Optimal Vitality Chiropractic
Brain - Body - Balance

ADULT INTAKE FORM

Dr. Amanda Meyers
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Franklin, IN 46131
317-412-9800

Name:_____ Age:_____ Date of Birth:_____ Sex:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone (H):_____ (W):_____ (C):_____

Email:_____ Occupation:_____

Hobbies:_____

Marital Status (Circle One): Single Married Divorced Widow Domestic Partner

# of Children:_____ Medical Doctors Name:_____

Referred By:_____

Have you ever received Chiropractic Care? (Circle One) Yes No

If yes, by who?_____ When?_____ For how long?_____ X-Ray's?_____

About Your Health:

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system. Following your exam, Dr. Meyers will outline a course of care to begin to correct these layers of damage and recover your innate healing potential.

Yes	No	1. Birth Process	If Yes, Please Comment	Dr. Meyers' Comments
O	O	Do you know any history of your birth?	_____	_____
O	O	Was it difficult? (Breech, Caesarean?)	_____	_____
O	O	Adopted? (If so, answer what you know.)	_____	_____
O	O	Home Birth?	_____	_____
O	O	Hospital Birth?	_____	_____
O	O	Abnormalities/Birth Defects	_____	_____
Yes	**No**	**2. Growth and Development**		
O	O	Were you breast-fed?	_____	_____
O	O	Childhood Sicknesses?	_____	_____
O	O	Childhood Accidents?	_____	_____
O	O	Major falls while learning to walk?	_____	_____
O	O	Exposure to toxins? (Explain)	_____	_____
O	O	Did you have any other traumas?	_____	_____
Yes	**No**	**3. Current Health Habits**		
O	O	Did/Do you smoke? (# packs & # years)	_____	_____
O	O	Did/Do you chew tobacco?	_____	_____
O	O	Did/Do you drink alcohol?	_____	_____
O	O	Diet (Do you follow a specific diet?)	_____	_____
O	O	Have a history of trauma/accidents?(List)	_____	_____
O	O	Have you had any surgeries? (List & date)	_____	_____
O	O	Exercise Regularly? (What/How Much?)	_____	_____
O	O	Hobby/Sports Injuries? (List)	_____	_____
O	O	Did/Do you have any work stress?	_____	_____
O	O	Physical Stress?	_____	_____
O	O	Mental &/or Emotional Stress?	_____	_____

Do you have other stress? O Financial O Family Other?_____

Sleeping Posture: O Side O Stomach O Back (Comment) _____

Symptoms/State of Health:

Present Complaint:_____

When did it start? _____

How did it happen? _____

What makes this complaint worse? _____ Better?_____

Is this complaint interfering with work?_____ Sleep?_____ Routine?_____ Other?_____

Is this complaint getting progressively worse?_____ Does the pain travel? (Where?)_____

Other doctors seen for this condition?_____ Home Remedies?_____

Is anything you're trying at home helping? (What?) _____

Other present health problems? _____

Please note **ANY** of the following signals that have presented, even if you feel they are unrelated.

<Under-Aroused>	***<Un-Stable>***	***<Over-Aroused>***
O Poor Attention	O Migraines	O Cold Hands
O Impulsive	O Headaches	O Cold Feet
O Easily Distracted	O Seizures	O Tight Muscles
O Disorganized	O Sleepwalking	O Teeth Grinding
O Depressed	O Hot Flashes	O Anxiety
O Lacking Motivation	O PMS	O Heart Palpitations
O Poor Concentration	O Food Sensitivities	O Restless Sleep
O Spaciness	O Bed Wetting	O Poor Expression of Emotions
O Constipation	O Eating Disorder	O Poor Immune System
O Low Pain Threshold	O Bipolar Disorder	O Racing Mind
O Difficulty Waking	O Mood Swings	O High Blood Pressure
O Worry	O Panic Attacks	O Accelerated Aging
O Irritable		O Irritable Bowel
O Low Energy		

<Exhausted>

O Cancer	O Rheumatoid Arthritis	O Diabetes
O Multiple Sclerosis	O Depression	O Chronic Fatigue Syndrome
O Fibromyalgia	O ALS	O Epstein-Barr Syndrome

<Additional Symptomatology>

O Eczema or Skin Problems	O Pins & Needles in Arms &/or Legs	O Buzzing in Ears	O Fainting
O Blood Pressure Problems	O Loss of Smell or Taste	O Dyslexia	O Loss of Memory
O Numbness in Fingers &/or Toes	O Diarrhea or Constipation	O Dizziness	O Sinus Problems
O Shortness of Breath	O Loss of Balance	O Face Flushed	O Bladder Problems
O Ear Infections	O Urinary Infections	O Frequent Infections	O ADHD or ADD

Are you under drug and/or medical care for any current conditions? (List)_____

What medications or supplements are you taking?_____

How long have you been taking them?_____ What side-effects have you experienced?_____

Is there a family history of:	High BP	Heart Disease	Arthritis	Cancer	Diabetes	Stroke	Other_____
Father's Side:	O	O	O	O	O	O	O
Mother's Side:	O	O	O	O	O	O	O

On a scale of 1-10, rate the importance of you wanting to achieve the following:	**1 = Not Important**									**10 = Necessary**
Eat Better	1	2	3	4	5	6	7	8	9	10
Reduce Stress	1	2	3	4	5	6	7	8	9	10
Stop Smoking	1	2	3	4	5	6	7	8	9	10
Increase Mobility	1	2	3	4	5	6	7	8	9	10
Improve Sleep	1	2	3	4	5	6	7	8	9	10
Learn About Wellness and Natural Health Care	1	2	3	4	5	6	7	8	9	10
Improve Immune Function	1	2	3	4	5	6	7	8	9	10

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

(Signature) (Date)