# ADULT INTAKE

TREE OF LIFE CHIROPRACTIC

## Personal information:

Full name: _____Goes by: _____ Date ___/___/___
Address: _____ City: _____
State:_____ Zip: _____
Phone #: _____ Email: _____
Which type of reminders would you like (circle): TEXT | EMAIL
If text reminders, who is your cell phone provider? _____
Sex: Male | Female DOB: _____ Age: _____
Marital Status: _____ Partner name: _____ # of children: _____
Emergency contact: _____Phone number: _____Relation? _____
**Whom may we thank for referring you?** _____

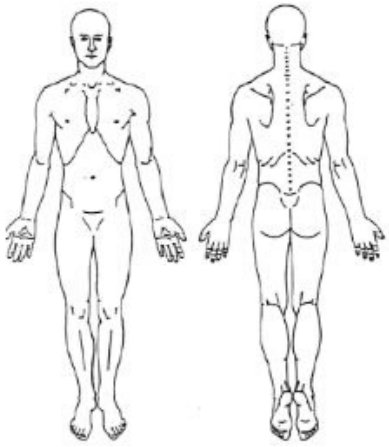
## Reason for seeking care:

What are your reasons for seeking care here: _____
_____
When did it first begin: _____ What makes it better?_____ What makes it worse?_____
How did the problem start: Suddenly / Gradually / Post-injury
Is the problem: Getting worse / Improving / Intermittent / Constant
Have you received care for this condition before? if so, please explain:
_____
Any additional notes on this problem/condition:_____
Have you seen a chiropractor before? yes no How long ago? _____
What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10
What are your goals for chiropractic care?_____
How would resolving this problem impact on your life? _____

## Please circle any current health conditions:

| | | |
|---|---|---|
| Anxiety | High blood pressure | Neck pain |
| Depression | Dizziness | Mid back pain |
| ADHD | Acid reflux | Low back pain |
| Nervousness | Sinus problems | Shoulder pain R/L |
| Irritability | Diabetes | Wrist pain R/L |
| Fatigue | Asthma | Hip pain R/L |
| Sleep concerns | Digestive issues | Sciatica R/L |
| Immune function | Menstrual cycle issues | Knee pain R/L |
| Headaches | Autoimmune conditions | Ankle pain R/L |
| Addictions | Dietary restrictions | Other_____ |

Please mark any areas of pain /discomfort:



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Are you working currently (circle one) YES / NO
Occupation: _____ Employer: _____
Job duties: _____
_____
Previous surgeries_____
Previous auto accidents / injuries: _____
Medications currently taking: _____
Vitamins/supplements currently taking: _____ _
_____
How many hours of sleep do you get per night? _____
Quality of sleep (circle): POOR | MODERATE | GREAT
Hobbies: _____
Current Exercise Regimen: _____
Anything else you want the Doctors to know? _____
_____

## Consent to Chiropractic care:

I hereby request and consent to chiropractic adjustments and other procedures by Doctors Kramer and their staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with TOLC personnel the 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 anticipate and explain all risks and complications, and wish to rely on the Doctors to exercise judgement during the course of any procedure which the Doctors feel at that time is in my best interest. I understand that TOLC will not be held responsible for any preexisting 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 TOLC responsible for any errors or omissions that I may have made in 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 about its consent 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: _____