

## Adult Intake Form – Female

Please fill out this form to the best of your knowledge. There is no correct or incorrect answer.

<b>Date:</b>			
<b>Client Name:</b>			
<b>Age:</b>	<b>Date of Birth:</b>	<b>Height:</b>	<b>Weight:</b>
<b>Gender:</b> Female Male			
<b>Relationship/Marital Status</b>		<b>If married, #years:</b>	<b># of Children:</b>
<b>Occupation:</b>		<b>Employer:</b>	
<b>Highest level of education:</b>			
<b>Address:</b>			
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
<b>Home Phone:</b>		<b>Cell Phone:</b>	
<b>Work Phone:</b>		<b>E-mail:</b>	
<b>Person to Contact in Case of Emergency:</b>			
<b>Relationship to Client:</b>			
<b>Phone:</b>			

<b>How Did You Hear About Us?</b>
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<b>Primary Care Doctor:</b>	
<b>Phone:</b>	<b>Fax:</b>

<b>If patient is a Minor, Name of Parent/Guardian(s)</b>
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**HEALTH CONCERNS:** Please list your current health concerns in order from the most bothersome to least bothersome. Please include mental, emotional, and physical concerns.

1)
2)
3)
4)
5)
6)
7)

## HOSPITALIZATIONS, SURGERIES, AND MAJOR ILLNESSES

Date	Condition or Procedure
1)	
2)	
3)	
4)	
5)	
6)	
7)	



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**MEDICATIONS:** Please list the medication and dosages that you are currently taking. Please include both prescription and over the counter.

Medication	Condition Treated	Dosage
1)		
2)		
3)		
4)		
5)		
6)		

**SUPPLEMENTS:** Please list all of the supplements that you are currently taking including dosages and brand names.

Supplement	Brand	Dosage
1)		
2)		
3)		
4)		
5)		
6)		

**ALLERGIES:** Please list any medication, food, environmental, or other allergies. Please describe the symptoms you experience when exposed to the allergen.

### Lifestyle:

<b>Exercise Type:</b>	<b>Intensity:</b>
<b>Duration (Minutes):</b>	<b>Frequency:</b>
<b>Sleep:</b> _____ hrs/night	<b>Do you wake refreshed?</b> Y N
<b>Trouble falling sleep, waking at night (time) _____, falling back asleep, waking too early</b>	
<b>Water intake:</b> _____ #cups/day (8oz/cup)	
<b>Alcohol :</b> Y N	<b>#drinks</b> _____ <b>per day/week/month</b>
<b>Coffee/tea:</b> Y N	<b># cups/day:</b> _____ <b>regular / decaf</b>
<b>Soda:</b> Y N	<b>#cups/day:</b> _____ <b>regular / diet</b>
<b>Cigarettes/Chewing Tobacco:</b> Y N <b>Past</b>	
<b>#pk/day #yrs:</b>	
<b>Recreation Drug Use:</b> Y N <b>Explain:</b>	
<b>Past Drug Rehab?</b> Y N <b>Explain:</b>	
<b>Do you currently have a Spiritual practice?</b>	
<b>What are your greatest sources of stress, past or present?</b>	
<b>What do you do for stress relief?</b>	



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### FAMILY HISTORY:

	Children	Mother	Father	Siblings	Maternal Grandparents	Paternal Grandparents
Alcoholism/Addiction						
Allergies						
Alzheimer’s Disease						
Anemia/Clotting disorder						
Anxiety Disorder						
Arthritis						
Asthma						
Birth Defect						
Cancer: _____						
Cancer: _____						
Depression or Bipolar						
Diabetes						
Epilepsy/Seizures						
Gallbladder Disease						
Heart Attack						
High Cholesterol						
High Blood Pressure						
Hypoglycemia						
Kidney Disease						
Liver Disease						
Migraines						
Stroke						
Thyroid disease						
Tuberculosis						
Other:						

### PAST MEDICAL CONDITIONS:

Please check any conditions in your history:

ADD/ADHD	Gallbladder Disease	Physical Abuse
AIDS	Glaucoma	Pneumonia
Alcoholism/Addiction	Goiter	Polio
Allergies	Gonorrhea	Prostate Problems
Anemia	Gout	Psoriasis/Eczema
Anorexia	Heart Disease	Psychiatric Hospitalization
Appendicitis	Hernia	Rheumatic Fever
Arthritis	Herpes (Oral / Genital)	Scarlet Fever
Asthma	High Cholesterol Disease	Sexual Abuse
Bleeding Disorder	HIV Positive	Stroke
Breast Lump	Kidney Disease	Suicide Attempt
Bronchitis	Leg Cramps	Thyroid Condition
Bulimia	Liver disease	
Cancers	Lyme Disease	Tonsillitis
Cataracts	Measles	Tuberculosis
Chemical Dependency	Migraine/Headaches	Typhoid Fever
Chicken Pox	Miscarriage	Ulcers
Depression/Anxiety/Bipolar	Mononucleosis	Vaginal Infections
Diabetes	Multiple Sclerosis	Venereal
Emphysema	Mumps	
Epilepsy	Pacemaker	



**Bluewater Natural Health at  
Bluewater Chiropractic Wellness Center**

4400 Hwy 20 E Ste 207 ♦ Niceville, FL 3257 ♦ P: 850.897.1177 ♦ F: 850.897.1377

[www.bluewaternaturalhealth.com](http://www.bluewaternaturalhealth.com) [www.bluewaterchiropractic.com](http://www.bluewaterchiropractic.com)

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## GENERAL:

- Have Had
- Tired, weak, lack of energy
  - Depression, moodiness
  - Worry, anxiety, nervousness
  - Sleeplessness or too much sleep
  - Frequent colds or other illnesses
  - Headaches, migraines
  - Dizziness, fainting, blacking out
  - Cannot sweat/ too much sweat/ night sweats

## EYES:

- Have Had
- Nearsightedness or farsightedness
  - Blurred or failing vision
  - Dry, burning or itching eyes
  - Eyes water excessively
  - Night blindness
  - Bloodshot, red or puffy eyes
  - Mucus or discharge in eyes
  - Pain in eyes

Date of last eye exam: \_\_\_\_\_

## EARS:

- Have Had
- Earaches
  - Noises
  - Ear discharges
  - Loss of hearing
  - Excess earwax

## NOSE and MOUTH:

- Have Had
- Allergies, sinusitis, runny nose
  - Dry mouth or nose
  - Nosebleeds
  - Cracks in corners of mouth
  - Dry or chapped lips
  - Sore throat or tonsillitis
  - Sore, red, or cracked tongue
  - Cold sores or herpes
  - Loss of smell or taste
  - Bleeding gums
  - Hoarseness
  - Grinding teeth
  - Dental problems
  - Difficulty swallowing

## SKIN and HAIR:

- Have Had
- Acne or pimples
  - Hives
  - Stretch marks
  - Skin rashes, sores, ulcers
  - Dryness, roughness or scaling
  - Hair loss or thinning
  - Dry, coarse hair
  - Bruise easily
  - Nails weak, ridged or split easily
  - Brown spots or bronzing on skin
  - Warts, moles, or skin tags
  - Sunburn easily
  - Cuts heal slowly or scar badly
  - Flush easily
  - Athletes' foot

## MUSCULO-SKELETAL:

- Have Had
- Muscle pain
  - Weakness
  - Joint pain (specify \_\_\_\_\_)
  - Joint swelling (specify \_\_\_\_\_)
  - Back pain
  - Neck pain
  - Joint stiffness
  - Numbness or tingling
  - Decreased range of motion

## CARDIOVASCULAR:

- Have Had
- Heart beats fast or irregularly
  - Tightness in chest
  - Discomfort in high altitude
  - Dizzy or weak on standing
  - Swollen feet, ankles or legs
  - Cold hands or feet
  - Fingers/hands or toes/feet turn blue
  - Leg pain with walking
  - High or low blood pressure

## CHEST:

- Have Had
- Cough frequently
  - Spitting up mucous or blood
  - Difficulty breathing
  - Chest pain
  - Wheezing
  - Palpitations

## GASTROINTESTINAL:

- Have Had
- Loss of appetite
  - Nausea or vomiting
  - Bad breath
  - Metallic or bitter taste in mouth
  - Belching
  - Heartburn
  - Indigestion
  - Heaviness after eating
  - Bloating or gas
  - Constipation
  - Bleeding gums
  - Foul smelling stool or gas
  - Diarrhea
  - Blood in stool or on paper
  - Hemorrhoids
  - Rectal pain/itching

## URINARY:

- Have Had
- Difficulty urinating
  - Urinating frequently at night
  - Bed wetting
  - Incomplete urination or dribbling
  - Pain when urinating
  - Bladder or kidney infection
  - Incontinence
  - Blood in urine

## FEMALE:

- Have Had
- Irregular menses
  - Pain prior to or with menses
  - Depression/irritability prior to menses
  - Painful or swollen breast
  - Lumps in breast
  - Nipple discharge
  - Vaginal discharge
  - Vaginal pain or itching
  - Heavy periods
  - Hot flashes
  - Diminished or excessive sex drive
  - Difficulty reaching orgasm
  - Miscariages (how many? \_\_\_\_\_)
  - Abortions (how many? \_\_\_\_\_)
  - Pain with intercourse
  - Pelvic pain
  - Inability to conceive



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Please fill out this form to the best of your knowledge. There is no correct or incorrect answer.

Do you use birth control?  
If yes, what kind?

Are you pregnant?  
Are you trying to become pregnant?  
Are you in a supportive relationship?

How many children do you have (list ages)?  
Are you currently breastfeeding?

Do you get regular gynecologic exams?  
When was the date of your last gyn exam?  
Have you ever had an abnormal PAP?  
If yes, explain findings:

Vaccinations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you had a reaction to the vaccination, please describe.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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



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Please fill out this form to the best of your knowledge. There is no correct or incorrect answer.

I certify that the above information is correct to the best of my knowledge:

*I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my relationship with Bluewater Natural Health, any fees for professional services rendered me will be immediately due and payable.*

***Clinic Policy requires payment at time of services.***

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Please Print Name



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