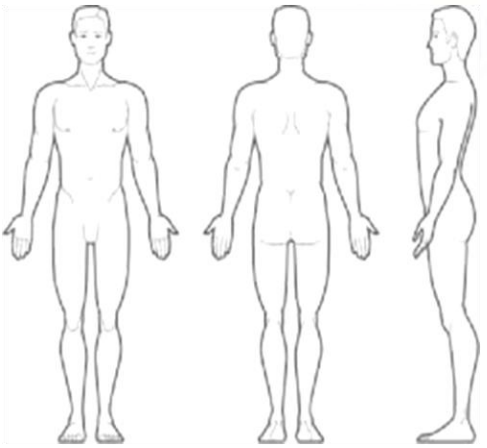
ADULT INTAKE

PATIENT INFORMATION		
Name:	Age:	Date:
Date of Birth:	Male / Female	
Current Address:		
City:	State:	Zip:
Primary Phone #:	Accept Texts: Yes / No	
Alternate Phone #:		
Email Address:		
Marital Status: Married / Single / Widowed / Separated / Divorced / Partnered for _____ Yrs. / Minor		
Employer/ School:	Occupation:	
Spouse's Name:	Employer:	Date of Birth:
Emergency Contact:	Relationship:	Phone #:
Whom may we thank for referring you:		
PATIENT CONDITION		
Have you ever received chiropractic care:	If yes, when:	
Primary reason for seeking chiropractic care:		
Chief complaint:		
Complaint began when and how:		
Is this condition getting progressively worse: Yes / No / Unknown		

SYMPTOMS	Currently	In Past		Currently	In Past
Low Back pain			Hyperactivity		
Neck pain			Bloody Noses		
Digestive Troubles			Meningitis		
Asthma			Diarrhea		
Headaches			Constipation		
Allergies			Bed Wetting		
Sleeping Disorders			Rashes		
Cold/Flu			Milk/Lactose Intolerance		
Ear/Throat Infections			Sinus problems		
Breathing Problems			Loss of hearing		
Fatigue			Learning disorders		
Irritability			Other_____		



Mark with an X on the picture where you continue to have pain, numbness or tingling
Rate the Severity of your pain on a scale from 1 (least) to 10 (severe pain) _____
Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____
Type of pain: (Circle) Sharp / Dull / Throbbing / Numbness / Aching / Shooting / Burning / Tingling / Cramps / Stiffness / Swelling / Other: _____
Is it painful to perform: Sitting / Standing / Walking / Bending
Does it interfere with: Work / Sleep / Daily Routine / Recreation
What treatments have you already received for your condition: Medications / Surgery / Physical Therapy / Chiropractic Services / None / Other: _____
Name and location of other doctor(s) who have treated you for your condition: _____

ADULT INTAKE

HEALTH HISTORY		
List Medications:		
Allergies:		
Vitamins/ Supplements:		
Exercise: None / Moderate / Daily / Heavy		
Work Activity: Sitting / Standing / Light Labor / Heavy Labor		
Habits: Smoking Yes / No ____ Packs per day Coffee or Caffeine: Yes / No _____ Cups per day		Alcohol: Yes / No _____Drinks per day High Stress: Yes/ No Reason: _____
Previous Injuries/ Surgeries you have had: Description & Approximate Date		
Falls/or Head Injuries:		Approx. Date:
Accidents:		Approx. Date:
Broken Bones:		Approx. Date:
Surgeries:		Approx. Date:
Illnesses:		Approx. Date:
FEMALE PATIENTS/PREGNANCIES		
Pregnancies/ Date of Delivery:		**Outcome:**
FINANCIAL AND INSURANCE INFORMATION		
Who is responsible for this account:		Relationship to patient:
Is condition due to an accident: Yes / No		Type of accident: Auto / Work / Home / Other
To who have you made a report of your accident: Auto Insurance / Employer / Work Comp / Other		
Name of Primary Insurance:		
Policy Holder Name:	Policy Holder DOB:	Relationship:
Name of Secondary Insurance:		
Policy Holder Name:	Policy Holder DOB:	Relationship:
I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Dr. Stephanie A. Hoglund to provide me with chiropractic care, in accordance with this state's statutes.		
Signature of patient/ guardian:		Date: