Chiropractic Wellness Centre, PC

James J. Peck, D.C. & Audrey E. Peck, D.C.

191 Chandler Road, Unit B, Andover MA 01810

Phone (978) 655-5217

Adult Intake Form

“Chiropractic is unique and powerful. It is truly a lifestyle and is most effective when used as a process rather than an event.”

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: S M D W (please circle) Spouse/Partner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Spouse/Partner DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Names and birthdates of your children:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your lifetime goal for your health?

Some examples of a lifetime goal are the following –

 “I want to be able to play and run with my grandchildren”

 “I want to be able to continue to be actively involved in my community” “I want to age gracefully”

Initial Visit Informative History

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We look forward to getting to know you. Please complete this form as candidly as possible.

What is the reason for your visit?

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

Have you had any previous chiropractic experience? Y N (please circle)

Name of chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long were you under care? \_\_\_\_\_\_ days \_\_\_\_\_\_ weeks \_\_\_\_\_\_ months \_\_\_\_\_\_\_\_ years

Date of last visit? \_\_\_\_\_\_\_\_\_\_\_

Why did you stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If female, are you pregnant? Y N (please circle) Date of last period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*“Your health is dependent on your nerve system. For you to function at your best your brain must have clear communication with the rest of your body. This is accomplished through your spinal cord which is protected by your spine. Chiropractors evaluate your spine to determine if there is interference. Interference (subluxation) occurs from stress, either physical (repetitive awkward positions, bumps and bruises), emotional (criticism, exhaustion, rudeness) or chemical (bad foods, drugs, pollution).”*

Physical Trauma:

Any known birth trauma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List surgeries with dates and reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List fractures or other significant injuries with dates and reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Car or work accidents with dates and reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Emotional Trauma:  1 2 3 4 5 

Childhood Stress: \_\_\_\_\_\_\_\_\_ Family Stress: \_\_\_\_\_\_\_\_ Work/School Stress: \_\_\_\_\_\_\_\_\_\_

Commute to Work: \_\_\_\_\_\_\_\_\_\_\_\_ Divorce/Separation: \_\_\_\_\_\_\_\_\_\_ Illness: \_\_\_\_\_\_\_\_\_\_\_

Financial: \_\_\_\_\_\_\_\_\_\_\_\_ Abuse: \_\_\_\_\_\_\_\_\_\_\_ Loss of loved one: \_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_

Chemical Trauma:

How many fast food meals do you eat per week? \_\_\_\_\_\_\_\_\_\_

How many alcoholic beverages do you drink per week? \_\_\_\_\_\_\_\_\_\_

How many caffeinated beverages (coffee, tea, cola etc.) do you drink per week?

Do you smoke? Y N (please circle) How many per day? \_\_\_\_\_\_\_

Do you consume any artificial sweeteners? Y N (please circle)

Do you take any over the counter drugs? Y N (please circle)

If yes what do you take? \_\_\_\_\_\_\_\_\_\_\_\_\_ how often? \_\_\_\_\_\_\_ day \_\_\_\_\_\_\_\_\_ week

Do you take any prescription drugs? Y N (please circle)

 If yes what do you take? List with dosage and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Do you take any supplements? Y N (please circle)

 If yes please list and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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We here at the Chiropractic Wellness Centre are excited to meet you. We offer excellent health care and will educate you about the ***seven essentials for health:***

* What you eat
* What you drink
* What you think
* How you breathe
* Your posture
* ***How much & how you exercise?*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* ***How you rest/sleep?*** \_\_\_\_\_\_\_ ***side/back/stomach (please circle)*** ***Number of hours?*** \_\_\_\_\_\_\_\_

Our goal is to improve the health of our community by providing the opportunity for entire families to experience optimum function, and physical, mental and social well-being.

While we hope you will choose our office, we recognize that it is an individual decision and we will respect you in the process.

Payment in full ($200.00) is expected on **FIRST VISIT**. This payment includes 1st visit (comprehensive exam and adjustment) and 2nd visit (a ROF and second adjustment). All other fees are to be paid at the time of service until other arrangements have been made and agreed upon in writing.

**PLEASE READ AND SIGN BELOW**

*The information I have provided on this intake form is true and accurate to the best of my knowledge. I give Dr. James Peck and/or Dr. Audrey Peck permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.*

*I also understand that Chiropractic Wellness Centre, PC is a cash practice (they do not bill any insurance companies) and that I am responsible for full payment of any services that I have received and may not submit receipts to my insurance company for any kind of reimbursement.*

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent (for minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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