

NEW PATIENT INTAKE FORM

Today's Date: _____

Name: _____

Lifetime Wellness

Cell#: (____) _____

CHIROPRACTIC

Age: _____ Date of Birth: ___/___/___

Louis C. Fabale, DC

Address: _____ Hm#: (____) _____

City/Zip: _____ e-mail: _____

Occupation: _____ Referred by: _____

___ single ___ married ___ divorced ___ widowed # of children with ages: _____

Briefly describe your current health problem: _____

When and how did it start? _____

Have you had this before? (If yes, when?) _____

Please list surgical procedures with dates: _____

Which areas of your life contribute *most* to your stress?

- | | | | |
|------------------|-----------------------|---------------------|---------------------------|
| ___ work | ___ health | ___ social issues | ___ family |
| ___ money | ___ past history | ___ substance abuse | ___ disappointment w/self |
| ___ relationship | ___ loss of loved one | ___ self image | ___ recent change |
| ___ weight gain | ___ chronic pain | ___ time management | ___ worry/anxiety |
- other _____

How do you grade your physical health? (please circle one in *each* category)

excellent / good / fair / poor getting better / getting worse / stable

How do you rate your emotional/mental health? (please circle one in *each* category)

excellent / good / fair / poor getting better / getting worse / stable

Do you exercise regularly? (Y) (N) How often per week? 1x 2x 3x 4x 5x 6x 7x 7+

List exercise activities: _____

How do you rate your dietary habits? excellent / good / fair / poor

Check if you regularly eat or drink:

- | | | | |
|---------------------|-----------------------|---------------|-----------------|
| ___ Diet sweetners | ___ fried foods | ___ margarine | ___ meat |
| ___ dairy products | ___ salty snack foods | ___ alcohol | ___ soft drinks |
| ___ breads/pastries | ___ candy/sweets | ___ tap water | ___ fast food |

Do you currently take any medications for a medical condition? (If yes, please list below)

Do you have a history of substance abuse? (Y) (N) Are you in recovery? (Y) (N) How long? _____

Do you have any specific, regularly scheduled strategies in place in your life to "de- stress?"

Please list: _____

Please indicate your most immediate response to insult or injury: anger___ fear___ other___

How committed are you to your health? strongly / fairly / weakly / barely / not sure

Are you willing to make some changes in your life to achieve your health goals? (Y) (N)

Sign: _____ Date: _____