



# MILADIN CHIROPRACTIC, INC.

## ADULT HISTORY FORM

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed  Other

Number of Children \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

### **Emergency Contact Information:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relation to You: \_\_\_\_\_

### **Referral Information:**

How did you hear about us?  Word of Mouth  Advertisement  Social Media  Direct marketing  Google

Referring Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Patient: \_\_\_\_\_

Are you working with an Attorney? :  Y  N

### **Employer Information:**

- Full time
- Part Time
- Unemployed
- Full Time Student

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Work Supervisor: \_\_\_\_\_  
Work Duties: \_\_\_\_\_

# Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the boxes for each symptom or condition you have experienced – including both past and present.



| REGIONS                 | FUNCTIONS                                 | SYMPTOMS                 |  |                          |                                  |
|-------------------------|---|--------------------------|--|--------------------------|----------------------------------|
|                         |   | PAST<br>PRESENT          | PAST<br>PRESENT                            |                          |                                  |
| Cervical                | • Autonomic Nervous System                | <input type="checkbox"/> | Colic & Excessive Crying                   | <input type="checkbox"/> | Epilepsy & Seizures              |
|                         | • ENT System                              | <input type="checkbox"/> | Ear & Sinus Infections                     | <input type="checkbox"/> | Sensory & Spectrum               |
|                         | • Vision, Balance & Coordination          | <input type="checkbox"/> | Allergies & Congestion                     | <input type="checkbox"/> | ADD / ADHD                       |
|                         | • Speech                                  | <input type="checkbox"/> | Immune Deficiency                          | <input type="checkbox"/> | Focus & Memory Issues            |
|                         | • Immune System                           | <input type="checkbox"/> | Headaches & Migraines                      | <input type="checkbox"/> | Anxiety & Stress                 |
|                         | • Digestive System                        | <input type="checkbox"/> | Vertigo & Dizziness                        | <input type="checkbox"/> | Balance & Coordination           |
|                         | • Nerve Supply to Shoulders, Arms & Hands | <input type="checkbox"/> | Sore Throat & Strep                        | <input type="checkbox"/> | Speech Issues                    |
|                         | • Sympathetic Nucleus                     | <input type="checkbox"/> | Swollen Tonsils & Adenoids                 | <input type="checkbox"/> | TMJ/Jaw Pain                     |
|                         | • Metabolism                              | <input type="checkbox"/> | Vision & Hearing Issues                    | <input type="checkbox"/> | Stiff Neck & Shoulders           |
|                         |   | <input type="checkbox"/> | Low Energy & Fatigue                       | <input type="checkbox"/> | Depression                       |
|                         |   | <input type="checkbox"/> | Difficulty Sleeping                        | <input type="checkbox"/> | High Blood Pressure              |
|                         |   | <input type="checkbox"/> | Pain, Numbness & Tingling in Arms to Hands | <input type="checkbox"/> | Poor Metabolism & Weight Control |
|                         | Upper Thoracic                            | • Upper G.I.             | <input type="checkbox"/>                   | Reflux / GERD            | <input type="checkbox"/>         |
| • Respiratory System    |   | <input type="checkbox"/> | Chronic Colds & Cough                      | <input type="checkbox"/> | Functional Heart Conditions      |
| • Cardiac Function      |   | <input type="checkbox"/> | Asthma                                     |                          |                                  |
| Mid Thoracic            | • Major Digestive Center                  | <input type="checkbox"/> | Gallbladder Pain / Issues                  | <input type="checkbox"/> | Indigestion & Heartburn          |
|                         | • Detox & Immunity                        | <input type="checkbox"/> | Jaundice                                   | <input type="checkbox"/> | Stomach Pains & Ulcers           |
|                         |   | <input type="checkbox"/> | Fever                                      | <input type="checkbox"/> | Blood Sugar Problems             |
| Lower Thoracic          | • Stress Response                         | <input type="checkbox"/> | Behavior Issues                            | <input type="checkbox"/> | Allergies & Eczema               |
|                         | • Filtration & Elimination                | <input type="checkbox"/> | Hyperactivity                              | <input type="checkbox"/> | Skin Conditions /Rash            |
|                         | • Gut & Digestion                         | <input type="checkbox"/> | Chronic Fatigue                            | <input type="checkbox"/> | Kidney Problems                  |
|                         | • Hormonal Control                        | <input type="checkbox"/> | Chronic Stress                             | <input type="checkbox"/> | Gas Pain & Bloating              |
| Lumbar, Sacrum & Pelvis | • Lower G.I. (Absorption & Motility)      | <input type="checkbox"/> | Constipation                               | <input type="checkbox"/> | Sciatica & Radiating Pain        |
|                         | • Gut-Immune System                       | <input type="checkbox"/> | Chrohn's, Colitis & IBS                    | <input type="checkbox"/> | Lumbopelvic/SI Joint Pain        |
|                         | • Major Hormonal Control                  | <input type="checkbox"/> | Diarrhea                                   | <input type="checkbox"/> | Hamstring Tightness              |
|                         |   | <input type="checkbox"/> | Bed-wetting                                | <input type="checkbox"/> | Disc Degeneration                |
|                         |   | <input type="checkbox"/> | Bladder & Urination Issues                 | <input type="checkbox"/> | Leg Weakness & Cramps            |
|                         |   | <input type="checkbox"/> | Cramps & Menstrual Issues                  | <input type="checkbox"/> | Poor Circulation & Cold Feet     |
|                         |   | <input type="checkbox"/> | Cysts & Endometriosis                      | <input type="checkbox"/> | Knee, Ankle & Foot Pain          |
|                         |   | <input type="checkbox"/> | Infertility                                | <input type="checkbox"/> | Weak Ankles & Arches             |
|                         |   | <input type="checkbox"/> | Impotency                                  | <input type="checkbox"/> | Lower Back Pain                  |
|                         |   | <input type="checkbox"/> | Hemorrhoids                                | <input type="checkbox"/> | Gluten & Casein Intolerance      |

## Wellness Intake Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### DIETARY INTAKE SUMMARY:

How many servings of fruit do you consume per day? \_\_\_\_\_

How many servings of vegetables do you consume per day? \_\_\_\_\_

How many servings of protein do you consume per day? \_\_\_\_\_

How many servings of bread/crackers/pasta do you consume daily? \_\_\_\_\_

Do you consume artificial sweeteners?  Yes  No If yes, what brands? \_\_\_\_\_

Do you consume fast food?  Yes  No If yes, what do you typically eat? \_\_\_\_\_

Do you eat breakfast?  Yes  No If no, what time is your first meal of the day? \_\_\_\_\_

Do you consume alcoholic beverages?  Yes  No If yes, how many per week? \_\_\_\_\_

Do you consume coffee?  No  Yes If yes, how many cups per day? \_\_\_\_\_

Do you consume dietary supplements?  No  Yes If yes, please list all of them below. Additionally, please bring them in so we can check for ingredients that are not healthful or may have contraindications with medications.

### Please indicate the areas of health that you want to improve:

- 1.Lose weight  2.More energy  3.Sleep better  4.Improve digestion  5. Allergies  6. Improve bloodwork  
 7.Immune Support  8.Anti-aging support  9.Improve general health  10.Stress Management

If you could improve ONE THING about your health, what is your priority?

### IDENTIFYING YOUR HEALTH GOALS:

To help our office understand your wellness goals and give you the type of care that you want, please use this chart to answer the questions below.

| -5  | -4                             | -3   | -2   | -1   | 0  | +1                    | +2                           | +3                           | +4                               | +5  |
|---|--------------------------------|--|--|--|--|-----------------------|------------------------------|------------------------------|----------------------------------|---|
| I have serious concerns about my overall health | I feel worried about my health | I have constant concerns that affect my health | I have health challenges that affect me on a daily basis | I have some minor complaints about my health | I feel okay about my health with no complaints | I feel good most days | I feel well on a daily basis | I feel energetic and healthy | I feel active, energetic and fit | I feel great and am proactive about my health |

1. What number best describes how you feel about your health today? \_\_\_\_\_
2. What health goal do you want to achieve?: \_\_\_\_\_

**NOTE:** In our commitment to your health, our office provides our patients with access to a free online resource for education, science and wellness support. We will create your login ID and provide access information. Please indicate which free wellness classes you wish to be informed of:

- Health Reality Check  The Meaning of Essential Nutrients  Creating Optimal Health  Other \_\_\_\_\_  
 Customizing Your Health Plan  Healthy Age Management  Genetics and Health  Healthy Weight Loss

# The Stress Test

**PATIENT:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

Each of us has had stress from birth to the present time and will continue to have stress as long as we are alive. Please circle when you have experienced these various stressors no matter how mild or severe your exposure may have been. Also the number of times, from few to many. Circle as many as apply.

C (child), T (teenager), A (adult) or N (None)

**I. PHYSICAL STRESS:**

**EXPLAIN**

- |                                      |         |  |
|--------------------------------------|---------|--|
| Birth Traumas (as a mother or child) | C T A N |  |
| Slips/Falls                          | C T A N |  |
| Car Accidents                        | C T A N |  |
| Sports Injuries                      | C T A N |  |
| Physical Abuse                       | C T A N |  |
| Work Injuries                        | C T A N |  |
| Poor Posture                         | C T A N |  |
| Sitting on your wallet for years     | C T A N |  |
| Sleeping Position - Stomach          | C T A N |  |
| Extensive Computer Work              | C T A N |  |
| Carrying Heavy Purse/Backpack/Child  | C T A N |  |
| Repetitive Lifting/Bending           | C T A N |  |
| Driving for Many Hours               | C T A N |  |
| Continuous Hours Sitting/Standing    | C T A N |  |
| Bone Fracture/Surgery                | C T A N |  |

**II. EMOTIONAL STRESS:**

- |                               |         |  |
|-------------------------------|---------|--|
| Relationships                 | C T A N |  |
| Career                        | C T A N |  |
| Children                      | C T A N |  |
| Money                         | C T A N |  |
| Fast-Paced Life               | C T A N |  |
| Hold in Feelings              | C T A N |  |
| Quick Tempered                | C T A N |  |
| Verbal Abuse                  | C T A N |  |
| Perfectionist                 | C T A N |  |
| Procrastinator                | C T A N |  |
| Sickness or Loss of Loved One | C T A N |  |

**III. CHEMICAL STRESS:**

- |                              |         |  |
|------------------------------|---------|--|
| Environment (i.e. pollution) | C T A N |  |
| Smoker or Second Hand Smoke  | C T A N |  |
| Poor Diet                    | C T A N |  |
| Caffeine - Amount?           | C T A N |  |
| Excessive Sugar              | C T A N |  |
| Artificial Sweeteners        | C T A N |  |
| Prescription Drugs           | C T A N |  |
| Over-the-counter Drugs       | C T A N |  |

(i.e. Tylenol, Motrin)

**IV. Which do you feel is your primary stress? (Circle)    Physical    Chemical    Emotional**

Please Explain: \_\_\_\_\_

\_\_\_\_\_

## INFORMED CONSENT TO TREATMENT

**I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_