ADULT INTAKE FORM

Thank you for taking the time to complete this form to the best of your ability. It is invaluable in aiding in your journey back to health.

Please bring this completed form to your first appointment. Completed forms can also be emailed to backtohealthwi@gmail.com This form must be completed to receive chiropractic care.

Name_____ Todays Date_____

Address_____City_____ State_____Zip_____

Telephone:(home) _____ (work) _____ (cell) _____

E-mail address_____ Age_____ **Date of Birth_____**

Gender: _____ Height _____ Weight_____

Education_____

Occupation_____ Hours per week_____ Retired Y N

Employer_____

How did you hear about Dr. English? _____

Has any other family member been under care by Dr. English? _____

What do you think the average cost of a chiropractic adjustment is per visit? _____

Are you interested in:
- ☐ Acute care (symptom relief)
- ☐ Wellness care (keep feeling good)
- ☐ Both

Do you have Medicare Y N
*Medicare patients require extra forms to be filled out

Financial Statement: Dr. English is out of network with all insurance companies and does not submit any billing to them. Patients are welcome to self-submit any charges or use any HSA or Flex cards to utilize your insurance benefits. Please let the doctor know if you would like to self-submit and you will then be sent the appropriate information to send to your insurance company on a monthly basis.
All payments shall be made at the time of the visit. Cash, Check or credit cards are excepted. Family discounts and prepaid single visit packages are available. Please ask for more information on these if you are interested. 24 hours' notice is needed to cancel any appointment without being charged for the missed visit. $25 for single visits, $50 for family visits and $100 for new patients that are missed.

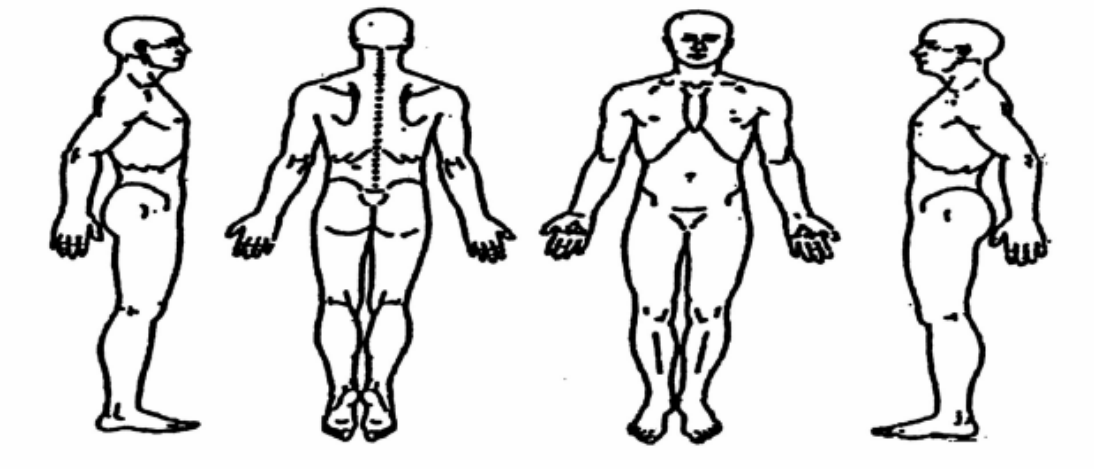
Patient Signature:_____

HEALTH HISTORY QUESTIONNAIRE

Have you had chiropractic care in the past? Y N If yes, when_____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation Date of Injury: _____

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?
   - □ Constantly (76-100% of the time)
   - □ Occasionally (26-50% of the time)
   - □ Frequently (51-75% of the time)
   - □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?
   - □ Sharp
   - □ Numb
   - □ Burning
   - □ Stabbing with motion
   - □ Dull
   - □ Tingly
   - □ Shooting
   - □ Electric like with motion
   - □ Diffuse
   - □ Sharp with motion
   - □ Stiff
   - Other:_____
   - □ Achy
   - □ Shooting with motion

5. How are your symptoms changing with time?
   - □ Getting Worse
   - □ Staying the Same
   - □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
   0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
   - □ Not at all
   - □ A little bit
   - □ Moderately
   - □ Quite a bit
   - □ Extremely

8. How much has the problem interfered with your social activities?
   - □ Not at all
   - □ A little bit
   - □ Moderately
   - Quite a bit□ Extremely

9. Who else have you seen for your problem?
   - □ Chiropractor
   - □ Neurologist
   - □ Primary Care Physician
   - □ ER physician
   - □ Orthopedist
   - □ Other: _____
   - □ Massage Therapist
   - □ Physical Therapist
   - □ No one

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe?
   - □ Yes
   - □ Yes, at times
   - □ No

13. What aggravates your problem? _____
14. What improves your problem? _____

15. What concerns you the most about your problem; what does it prevent you from doing?
_____

PERSONAL HISTORY

COVID
Have you ever had COVID or a + Test? _____ Estimated dates of infection: _____
Have you ever had a COVID vaccination or booster? _____ Dates of shots: _____
Any reactions to vaccinations: _____
Any residual COVID symptoms: _____

Hospitalization and Surgery
Have you ever had a/an…? Ear Tubes Y N Tonsillectomy Y N
What other hospitalizations or surgeries have you had?
_____ Year: _____ _____ Year: _____
_____ Year: _____ _____ Year: _____

X-Rays and Special Studies
Please note when and why you have had each of the following and results:
X-Rays:_____ MRI/CT scans: _____
Ultrasounds: _____ Thermography: _____
Surgeries: _____ Other: _____

Allergies
Are you hypersensitive or allergic to…?
Any medications? _____
Any foods? _____
Any environmentals? _____
Any chemicals? _____

Medications and Supplements
Y = Yes, you **take now** **N = No,** you **never have** **P =** you have taken in the **past**
Do you take or use…

Laxatives	Y	N	P	Pain Relievers	Y	N	P	Hormones	Y	N	P
Blood pressure pills	Y	N	P	Insulin	Y	N	P	Antacids	Y	N	P
Birth Control	Y	N	P	Antibiotics	Y	N	P	Sleeping pills	Y	N	P
Thyroid pills	Y	N	P	Cortisone	Y	N	P	Sedatives	Y	N	P

Current Medications

	Name	Strength	Dosage	Reason	How long?
1.					
2.					
3.					

Current Supplements & Herbs

	Name	Strength	Dosage	Reason	How long?
1.					
2.					
3.					

TYPICAL FOOD INTAKE
Do you have any dietary restrictions or follow a particular dietary regimen? If yes, please describe:
_____
_____
What is a typical range of food and drinks that you consume_____
_____
Water intake: _____ per day.

LIFESTYLE
Main interests and hobbies? _____
Do you exercise? Y N P

If yes, what kind? _____ How often? _____

Average 7-8 hrs. sleep?	Y	N	P	Enjoy your work?	Y	N	P
Sleep well?	Y	N	P	Take vacations?	Y	N	P
Awaken rested?	Y	N	P	how many weeks/yr? _____			
Have a supportive relationship?	Y	N	P	Watch television?	Y	N	P
Have a history of abuse?	Y	N	P	how many hours/wk? _____			
Any major traumas?	Y	N	P	Read for pleasure or interest?	Y	N	P
Spend time outside?	Y	N	P	how many hours/wk? _____			
Use recreational drugs?	Y	N	P	Do you use tobacco?	Y	N	P
What drugs? _____							
Use alcoholic beverages?	Y	N	P				

Do you purchase organic fruits and vegetables? Y N

Do you purchase organic meats and dairy products? Y N

When during the day is your energy the best? _____Worst?_____

Trauma

Have you ever been in a car accident? Y N

Have you ever been treated for a work injury? Y N

List any trauma injuries (fractures, sprains, concussions, disc herniation's, etc.)

a. _____
b. _____
c. _____

List any repetitive stress you currently or have experienced (stomach sleeping, work movements, sports, etc.)

a. _____
b. _____
c. _____

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Miscarriage
□	□ Cancer	□	□ General Fatigue	□	□ IVF
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

Is there anything else you would like to add or comment on? _____

_____

_____

Thank you for your time and effort. I look forward to aiding you in your healing process.