Wild Womxn Medicine

719 Hamline Ave N St. Paul, MN 55104

Adult Intake Form

Name:_____

Address:_____City:_____State: _____Zip:_____

Phone Number:_____Email:_____

Date of Birth:_____ Age:_____Preferred Pronouns:_____

Children/Ages:_____

Employer Name:_____Position:_____

Who referred you?_____

Have you been adjusted by a chiropractor before?_____

By Whom?_____

Reason for visit?_____

Have you had cranial sacral therapy, visceral manipulation, or somatic trauma resolution care before?
Which?_____

By whom?_____

Reason for visit?_____

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Do you now, or have you ever suffered from:

Dizziness ___

Poor Circulation ___

Heart disease ___

Heart palpitations or arrhythmia____

Anemia ___

High Blood Pressure ___

Frequent UTIs_____

Kidney stones___

Digestive disorder or troubles___

Frequent Cravings____

Reflux____

Heart Burn ___

Diabetes ___

Asthma ___

Allergies __

Sinus pain/congestion ___

Skin Irritations_____

Acne____

Frequent Colds/URIs_____

Headaches___

Neuritis ___

Arthritis ___

Cold/Tingling/Numbness in Hands/Feet ___

Muscle aches _____

Anxiety ___

Irritability___

Low Energy___

Depression___

Brain Fog ___

Tire Easily ___

Mood swings____

Hyperactivity____

Restlessness____

Adrenal dysfunction____

Cognitive Changes____

Concentration Challenges____

Balance or Coordination Decline____

Menstrual Pain or Difficulties __

PCOS____

Thyroid Dysfunction____

Hormone dysfunction____

Difficulty Sleeping ___

Memory Decline____

Speech changes____

Cancer___

Painful breasts or breast cancer_____

Autoimmune Conditions_____ If so, list:_____

Have you at any time in your life taken “broad spectrum” antibiotics? Yes / No

Are your symptoms worse on damp, muggy days or in moldy places? Yes / No

Do you crave sugar? Yes / No

Do you have a feeling of being drained? Occasional or Mild / Frequent/Moderate/ Severe

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Please list any other health concerns you have at this time:

_____

_____

What would you like to re-gain in your life by becoming healthier? _____

_____

Are you avoiding any specific foods? If so, Why? _____

_____

Do you eat fresh fruits and/or vegetables on a daily basis? If not, how often?_____

Physical Stressors:

Any Accidents or Injuries (childhood, broken bones, falls, motor vehicle accidents, etc.)?_____

Surgeries:_____

Any Other Medical Procedures?_____

Do you do any physical activity on a daily basis? Please Describe. _____

Chemical Stressors:

List any and all Prescriptions or OTC drugs:_____

_____

Do you smoke or chew tobacco?_____

Do you drink alcohol, how often?_____

Do you drink diet sodas or eat sugar-free foods? _____

Emotional Stressors:

Have you had any strong emotional stressors either recently, or that has an effect on your daily life?_____

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What aspects of Wellness do you want for yourself?

(Please check as many as you'd like)

___ Freedom from pain

___ Reduce/Eliminate Medication use

___ Greater resistance to Disease

___ Better reaction time/reflexes

___ Overall Health Improvement

___ More Energy

___ Better Concentration

___ Improved Digestion

___ Easier breathing, Deeper breaths

___ Better Sleep

___ Enhanced emotional Well-being

___ Improved strength and endurance

___ Better sports performance

___ Better Balance

___ Increased zest for Living

___ Improved Posture

Wellness goals you have for yourself: _____

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Policies

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation. I understand that I am responsible for all payment of fees charged in this office of services rendered.

X_____

Signature Date

Privacy Act:

I consent to the use of my protected health information by Wild Womxn Medicine, LLC for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or conduct health care operations (HIPAA Compliance).

X _____

Signature of Patient Date

X _____

Printed Name of Patient

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Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that which will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine.

Health: The state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer the diagnosis or treatment of any disease. We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter unusual finding which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

I, _____ have read and fully understand the above statements. (Print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

_____ _____

(Signature) (Date)