Apex Health

New Patient Intake

Your Information Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Date:_____

First Name: _____ Middle Initial: _____ Last Name:_____

Address: _____

City: _____ State:_____ Zip Code:_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Ethnicity:_____

Date of Birth: _____/_____/_____ Sex: Male / Female Marital Status: ☐ Single ☐ Married ☐ Other

Family Medical Doctor: _____ Location:_____

Employer/School Data Employment Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Other

Name: _____ Work Phone: (_____)_____-_____

Address:_____

City: _____ State: _____ Zip Code: _____

Please describe your occupation(s):_____

Spouse/Partner Data Is your spouse/partner a patient in this clinic? ☐ Yes ☐ No

First Name: _____ Middle Initial: _____ Last Name: _____

Cell Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Emergency Contact

Contact Name: _____Contact Phone: (_____)_____-_____

Chiropractic Health History

Have you received chiropractic care in the past? Y / N When? _____

Why?_____ Chiropractors Name:_____

Primary reason(s) for seeking chiropractic care today:_____

Have you seen anyone else for this condition? Y/N Who?_____

How did you hear about Apex Health?_____

Health Goals

I would like to improve my health beyond my current state Y/N. I am interested in nutrition and lifestyle changes Y/N.

If offered I would attend nutrition/lifestyle and health improvement activities Y/N.

Past Health History

Please list any health conditions you have experienced in the last 6 months:

_____

_____

_____

Medication	Dosage	Reason	How long

Please list all current supplements:

Supplement	Dosage	Reason	How long

Explanation for Medications and supplements:_____

_____

_____

Review of Systems: Have you ever had any of the following?

Cardiovascular ☐ **No to all**

☐ Poor Circulation ☐ High Blood Pressure ☐ Aortic Aneurysm ☐ Heart Disease ☐ Vascular Disease ☐ Heart Attack
☐ Chest Pain ☐ High Cholesterol ☐ Pace Maker ☐ Jaw Pain ☐ Irregular Heartbeat ☐ Swelling of Legs ☐ Other
Explanation:_____

Respiratory ☐ **No to all**

☐ Asthma ☐ Tuberculosis ☐ Shortness of Breath ☐ Emphysema ☐ Cold/Flu ☐ Cough/Wheezing ☐ Sputum
☐ Coughing Blood ☐ Other
Explanation:_____

Genitounrinary ☐ **No to all**

☐ Kidney Disease ☐ Lower Side Pain ☐ Burning Urination ☐ Frequent Urination ☐ Blood in Urine ☐ Kidney Stones
☐ Other
Explanation:_____
How often do you urinate during the day?_____ Most common Urine Color?_____

Neurological ☐ **No to all**

☐ Stroke ☐ Seizures ☐ Head Injury ☐ Brain Aneurysm ☐ Numbness ☐ Pinched Nerves ☐ Carpal Tunnel
☐ Balance Problems ☐ Other
Explanation:_____

Musculoskeletal ☐ **No to all**

☐ Gout ☐ Arthritis ☐ Joint Stiffness ☐ Muscle Weakness ☐ Osteoporosis ☐ Broken Bones ☐ Joints Replaced
☐ Other
Explanation:_____

Skin ☐ **No to all**

☐ Skin Lesions ☐ Skin Ulcers ☐ Skin Disease/Cancer ☐ Eczema ☐ Psoriasis ☐ Other
Explanation:_____

Allergic/Immunologic ☐ **No to all**

☐ Hives ☐ Immune Disorder ☐ HIV/AIDS ☐ Allergy Shots ☐ Cortisone Use ☐ Known Autoimmune Disorder ☐ Other
Explanation:_____
☐ Food Intolerance ☐ Medication intolerance ☐ Other
Please list all known allergies:_____
_____
Have you received any vaccinations? Y/N If yes please list any and all that you can remember:_____
_____

Gastrointestinal ☐ **No to all (for this section you may want to observe your bowel movements for a couple of days)**

☐ Gallbladder Problems ☐ Bowel Problems ☐ Constipation ☐ Liver Problems ☐ Ulcers ☐ Diarrhea ☐ Nausea/Vomiting
☐ Bloody Stools ☐ Poor Appetite ☐ Bloating/Gas after eating Floating Stool Heavy/Sinking Stool☐ Other
Explanation:_____
How often do you move your bowels?_____
Do you ever get stomach pains in and around eating?_____
Is there ever a sheen/oil on the water after moving your bowels?_____
Are there food particles in your stool?_____

Hematologic/Lymphatic ☐ **No to all**

☐ Hepatitis ☐ Blood Clots ☐ Cancer ☐ Easy Bruising ☐ Easy Bleeding ☐ Fevers/Chills/Sweats ☐ Other
Explanation:_____

Endocrine ☐ **No to all**
☐ Thyroid Disease ☐ Diabetes ☐ Hair Loss ☐ Excessive appetite/thirst ☐ Frequent Urination ☐ Other
Explanation:_____

Psychiatric ☐ **No to all**
☐ Depression ☐ Anxiety Disorder ☐ Unusual Stress ☐ Confusion/Memory loss ☐ Mood Change ☐ Other
Explanation:_____

Eyes ☐ **No to all** ☐ **Glasses/Contacts**
☐ Glaucoma ☐ Double Vision ☐ Blurred Vision ☐ Other
Explanation:_____

Head ☐ **No to all**
☐ Headaches ☐ Severe Headaches ☐ Migraines ☐ Head Injury ☐ Other
Explanation:_____

Ears/Nose/Throat ☐ **No to all**
☐ Hearing Loss ☐ Sinus Infection ☐ Nosebleed ☐ Sore Throat ☐ Difficulty Swallowing ☐ Bleeding Gums
☐ TMJ problems ☐ Ringing in Ears ☐ Other
Explanation:_____

General ☐ **No to all**
☐ Weight Loss ☐ Weight Gain ☐ Energy Level Problem ☐ Other
Explanation:_____

Sleep ☐ **No to all**
☐ Difficulty sleeping ☐ Difficulty falling asleep ☐ Difficulty staying asleep
Explanation:_____
What time do you go to bed:_____ When do you wake up for the day:_____
Do you wake at any other time consistently? Y/N If Yes, what time?_____
Do you wake refreshed or could you stay in bed?_____
Any time of day where you could take a nap or feel sleepy? Y/N Time:_____

Female ☐ **No to all** ☐**Currently Pregnant**
☐Birth Control ☐Cramps ☐Irregular menstruation ☐Breast lumps/pain ☐ Vaginal discharge ☐ Other
Number of pregnancies:_____ Number of Children:_____ Complicated Births: Y/N.
Explanation:_____

Male ☐ **No to all**
☐Prostate problems ☐ Hesitancy/Dribbling ☐ Erectile dysfunction ☐ Hormonal Imbalances ☐ Other
Explanation:_____

Surgeries/Injuries
Please give a complete list of surgeries and severe injuries you have undergone including
month/year:_____
_____

Other problems not elsewhere listed:
_____
_____
_____
Have you had bloodwork performed in the last 2 years? Y/N When was the last date?_____
Have you had a physical by your primary care in the last 2 years? Y/N When was the last date?_____

Family History

Has anyone in your family had any of the following problems? ☐ Arthritis ☐ Cholesterol ☐ Heart Problems ☐ Psychiatric Problems ☐ Thyroid ☐ Cancer ☐ Diabetes☐ High Blood Pressure ☐ Stroke ☐Other

Explanation:_____

_____

Do you have children? Y/N If yes how many? Female_____ Male_____

Child health concerns/conditions?_____

_____

Do you have siblings? Y/N If yes how many? Female_____ Male_____

Sibling Health Concerns?_____

_____

Current Lifestyle

Physical

How often do you exercise? ☐ Daily ☐ 3x week ☐ Occasionally ☐ Rarely ☐ Never Hours per week?:_____

Do you stretch daily? Y/N Do you pay attention to your posture? Y/N

Please list your hobbies or activities: _____

_____

Bio-Chemical

Do you smoke or have you in the past? Y/N If yes how often and how much?_____

Do you use / consume? ☐ Tobacco ☐ Alcohol ☐ Caffeine How often day/week?_____

Do you eat prepared, processed or fast foods? Y/N How often?_____

Do you consume carbonated or drinks high in sugar daily? Y/N How often do you drink water?_____

Are you on any special diet? Y/N If yes for what reason?_____

Your diet emphasizes fruits, vegetables, whole grains, lean meats and other protein sources and is low in sugar and artificial sweeteners? Y/N please rate your diet 10 being healthy: 1 2 3 4 5 6 7 8 9 10.

Do you feel stressed out regularly? Y/N Do you handle stress in a positive way? Y/N

Do you practice meditation or relaxation methods daily? Y/N Lack of time and Energy stresses you? Y/N

Please list your specific current goals for health and this office:_____

_____

_____

It is important that our patients and we have the same health objectives concerning chiropractic and wellness care. Regardless of what a disease or condition is called our practice objective is to eliminate a major interference to the expression of the body's internal ability to heal and thrive. By adjusting the spine, removing subluxations, we help restore the neurological communication of the brain to the body and improve the biomechanical supports of this system. With the addition of lifestyle, nutrition and exercise recommendations we support the healing of this system and therefore maximize the bodies inborn abilities, bringing you beyond the comfort zone of no symptoms and constantly challenge you to reach for optimal health! Your signature here verifies that the information provided on this form is complete and correct and that you are willing to begin your journey with chiropractic care!

Patient Signature: _____ Date: _____