

### 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

<u>Principal Health Problems</u>	<u>Type</u> *	<u>Pain</u> **
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:  
\_\_\_\_\_

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
___ Wheat (bread etc.)/day			(cheese, milk, yogurt)

## 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:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Polio                |
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Dyslexia        | <input type="checkbox"/> Lupus               | <input type="checkbox"/> Rheumatism           |
| <input type="checkbox"/> Appendicitis   | <input type="checkbox"/> Diverticulitis  | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> ADD/ADHD       | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Malaria             | <input type="checkbox"/> Scoliosis            |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Goiter          | <input type="checkbox"/> Mental Illness      | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Grave's Disease | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Tuberculosis         |

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Cerebral Palsy            | <input type="checkbox"/> Hashimoto's Disease | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Typhoid Fever    |
| <input type="checkbox"/> Chronic Fatigue           | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Osteopenia         | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Colitis/Bowel Disease     | <input type="checkbox"/> HIV Positive        | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Whooping Cough   |
| <input type="checkbox"/> Crohn's Disease           | <input type="checkbox"/> Influenza           | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Other_____       |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> 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:

- |  |   |                                      |   |
|--|---|--------------------------------------|---|
| <input type="checkbox"/> Bronchitis      | <input type="checkbox"/> Allergies                | <input type="checkbox"/> Measles     | <input type="checkbox"/> Rheumatic Fever                              |
| <input type="checkbox"/> Recurrent Colds | <input type="checkbox"/> Colic                    | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Frequent Antibiotics<br>number of times ____ |
| <input type="checkbox"/> Ear Infections  | <input type="checkbox"/> Persistent Diaper Rashes | <input type="checkbox"/> Rubella     | <input type="checkbox"/> Other _____                                  |
| <input type="checkbox"/> Tonsilitis      | <input type="checkbox"/> Bedwetting               | <input type="checkbox"/> Chicken Pox |   |

Was your home life (check all that apply):

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Loving                                  | <input type="checkbox"/> Fun                  | <input type="checkbox"/> Loud                 | <input type="checkbox"/> Alcoholic          |
| <input type="checkbox"/> Supportive                              | <input type="checkbox"/> Educational          | <input type="checkbox"/> Argumentative        | <input type="checkbox"/> Physically Abusive |
| <input type="checkbox"/> Peaceful                                | <input type="checkbox"/> Stressful            | <input type="checkbox"/> Single Parent        | <input type="checkbox"/> Verbally Abusive   |
| <input type="checkbox"/> Filled with positive<br>extended family | <input type="checkbox"/> Financially Stressed | <input type="checkbox"/> Lonely or Neglectful | <input type="checkbox"/> Sexually Abusive   |

Comments: \_\_\_\_\_

## FAMILY HISTORY

	Diabetes	Heart Disease/High Blood Pressure	Cancer	Musculoskeletal Problems	Other _____
Grandparent(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Number of siblings \_\_\_\_\_ Sibling age(s) and health status \_\_\_\_\_

Age of biological parents \_\_\_\_\_ If deceased, age and cause: \_\_\_\_\_

# SYSTEMS REVIEW

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

<p><b>GENERAL</b></p> <p>_____ Allergies</p> <p>_____ Chills</p> <p>_____ Convulsions</p> <p>_____ Dizziness</p> <p>_____ Fainting</p> <p>_____ Fatigue</p> <p>_____ Fever</p> <p>_____ Headache</p> <p>_____ Loss of Sleep</p> <p>_____ Nervousness</p> <p>_____ Night Sweats</p> <p>_____ Thirst Abnormal</p> <p>_____ Weight Loss</p> <p>_____ Weight Gain</p> <p><b>GASTRO-INTESTINAL</b></p> <p>_____ Belching or gas</p> <p>_____ Colon trouble</p> <p>_____ Constipation</p> <p>_____ Diarrhea</p> <p>_____ Excessive hunger</p> <p>_____ Gall bladder trouble</p> <p>_____ Hemorrhoids (piles)</p> <p>_____ Intestinal parasites</p> <p>_____ Jaundice</p> <p>_____ Liver trouble</p> <p>_____ Nausea</p> <p>_____ Pain over stomach</p> <p>_____ Poor appetite</p> <p>_____ Poor digestion</p> <p>_____ Vomiting</p> <p><b>THYROID</b></p> <p>_____ Overactive</p> <p>_____ Underactive</p> <p>_____ Enlarged</p>	<p><b>MUSCLES &amp; JOINTS</b></p> <p>_____ Arthritis</p> <p>_____ Bursitis</p> <p>_____ Hernia</p> <p>_____ Leg cramps when walking</p> <p>_____ Low back pain</p> <p>_____ Musculoskeletal birth defects</p> <p>_____ Neck pain or stiffness</p> <p>Pain, numbness or tingling in:</p> <p>_____ Shoulders</p> <p>_____ Arms</p> <p>_____ Elbows</p> <p>_____ Hands</p> <p>_____ Hips</p> <p>_____ Legs</p> <p>_____ Knees</p> <p>_____ Feet</p> <p>Painful tailbone</p> <p>_____ Paralysis</p> <p>_____ Poor posture</p> <p>_____ Sciatica</p> <p>_____ Stiff neck</p> <p>_____ Spinal curvature</p> <p>_____ Swollen joints</p> <p><b>SKIN</b></p> <p>_____ Boils</p> <p>_____ Bruising easily</p> <p>_____ Dryness</p> <p>_____ Eczema</p> <p>_____ Psoriasis</p> <p>_____ Hives or allergies</p> <p>_____ Itching</p> <p>_____ Sensitive skin</p> <p>_____ Skin eruptions</p>	<p><b>CARDIOVASCULAR</b></p> <p>_____ Easy Bruising</p> <p>_____ Hardening of arteries</p> <p>_____ High blood pressure</p> <p>_____ Low blood pressure</p> <p>_____ Pain over heart</p> <p>_____ Poor circulation</p> <p>_____ Rapid heart</p> <p>_____ Slow heart</p> <p>_____ Swelling ankles</p> <p>_____ Varicose veins</p> <p><b>EYE/EAR/NOSE/THROAT</b></p> <p>_____ Crossed eyes</p> <p>_____ Dry eyes</p> <p>_____ Eye pain</p> <p>_____ Farsightedness</p> <p>_____ Nearsightedness</p> <p>_____ Light sensitivity</p> <p>_____ Earache</p> <p>_____ Ear discharge</p> <p>_____ Ear noises</p> <p>_____ Hearing difficulty</p> <p>_____ Hearing sensitivity</p> <p>_____ Nasal obstruction</p> <p>_____ Nose bleeds</p> <p>_____ Sinusitis</p> <p>_____ Stuffy nose</p> <p>_____ Hay fever</p> <p>_____ Frequent colds</p> <p>_____ Hoarseness</p> <p>_____ Sore throats</p> <p>_____ Enlarged glands</p> <p>_____ Enlarged thyroid</p> <p>_____ Dental decay</p> <p>_____ Grinding teeth</p>	<p><b>RESPIRATORY</b></p> <p>_____ Asthma</p> <p>_____ Chest pain</p> <p>_____ Chronic cough</p> <p>_____ Difficulty breathing</p> <p>_____ Spitting blood</p> <p>_____ Spitting phlegm</p> <p>_____ Wheezing</p> <p><b>GENITO-URINARY</b></p> <p>_____ Bed wetting</p> <p>_____ Blood in urine</p> <p>_____ Frequent urination</p> <p>_____ Incontinence</p> <p>_____ Kidney infection</p> <p>_____ Kidney stones</p> <p>_____ Night urination</p> <p>_____ Painful urination</p> <p>_____ Prostate trouble</p> <p><b>FOR WOMEN ONLY</b></p> <p>_____ Cramps or backache</p> <p>_____ Excessive flow</p> <p>_____ Hot flashes</p> <p>_____ Irregular cycle</p> <p>_____ Lumps in breast</p> <p>_____ Miscarriage</p> <p>_____ Painful periods</p> <p>_____ PMS</p> <p>_____ Vaginal discharge</p> <p><input type="checkbox"/>Y <input type="checkbox"/>N Pregnant at this time?</p> <p>Last Pap _____</p> <p>Menstrual cycle: _____ days</p> <p>Date of last period: _____</p>
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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:**