Adult Intake

Appointment Date_____

2205 Blairsferry Crossing B
Hiawatha, Iowa 52233
319.826.6879
awakenfamilychiro@gmail.com

Patient Information

Name_____ Preferred name_____
Street Address _____
City, State, Zip _____
Cell Phone _____ Other Phone _____ Can we leave a voicemail? ☐ Yes ☐ No
Email _____
Would you like to receive emails (special offers, upcoming events)? ☐ Yes ☐ No
Occupation _____ Employer _____
Birthdate _____ Age _____ Gender _____ Marital Status _____
Spouse's Name _____ Number of Children _____
How did you hear about our office? _____
Emergency Contact Name _____
Phone _____ Relationship _____
Who is your primary care physician? _____
Date and reason for last visit _____

Your Current Health

My overall health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Reason for seeking care at our office _____
If applicable, when did this condition begin? _____
What symptoms are you experiencing? _____
Since the onset, symptoms seem to be: ☐ Getting better ☐ Getting worse ☐ Staying the same
This condition began: ☐ Suddenly ☐ Gradually ☐ Due to injury or accident
What makes the symptom(s) better? _____
What makes the symptom(s) worse? _____
Have you received any other treatment for this condition? _____
How is this condition affecting your daily activities? _____
_____

For Women Only

Are you currently pregnant? ☐ Yes ☐ No
If yes, when is your due date? _____
Any symptoms you are experiencing during this pregnancy _____
_____
Current OB and/or Midwife _____
Have you been pregnant in the past? ☐ Yes ☐ No If yes, how many times? _____
Have you ever experienced: ☐ Miscarriage ☐ Abortion ☐ Preeclampsia ☐ Ectopic pregnancy ☐ Anemia
☐ Gestational diabetes ☐ Hyperemesis gravidarum ☐ Placenta previa
☐ Other complications (please describe) _____
Are you nursing? ☐ Yes ☐ No
Do you have breast implants? ☐ Yes ☐ No
Do you experience irregular menstrual cycles? ☐ Yes ☐ No

Your Health Habits

Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per week? _____

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how much per day? _____

Do you have any dietary restrictions, allergies, sensitivities, etc? _____

_____

How much do you exercise? ☐ None ☐ Rarely ☐ Weekly ☐ Daily

What type of exercise? _____

How many hours of sleep do you average per night? _____ How do you sleep? ☐ Back ☐ Side ☐ Stomach

How many hours per day do you spend on a computer/tablet/phone? _____

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please like reason and year _____

_____

Please list all surgeries, including year _____

_____

_____

Have you been in a motor vehicle accident? ☐ Yes ☐ No

If yes, please describe _____

Have you broken any bones? ☐ Yes ☐ No

If yes, please describe _____

Have you had any major falls, injuries, or other accidents? ☐ Yes ☐ No

If yes, please describe _____

_____

Have you had any significant illnesses (including COVID-19)? _____

_____

Did you receive the COVID-19 vaccine? ☐ Yes ☐ No Booster dose(s) ☐ Yes ☐ No

Any reactions? _____

Please list current medications/supplements you are taking and reasons for taking them _____

_____

_____

Please list any significant family medical history (immediate family members) _____

_____

_____

Chiropractic Care

Have you previously been under chiropractic care? ☐ Yes ☐ No

If yes, please list office name and date of last visit? _____

Did you know that Doctors of Chiropractic work with the nervous system? ☐ Yes ☐ No

Did you know that chiropractic care is the most utilized natural, drug-free healthcare profession? ☐ Yes ☐ No

Do you know what a **subluxation** is? ☐ Yes ☐ No

What is your health goal while under care at our office? _____

_____

Do you have any other concerns you would like to address with us (health-related or not)? _____

_____

_____

Patient Review of Systems

AWAKEN FAMILY CHIROPRACTIC
PEDIATRIC AND FAMILY WELLNESS

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EYES/EARS/NOSE/THROAT □ None

Past	Present	
□	□	Blurred or double vision
□	□	Vertigo & dizziness
□	□	Ear & sinus infections
□	□	Sore throat
□	□	Nosebleeds
□	□	Swollen tonsils & adenoids
□	□	Hearing loss
□	□	Tinnitus (ringing in ears)
□	□	Speech issues
□	□	TMJ/jaw pain

RESPIRATORY □ None

Past	Present	
□	□	Asthma
□	□	Seasonal allergies
□	□	Chronic colds or cough
□	□	Pneumonia
□	□	Shortness of breath
□	□	RSV

GASTROINTESTINAL □ None

Past	Present	
□	□	Food sensitivities/allergies
□	□	Reflux/GERD
□	□	Stomach pains
□	□	Nausea/vomiting
□	□	Ulcers
□	□	Jaundice
□	□	Constipation
□	□	Diarrhea
□	□	Excessive gas or bloating
□	□	Chron's, colitis, IBS
□	□	Gallbladder pain/issues
□	□	Poor appetite
□	□	Hemorrhoids
□	□	Gluten/casein intolerance

CARDIOVASCULAR □ None

Past	Present	
□	□	High blood pressure
□	□	High cholesterol
□	□	Anemia
□	□	Stroke
□	□	Heart condition
□	□	Leg cramping/swelling
□	□	Aneurysm
□	□	Poor circulation

ENDOCRINE □ None

Past	Present	
□	□	Infertility
□	□	Cysts or endometriosis
□	□	Menstrual issues
□	□	Hair loss
□	□	Diabetes Type I or II
□	□	Thyroid issues
□	□	Weight gain
□	□	Weight loss
□	□	Chronic fatigue
□	□	Impotency

NEUROLOGICAL □ None

Past	Present	
□	□	Headaches or migraines
□	□	Sleep disturbances
□	□	Walking challenges
□	□	Numbness/tingling
□	□	Sciatica
□	□	Carpal tunnel syndrome
□	□	Seizures
□	□	Sensory/spectrum disorder
□	□	ADD/ADHD
□	□	Focus or memory issues
□	□	Tics/tremors/shaking
□	□	Toe walking
□	□	Anxiety
□	□	Depression
□	□	Behavior issues
□	□	Colic or excessive crying
□	□	Balance/coordination issues

IUMMUNE/SKIN □ None

Past	Present	
□	□	Eczema
□	□	Rashes or skin issues
□	□	Recurrent fevers
□	□	Immune deficiency
□	□	Autoimmune disorder
□	□	Swollen glands
□	□	Cancer

GENITOURINARY □ None

Past	Present	
□	□	Bedwetting (enuresis)
□	□	Kidney problems
□	□	Frequent urination
□	□	Prostate problems

MUSCULOSKELETAL □ None

Past	Present	
□	□	Neck pain
□	□	Low back pain
□	□	Scoliosis
□	□	Arthritis
□	□	Poor posture
□	□	Disc degeneration
□	□	Muscle weakness
□	□	Osteoporosis
□	□	Shoulder/arm/hand pain
□	□	Knee/ankle/foot pain
□	□	Weak ankles or arches
□	□	Hip dysplasia
□	□	Torticollis

Consent for Chiropractic Examination

I hereby grant consent for myself and/or my child to receive a chiropractic examination which may include discussing health history, spinal scans, physical examination and other neurologic or orthopedic testing by Dr. Erica Smothers at Awaken Family Chiropractic. I understand that findings will be communicated with me prior to commencement of care. By signing, I agree that I have provided accurate health information, both past and present. Awaken Family Chiropractic will not be held responsible for any omissions or errors made in the completion of this paperwork.

_____ _____

Signature of Patient or Legal Guardian Date