

UNDERWOOD CHIROPRACTIC

NEW ADULT PATIENT HISTORY INTAKE

To our new patients: *Welcome* to the Chiropractic practice of Dr. Scott R. Underwood. To help us establish you with our practice, please provide us with your complete health history: body, mind and spirit.

Personal History

Name: _____ Date of Birth ____/____/____ Age: ____ Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone # _____ Cell Phone# _____ Work Phone # _____
Occupation _____ Birthplace _____ Date of Last Examination _____
Your Doctor: _____ Referred by: _____

ALLERGIES:

MAIN PROBLEMS/ REASONS FOR THIS APPOINTMENT: (if possible, rank in terms of importance to you)

1. _____
2. _____
3. _____
4. _____
5. _____

Additional problems or concerns you would like addressed:

_____ *Note: we may not be able to address every problem during the course of one visit.

Current Medications

	Dose	Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Herbs / Vitamins/ Supplements

	Dose	Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Chiropractic History

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							

SOCIAL HISTORY (check those that apply):

Patient Name: _____

Marital status:

- single
 married
 divorced
 Widowed

Education level completed:

- high school
 college
 professional school
 other:

Memories of your childhood

- Mostly happy
 Mostly painful
 Normal
 don't recall

Do You Find Your Life

- Generally Unsatisfactory
 Too Demanding
 Boring
 Satisfactory

Living arrangement:

- alone family roommate significant other
 children (list sex/ages): _____
 Major stresses in last 6 months Money Job Marriage Home Life Children
 other stressors _____

Pertinent travel history:(out of USA, epidemic areas)**LIFESTYLE / SELF-CARE ISSUES**

- Do you smoke cigarettes? YES NO If yes, how many? # _____ yrs. _____ packs per day
 Did you ever smoke? YES NO If yes, when did you quit? _____
 Do you drink alcohol? YES NO If yes, how much? Type _____ & _____ drinks per week
 Do you drink caffeinated beverages? YES NO If yes, which? _____
 Do you use recreational drugs? YES NO If yes, which? _____
 Do you manage stress well? YES NO NOT SURE NEED HELP
 Do you exercise regularly? YES NO If no, why? _____
 Do you enjoy your job? YES NO If no, why? _____
 Do you allow time to unwind and relax? YES NO If no, why? _____
 Do you sleep soundly? YES NO If no, why? _____
 Are you satisfied with your sex life? YES NO If no, why? _____
 Are you satisfied with your social life? YES NO If no, why? _____
 Are you satisfied with your spiritual life? YES NO If no, why? _____
 Is your diet healthy enough? YES NO NOT SURE NEED HELP

Typical

breakfast _____

Typical lunch _____

Typical dinner _____

Typical snacks _____

Devices**Do You Use:**

____ Eyeglasses _____ Contact Lens _____ Hearing Aid _____ Dentures
 ____ Brace (Neck, Back) _____ Pacemaker _____ IUD, Diaphragm _____ Artificial Limbs

HEALTH SCREENING HISTORY**Patient Name:** _____

List the date of your most recent test or exam.

Mammogram _____ Pap Smear _____ Self Breast Exam _____ Breast Exam by Doctor _____

Blood test for Cholesterol _____ Blood Sugar _____ Other Blood tests _____

Immunizations: Polio _____ Tetanus _____ Hepatitis _____ Pneumonia _____ Flu Shot _____

Test for Blood in stool _____ Rectal Exam _____ Feeling the Prostate _____ Scope Lower Bowel _____

Self Exam Testicle _____ Testicle Exam by Professional _____

Anatomy\Procedure	X-ray	MRI	CT Scan	Ultrasound	Bone Scan	Pet Scan	EMG
Back							
Brain							
Chest							
Colon							
Extremities (Arm/ Leg)							
Gallbladder							
Kidney							
Neck							
Pelvis							
Stomach							
Other							

YOUR PRIMARY CARE DOCTOR'S NAME _____ DR's PHONE # _____

YOUR PRIMARY CARE DOCTOR'S ADDRESS _____

MAY WE CONTACT YOUR REGULAR OR REFERRING DOCTOR? _____

This history record has been designed to facilitate our patients continuity of care at Underwood Chiropractic. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.

Patient/Guardian signature who filled out the history

_____ Date: _____

Physician Signature

_____ Date: _____