LONGSGATE CHIROPRACTIC
CENTER FOR WELLNESS

Nutritional Patient Intake Form

Today's Date: _____
Name: _____
I prefer to be called: _____
Address: _____
City: _____
State: _____
Zip: _____
Home Phone: _____
Cell Phone: _____
Who may we thank for your referral?
_____

Email Address (for our monthly newsletter- will not be given to any other businesses):
_____
Birthdate: _____
SSN: _____
Marital Status: _____
Employer: _____
Occupation: _____

Occupational Stress Level (1-10): (no stress) 1 2 3 4 5 6 7 8 9 10 (very stressful)
Personal Stress Level (1-10): (no stress) 1 2 3 4 5 6 7 8 9 10 (very stressful)
Recreational Activities/Hobbies: _____
Habits: Smoking: in past never current <1 pack/day 1 pack/day 2 packs/day 3 packs/day
Other Tobacco: _____
Alcohol: in past never current 0-1drink/day 1-2 2-3 3-4 4-5 5+
Caffeinated Drinks: never 0-1/day 1-2 2-3 3-4 4-5 5+
Exercise type and amount: _____
Hours of sleep a night: _____

Please rate your overall health status: (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
Are you healthier today than you were 5 years ago? _____
What are your health goals? _____
_____

MEDICAL HISTORY
List any surgeries: _____
List any past injuries: _____

Medications	Reason for Taking	Supplements	Reason for Taking

Circle any of the following you have had in the past 6 months:

MUSCULOSKELETAL
- Neck pain/stiffness
- Shoulder pain/stiffness
- Arm pain/tingling/numbness
- Hand pain/tingling/numbness
- Mid back pain/stiffness
- Low back pain/stiffness
- Hip pain
- Knee pain
- Pain/tingling down leg
- Foot/ankle pain
- Jaw pain/clicking

NERVOUS SYSTEM
- Headaches
- Dizziness
- Fainting
- Convulsions

GASTROINTESTINAL
- Decreased/Increased appetite
- Excessive thirst
- Frequent nausea
- Vomiting
- Diarrhea
- Constipation
- Excessive gas
- Hemorrhoids
- Liver problems
- Gallbladder problems
- Abdominal pain/cramps
- Heartburn

GENERAL
- Weight problems
- Allergies
- Fever

EARS, EYES, NOSE, THROAT
- Hearing loss
- Ringing in ears
- Ear aches/pressure
- Vision problems
- Dental problems
- Sore throat
- Stuff nose
- Loss of smell
- Sinus pressure
- Sinus infections

HEART AND LUNGS
- Chest pain
- Shortness of breathe
- Blood pressure problems
- Heart problems
- Stroke
- High Cholesterol
- Murmur
- Palpitations
- Lung problems/congestion
- Cough
- Wheezing
- Varicose veins
- Swollen extremities
- Blue extremities

ENDOCRINE
- Heat/cold intolerance
- Goiter

PSYCHOLOGIC
- Anxiety
- Depression
- Phobias
- Mood Swings

GENITOURINARY
- Bladder infections
- Painful urination
- Frequent urination
- Prostate problems

FEMALE
- Menstrual irregularity
- Menstrual cramps
- Vaginal pain/bleeding
- Yeast infections
- History of breast cancer
- Breast pain/lumps
- Inferitility/trouble conceiving

MALE
- Prostate problems
- Impotence

FAMILY HISTORY

Please include cancer, heart disease, stroke, diabetes, osteoporosis, scoliosis, etc.

Member	Living?/Age	Major illness or chronic conditions
Mother		
Father		
Siblings		

I understand that nutritional consultations may or may not be covered by insurance and that I am responsible for full payment.

Patient's Signature _____