Please list the City, State, & Doctor):

Additional Emergency Contact

Name: Number: Relationship:

NEW LIFE
HEALTH & WELLNESS

Name: Date: / /

Many types of stressors (physical, mental, chemical) can interfere with your child's growing brain, spine, and nervous system. To serve them better, please complete the following information
We look forward to working with you to build better health for your family.

Current Health & Lifestyle Goals For Your Child

- ☐ Relieve Pain/ Discomfort
- ☐ Relieve Muscle Tension
- ☐ Restore Proper Function
- ☐ Strengthen Immune System
- ☐ Improve Posture
- ☐ Increase Energy
- ☐ Get Adequate Sleep
- ☐ Increase Self Confidence
- ☐ Improve Diet/ Nutrition
- ☐ Maintain Health Body Weight
- ☐ Improve Mood/ Temperament
- ☐ Improve Focus/ Concentration
- ☐ Improve Athletic Performance
- ☐ Reduce Medication(s):_____
  _____
- ☐ Other:_____
  _____

Prenatal History

Are you the birth mother/ father? ☐ Yes ☐ No, (Answer the questions to the best of your knowledge)

Name of the Doctor/ Midwife? ☐ Yes ☐ No

Did the birth mother experience any complications, serious illness, or health emergency during pregnancy? ☐ Yes ☐ No

(If Yes, explain):

Did the birth mother **smoke** before or during pregnancy? ☐ Yes, before ☐ Yes, during ☐ No

Did the birth mother **drink** before or during pregnancy? ☐ Yes, before ☐ Yes, during ☐ No

Did the birth mother **exercise** during pregnancy? ☐ Yes ☐ No

Birth History & Infancy

At how many weeks of pregnancy was your child born? weeks

Birth Weight: Birth Height: APGAR Scores:

Select the delivery method of your child's birth:

☐ Vaginal ☐ Vaginal Birth After Cesarean
☐ Planned Cesarean ☐ Emergency Cesarean

Select the location of your child's birth:

☐ Home ☐ Hospital ☐ Birthing Center
☐ Other:

NEW LIFE
HEALTH & WELLNESS

Name: Date: / /

Current Symptoms

☐ Select all following symptoms/ conditions your child experiences:

☐ Acid Reflux	☐ Autism Spectrum	☐ Epilepsy	☐ Restless Sleep
☐ ADHD/ ADD	☐ Back Pain/ Neck Pain	☐ Growing Pains	☐ Scoliosis
☐ Allergies	☐ Bed Wetting	☐ Headaches	☐ Sinus Problems
☐ Anxiety	☐ Colic	☐ Nosebleeds	☐ Skin Problems
☐ Asthma	☐ Digestive Problems	☐ Poor Posture	☐ Tantrums/ Temperament
☐ Athletic Injury	☐ Ear Infections	☐ Recurring Colds/ Fevers	☐ Other:_____

When did the symptom(s) begin? _____Years _____Months _____Weeks

What have you tried that **HAS NOT** helped to relieve your child's symptom(s)?

What have you tried that **HAS** helped to relieve your child's symptom(s)?

Case History & Lifestyle

How often does your child exercise? ☐ Never ☐ Occaisionally ☐_____times per week ☐ Daily

List your child's regular physical activities:

List your child's hobbies & interest:

Does your child have any genetic disorder or disability? ☐ No ☐ Yes, (Explain):

At what age did you child begin to walk? _____ Speak? _____

Has your child ever had a serious illness, operation, or health emergency? ☐ No ☐ Yes, (Explain):

Is your child taking any drugs/ medications/ vitamins/ supplement or natural remedy? ☐ No ☐ Yes, (List the name & reason for taking):

NEW LIFE
HEALTH & WELLNESS

Name: Date: / /

Check any of the following that apply

	Child	Mother	Father
Acid Reflux			
ADD/ ADHD			
Allergies			
Anxiety			
Arthritis			
Asthma			
Autoimmune problems			
Bed Wetting			
Cancer			
Depression			
Digestive Problems			
Diabetes			
Dizziness			
Ear Problems			
Eczema			
Fatigue			
Flu			
Headaches			
Heart Problems			
Immune Problems			
Indigestion			
Infertility			
Kidney Problems			
Liver Problems			
Menstrual Problems			
Migraines			
Muscle spasms			
Nausea			
Numbness			

	Child	Mother	Father
Sciatica			
Scoliosis			
Seizures			
Sinus Problems			
Sleeping Problems			
Stiffness			
Stomach Trouble			
Thyroid Problems			
TMJ Pain			
Ulcers			
Vertigo			
Weight Gain / Loss			
Other (Please explain)			