LYDIAN CHIROPRACTIC

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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	Date of Onset	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

 Name ______________________ DOB __________

☐ 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 ☐ COVID-19

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 number of times ____

☐ Ear Infections ☐ Persistent Diaper Rashes ☐ Rubella

☐ 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 non-chiropractic 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 ______________