

Adult Intake Form – Male

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

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

How Did You Hear About Us?

Primary Care Doctor:	
Phone:	Fax:

If patient is a Minor, Name of Parent/Guardian(s)
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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:

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



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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:

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



**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 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

MALE:

- Have Had
- Difficulty Urinating (delayed stream or reduced stream pressure)
 - Pain during urination
 - Genital discharge
 - Pain in genitals
 - Pain in testicals
 - Prostate problems

Date of last DRE/prostate exam: _____



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Vaccinations: _____

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

Additional Comments: _____



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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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