LYDIAN CHIROPRACTIC

777 Concord Avenue, Suite 301 • 617-876-9099 tel.
Cambridge, MA 02138 • 617-876-9011 fax

DEMOGRAPHIC INFORMATION

Name _____ Today's Date _____

Address _____ Employer _____

City, State, Zip: _____ Type of work _____

Email _____ If retired, what was your occupation?_____

Phone (home) _____ (cell)_____ (work) _____

Date of Birth _____ Age _____Travel time to this office _____

Gender: ☐F ☐M ☐ Other • ☐ Enrolled in Medicare? Height: _____ ft _____ in • Current weight: _____

Marital Status: ☐S ☐M ☐W ☐D ☐Partnered Lowest adult weight _____ Highest _____ Desired _____

Name of Spouse/Partner _____ Medical Doctor _____

Spouse's Occupation _____ Referred to our office by _____

Name(s) and Age(s) of Children _____

Other Household Members (include extended family, non-family and pets) _____

_____

Name of person responsible for payment of professional services _____

Practitioners at the Lydian Center you have previously seen _____

CURRENT HEALTH REPORT

Please describe the principal health problems for which you would like to come to this office. Include approximate date of onset.

* Type: P=Pain; A=Ache; ST=Stiffness; N=Numbness; T=Tingling; S=Soreness; O=Other
** Pain: For each complaint, rate the level of current pain on a scale of 1-10. 1=no pain; 10=severe pain

	Principal Health Problems	Type *	Pain **
1.			
2.			
3.			

What are your long-term goals in coming to this office? _____

How long has it been since you have felt well? _____

Are your present complaints due to an injury? ☐no ☐yes ☐auto accident ☐ other

_____

Is your condition getting progressively worse? ☐ no ☐ yes • Pain is: ☐ constant ☐ comes and goes

Is your condition interfering with your: ☐ work ☐ sleep ☐ daily routine ☐ other _____

Have you lost any days of work? ☐ no ☐ yes Dates _____

What activities aggravate your condition? _____

_____

_____

What makes it feel better? _____

_____

Have you had this or a similar condition before? ☐ no ☐ yes If yes, explain _____

_____

Has anyone in your family had a similar condition before? ☐ no ☐ yes If yes, who? _____

Past chiropractic treatment ☐ no ☐ yes When? _____ Explain _____

_____

Have you seen any other physicians for this condition? _____

List diagnoses and describe treatment _____

_____

_____

Do you wear: ☐ Glasses/contacts ☐ Heel lifts ☐ Orthotics ☐ Dental night guard

Did/do you wear dental braces? ☐no ☐ yes When? _____

Have you been treated for any other health condition by a physician in the last year? ☐ no ☐ yes If yes, explain:

_____

Are you currently taking prescription medication? ☐ no ☐ yes If yes, what?_____

_____

_____

Have you ever been on frequent or prolonged antibiotic therapy (such as erythromycin, penicillin, tetracycline, etc.)?

Please describe: _____

_____

Current non-prescription pain relievers (Alleve, Tylenol, Aspirin, Ibuprofen, etc.). How many per day?

_____

Other current non-prescription medications (laxatives, antihistamines, decongestants, stimulants, etc.):

_____

Are you currently taking any vitamins or supplements? ☐ no ☐ yes If yes, what? _____

Allergies or sensitivities to drugs, foods, pollens, chemicals, animals, etc. _____

_____

HABITS OF DAILY LIVING

Exercise: ☐ None ☐ Moderate ☐ Heavy • ☐ <1 per week ☐ 1-3 times per week ☐ Daily • Hours/ week _____

Work Activity (check all that apply): ☐ Sitting ☐ Standing ☐ Walking ☐ Light Labor ☐ Heavy Labor

Stress level: ☐ High ☐Moderate ☐ Low • Do you do any stress reduction or relaxation activities such as meditation, yoga, prayer, etc.? _____

Are you currently on psychotropic medication or receiving psychological counseling? Please describe:

_____

 Name _____ DOB _____

What are your favorite hobbies or other life interests? _____

_____

Sleep habits: Hours per night _____ Restless or restful? _____ Do you dream? _____

What time do you go to bed? _____ Do you sleep through the night? _____

Alcohol consumption: Drinks per week _____ Have you ever felt the need to cut down? _____

Tobacco consumption: Do you smoke? _____ How much per day? _____ How long? _____

Did you ever smoke? _____ How much for how long? _____ When did you stop? _____

Non-medical drug use: Type and frequency _____

Chemical exposure: Do you regularly use: ☐ Cosmetics ☐ Perfumes ☐ Aftershaves ☐ Scented soaps/products

Do you have amalgam dental fillings? ☐ yes ☐ no • Any prolonged exposure to paints or solvents? ☐ yes ☐ no

Other known notable chemical exposures: _____

Diet: Do you eat regular meals? ☐ yes ☐ no • Do you sit down for meals? ☐ yes ☐ no • Do you normally eat or drink between meals? ☐ yes ☐ no What? _____

How often does your diet consist mainly of some or all of the following: salads, whole grains, eggs, fresh fruits and vegetables, lean meats, beans or legumes? ☐ rarely ☐ sometimes ☐ often ☐ almost always

Are you a vegetarian? ☐ yes ☐ no • Do you eat processed foods with artificial colorings, flavorings or preservatives (e.g. bologna, sausage, cheese spreads, baked goods)? ☐ rarely ☐ sometimes ☐ often

Do you eat "fast food"? ☐ rarely ☐ sometimes ☐ often What and how often? _____

Do you add sugar to coffee, tea, cereals, other foods? ☐ yes ☐ no • Do you use artificial sweeteners? ☐ yes ☐ no

How many servings of:

____ Fruit/day	____ Fish/week	____ Water/day	____ Tea/day
____ Vegetables/day	____ Fowl/week	____ Soft Drinks/day	____ Chocolate/Cocoa/day
____ Sweets/day	____ Red meat/week	____ Coffee/day	____ Cow dairy/day (cheese, milk, yogurt)
____ Wheat (bread etc.)/day			

GENERAL HEALTH HISTORY

List any major accidents, serious falls or injuries (with dates) _____

_____

Broken bones, cranial injuries _____

_____

List surgeries/hospitalizations (with dates) _____

_____

List X-rays or special imaging taken in the last 10 years and their dates _____

Please check all that you have or have had:

☐ Alcoholism	☐ Diabetes	☐ Learning Disability	☐ Polio
☐ Anemia	☐ Dyslexia	☐ Lupus	☐ Rheumatism
☐ Appendicitis	☐ Diverticulitis	☐ Migraine Headaches	☐ Rheumatoid Arthritis
☐ ADD/ADHD	☐ Epilepsy	☐ Malaria	☐ Scoliosis
☐ Osteoarthritis	☐ Goiter	☐ Mental Illness	☐ Stroke
☐ Cancer	☐ Grave's Disease	☐ Multiple Sclerosis	☐ Tuberculosis

☐ Cerebral Palsy ☐ Hashimoto's Disease ☐ Muscular Dystrophy ☐ Typhoid Fever

☐ Chronic Fatigue ☐ Heart Disease ☐ Osteopenia ☐ Ulcers

☐ Cold Sores/Fever Blisters ☐ Hepatitis ☐ Osteoporosis ☐ Venereal Disease

☐ Colitis/Bowel Disease ☐ HIV Positive ☐ Pleurisy ☐ Whooping Cough

☐ Crohn's Disease ☐ Influenza ☐ Pneumonia ☐ Other_____

☐ Depression ☐ Autism

Have you ever lived or traveled outside of the United States? ☐ yes ☐ no • Had travelers diarrhea? ☐ yes ☐ no

Have you ever been tested for intestinal parasites? ☐ yes ☐ no • Been treated for intestinal parasites? ☐ yes ☐ no

If yes, please describe when, and what parasite(s) _____

CHILDHOOD HISTORY

Were you adopted? _____ If so, at what age? _____Were you breast or bottle fed? _____

Vaginal birth or C-section? _____ Complications? _____

_____

Childhood illnesses:

☐ Bronchitis ☐ Allergies ☐ Measles ☐ Rheumatic Fever

☐ Recurrent Colds ☐ Colic ☐ Mumps ☐ Frequent Antibiotics

☐ Ear Infections ☐ Persistent Diaper Rashes ☐ Rubella number of times ____

☐ Tonsilitis ☐ Bedwetting ☐ Chicken Pox ☐ Other _____

Was your home life (check all that apply):

☐ Loving ☐ Fun ☐ Loud ☐ Alcoholic

☐ Supportive ☐ Educational ☐ Argumentative ☐ Physically Abusive

☐ Peaceful ☐ Stressful ☐ Single Parent ☐ Verbally Abusive

☐ Filled with positive extended family ☐ Financially Stressed ☐ Lonely or Neglectful ☐ Sexually Abusive

Comments: _____

FAMILY HISTORY

	Diabetes	Heart Disease/High Blood Pressure	Cancer	Musculoskeletal Problems	Other _____
Grandparent(s)	☐.	☐.	☐.	☐.	☐.
Mother	☐.	☐.	☐.	☐.	☐.
Father	☐.	☐.	☐.	☐.	☐.
Sibling(s)	☐.	☐.	☐.	☐.	☐.

Number of siblings _____ Sibling age(s) and health status _____

Age of biological parents _____ If deceased, age and cause: _____

 Name _____ DOB _____

SYSTEMS REVIEW

Please write: C = Constantly in the present O = Occasionally in the present P = In the past

GENERAL

_____ Allergies
_____ Chills
_____ Convulsions
_____ Dizziness
_____ Fainting
_____ Fatigue
_____ Fever
_____ Headache
_____ Loss of Sleep
_____ Nervousness
_____ Night Sweats
_____ Thirst Abnormal
_____ Weight Loss
_____ Weight Gain

GASTRO-INTESTINAL

_____ Belching or gas
_____ Colon trouble
_____ Constipation
_____ Diarrhea
_____ Excessive hunger
_____ Gall bladder trouble
_____ Hemorrhoids (piles)
_____ Intestinal parasites
_____ Jaundice
_____ Liver trouble
_____ Nausea
_____ Pain over stomach
_____ Poor appetite
_____ Poor digestion
_____ Vomiting

THYROID

_____ Overactive
_____ Underactive
_____ Enlarged

MUSCLES & JOINTS

_____ Arthritis
_____ Bursitis
_____ Hernia
_____ Leg cramps when walking
_____ Low back pain
_____ Musculoskeletal birth defects
_____ Neck pain or stiffness

Pain, numbness or tingling in:

_____ Shoulders
_____ Arms
_____ Elbows
_____ Hands
_____ Hips
_____ Legs
_____ Knees
_____ Feet
_____ Painful tailbone
_____ Paralysis
_____ Poor posture
_____ Sciatica
_____ Stiff neck
_____ Spinal curvature
_____ Swollen joints

SKIN

_____ Boils
_____ Bruising easily
_____ Dryness
_____ Eczema
_____ Psoriasis
_____ Hives or allergies
_____ Itching
_____ Sensitive skin
_____ Skin eruptions

CARDIOVASCULAR

_____ Easy Bruising
_____ Hardening of arteries
_____ High blood pressure
_____ Low blood pressure
_____ Pain over heart
_____ Poor circulation
_____ Rapid heart
_____ Slow heart
_____ Swelling ankles
_____ Varicose veins

EYE/EAR/NOSE/THROAT

_____ Crossed eyes
_____ Dry eyes
_____ Eye pain
_____ Farsightedness
_____ Nearsightedness
_____ Light sensitivity
_____ Earache
_____ Ear discharge
_____ Ear noises
_____ Hearing difficulty
_____ Hearing sensitivity
_____ Nasal obstruction
_____ Nose bleeds
_____ Sinusitis
_____ Stuffy nose
_____ Hay fever
_____ Frequent colds
_____ Hoarseness
_____ Sore throats
_____ Enlarged glands
_____ Enlarged thyroid
_____ Dental decay
_____ Grinding teeth

RESPIRATORY

_____ Asthma
_____ Chest pain
_____ Chronic cough
_____ Difficulty breathing
_____ Spitting blood
_____ Spitting phlegm
_____ Wheezing

GENITO-URINARY

_____ Bed wetting
_____ Blood in urine
_____ Frequent urination
_____ Incontinence
_____ Kidney infection
_____ Kidney stones
_____ Night urination
_____ Painful urination
_____ Prostate trouble

FOR WOMEN ONLY

_____ Cramps or backache
_____ Excessive flow
_____ Hot flashes
_____ Irregular cycle
_____ Lumps in breast
_____ Miscarriage
_____ Painful periods
_____ PMS
_____ Vaginal discharge

□Y □N Pregnant at this time?

Last Pap _____

Menstrual cycle: _____ days

Date of last period: _____

Your completion of this Intake Form will help us determine whether our services might meet your needs. Upon our review of this Form, we will contact you to set up an initial appointment as a new patient, or, if we believe that the Practice's services may not meet your needs, we may offer to discuss possible alternative practitioners at the Lydian Center. In both cases, we will maintain the information you have provided in this Intake Form in a confidential manner in accordance with our privacy practices, regardless of whether you become a patient of the Practice.

Please note that each practitioner practicing at the Lydian Center owns and operates his/her own clinical practice and is not affiliated with Lydian Chiropractic. While we may work closely with the practitioner(s) we discuss with you, we are not liable for any care or treatment provided by him/her. In addition, we would like to remind you that you have the right to seek your treatment and care from any practitioner at any facility you choose.

Because some of our patients have allergies, we ask you not to wear scented products (e.g., perfumes, hair products, aftershaves, clothing dried with Bounce® dryer sheets) to this office. Please check here to acknowledge this request: □

Name _____ DOB _____