Patient Intake

Patient Information

Legal Name: (last) _____ (first) _____ (MI): _____

Email: _____ Primary Phone: _____ ☐Home ☐Work ☐Cell

Address: _____ City: _____

State: _____ Zip: _____ Sex: ☐ M ☐ F Age: _____ DOB: _____

Social Security # or DL #: _____ ☐Married ☐Single ☐Partnered ☐Widowed

☐Children How Many: _____

Occupation: _____ Patient Employer/School: _____

Address: _____ Phone: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Who may we thank for referring you? Event you attended? _____

Values

Please list your interests in order of importance from 1 to 7 (1=most important)

Family_____ Financial _____ Social_____ Physical_____ Mental_____Spiritual_____Work_____

Payment/Insurance Information

Who is financially responsible for this account? ☐ Self-Pay or. ☐Other (Name): _____

Relationship to patient? _____

If insured, who is the main subscriber/policy holder?_____

Birth Date: _____ Phone: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

☐ Health Insurance Co Name: _____ ID# _____ Group# _____

☐ Government Program Name: _____ ID #_____

Is this policy associated with an ☐ HSA ☐FSA ☐HRA ☐N/A

Is patient covered by additional/secondary insurance? ☐ Yes ☐ No

Insurance Co. Name: _____ ID#_____Group# _____

Subscriber Name: _____ DOB: _____ Relationship to patient:_____

Assignment and Release

On behalf of yourself and any patient for whom you are the parent or legal guardian, you 1)certify that the information on this form is accurate and up-to-date, 2) consent to treatment by this Chiropractic Office, 3)assign to this Chiropractic Office, any healthcare insurance or reimbursement benefits to which you are entitled for the care provided by this Chiropractic Office, authorize their payment directly to this Chiropractic Office, and authorize the use of your signature for this limited purpose, 4)agree to be primarily responsible for all charges owed to this Chiropractic Office (other than those included in any pre-paid offer), including attorney fees, court costs, and other expenses of collection, 5)consent to this Chiropractic office releasing any "protected health information," as defined by federal HIPAA regulations, for the purposes allowed by law, and 6)acknowledge receipt of this Chiropractic offices's Notice of Privacy Practices.

_____ _____

Printed Name of Patient, Parent, Guardian or PR Signature of Patient, Parent, Guardian or PR

Relationship: _____ Date: _____

Medications

1) _____

2) _____

3) _____

Pharmacy Name: _____

Pharmacy Phone: _____

Vitamins/Supplements

1) _____

2) _____

3) _____

4) _____

☐Daily ☐Weekly ☐Occasionally

Allergies

1) _____

2) _____

3) _____

4) _____

How often do they occur?

_____

Family History

☐ Autoimmune Dis.
☐ Bleeding Disorder
☐ Clotting Disorder
☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Kidney Disease
☐ Migraines
☐ Osteoporosis
☐ Stroke
☐ Thyroid Disease
☐Other: _____

Medical History

Name and address of other doctors(s):

_____

Date of Last: Physical Exam _____ Spinal X-Ray_____Spinal Exam _____ Chest X-ray_____
MRI, CT-Scan, Bone Scan_____ Blood Test _____ Urine Test _____

Circle "yes" or "no" to indicate whether you have experienced each of the following and complete the information below:

AIDS/HIV	Yes	No	Chemical Depend./			Hernia	Yes	No	**Pinched Nerve**	Yes	No
Allergies	Yes	No	Alcoholism	Yes	No	**Herniated Disk**	Yes	No	Pneumonia	Yes	No
Anemia	Yes	No	Chicken Pox	Yes	No	Hypertension	Yes	No	Prostate Problem	Yes	No
Anxiety/Depression	Yes	No	**Clotting Disorder**	Yes	No	Kidney Disease	Yes	No	Psychiatric Care	Yes	No
Appendicitis	Yes	No	Diabetes	Yes	No	Liver Disease	Yes	No	Rheum. Arthritis	Yes	No
Arthritis	Yes	No	Eating Disorder	Yes	No	Migraines	Yes	No	STD	Yes	No
Asthma	Yes	No	Emphysema	Yes	No	Mononucleosis	Yes	No	Stroke	Yes	No
Autoimmune Dis.	Yes	No	**Epilepsy/Seizure Dis.**	Yes	No	**MS**	Yes	No	Thyroid Disease	Yes	No
Bleeding Disorder	Yes	No	Headaches	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Bronchitis	Yes	No	Heart Disease	Yes	No	Pacemaker	Yes	No	Tumors, Growths	Yes	No
Cancer	Yes.	No	Hepatitis	Yes.	No	Parkinson's	Yes.	No	Ulcers	Yes.	No
Are you pregnant?	Yes.	No	If yes, how many weeks? _____						Other:_____		

Motor Vehicle Accident ☐ Denied

Please indicate any motor vehicle accidents below, making sure to note any minor accidents or those that have taken place 5+ years ago.

Date of accident (MO-YR):_____-_____

Impact: ☐ Front ☐ Rear ☐ Side/Passenger ☐ Side/Driver
☐ Seat Belt ☐ Airbag(s)

Speed at which your car was traveling: _____

Speed at which the second car struck your car:_____

Medical Care Description:

_____

_____

_____

Chiropractic Care Description:

_____

_____

_____

Motor Vehicle Accident ☐ Denied

Please indicate any motor vehicle accidents below, making sure to note any minor accidents or those that have taken place 5+ years ago.

Date of accident (MO-YR): _____-_____

Impact: ☐Front ☐ Rear ☐Side/Passenger ☐Side/Driver
☐ Seat Belt ☐Airbag(s)

Speed at which your car was traveling: _____

Speed at which the second car struck your car:_____

Medical Care Description:

_____

_____

_____

Chiropractic Care Description:

_____

_____

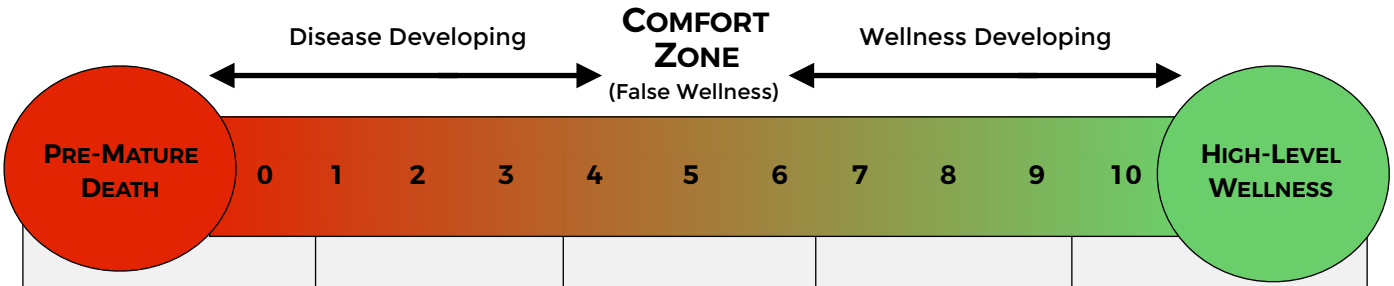
_____

Physical Trauma Information

Please indicate any physical and/or trauma occurrences below, making sure to note any minor injuries as well by checking 'Yes'. Please describe when applicable.

Work Activities: ☐ Sitting ☐ Standing ☐Light Labor ☐ Heavy Labor ☐ Retired
Work Injuries: ☐Yes ☐ No If yes: _____
Sport Activities:
Sport Injuries: ☐Yes ☐ No If yes: _____
Exercise: ☐ None ☐Light ☐ Moderate ☐ Heavy
Home Injuries: ☐Yes ☐ No If yes: _____
Habits: ☐Nicotine ☐Alcohol ☐Coffee/Caffeine Drinks ☐ High Stress Level ☐None
How Much? How Often? ☐ Daily ☐Weekly ☐Occasionally
Falls: ☐Yes ☐ No If yes: _____
Head Injuries: ☐Yes ☐ No If yes: _____
Dislocations: ☐Yes ☐ No If yes: _____
Broken Bones: ☐Yes. ☐ No If yes: _____
Surgeries: ☐Yes. ☐ No If yes: _____
Your Birth Delivery: ☐ Vaginal ☐Cesarean Complications: ☐Breech ☐Fetal ☐Distress ☐CPD ☐Placenta Previa
☐ Unknown ☐ Premature ☐ Umbilical Cord ☐ Meconium Aspiration ☐ None

Illness-Wellness Continuum



Disease	Poor Health	Neutral	Good Health	Optimal Health
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug Therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today?_____

B. In what direction is your health currently headed?_____

What are your health goals?

Immediate _____

Short Term _____

Long Term _____

Primary Complaint

Please note **ONE** complaint in the following section. The Primary Complaint is your chief complaint or most problematic concern at this time that brought you in today.

Primary complaint: _____

Please describe the condition: _____

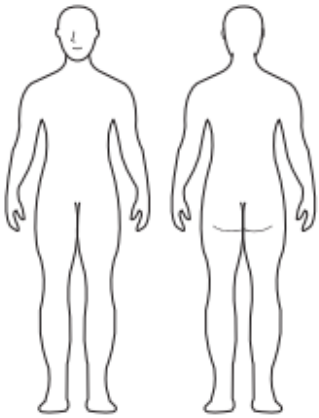
When did your symptoms first appear? _____

Most recent occurrence date: _____

What do you think caused this problem? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you have pain, numbness or tingling:



Rate the severity of your pain

(please circle) ...at its worst: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

...at its least severe: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

...at present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐ Numbness ☐Aching ☐Shooting ☐ Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

Does the pain travel from one location to another? From where to where? _____

How often do you have this pain? ☐Constantly ☐ Comes and goes ☐Infrequently ☐Daily ☐Weekly ☐Monthly

Do activities make it worse in the AM or PM? ☐ AM ☐PM ☐ N/A

Which activities are affected by this? ☐ Work ☐Sleep ☐Daily Routine ☐Recreation ☐ N/A Other ☐Sitting ☐Standing ☐Walking ☐ Bending ☐ Lying Down

Past Treatments: ☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic Services ☐None ☐ Other_____

Were they successful? ☐Yes ☐ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

Additional Complaint I

Please note **ONE** complaint in the following section. The Additional Complaint I is any other problem/complaint you may be experiencing.

Additional complaint: _____

Please describe the condition: _____

How often does it occur? _____

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Rate the severity of your pain at the present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Does the pain travel from one location to another? From where to where? _____

How often do you have this pain? ☐ Constantly ☐ Comes and goes ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ N/A Other ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Past Treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Were they successful? ☐ Yes ☐ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

Additional Complaint II

Please note **ONE** complaint in the following section. The Additional Complaint II is any other problem/complaint you may be experiencing.

Additional complaint: _____

Please describe the condition: _____

How often does it occur? _____

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Rate the severity of your pain at the present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Does the pain travel from one location to another? From where to where? _____

How often do you have this pain? ☐ Constantly ☐ Comes and goes ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ N/A Other ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Past Treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other _____

Were they successful? ☐ Yes ☐ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

Is there anything else you would like the Doctor of Chiropractic to know?

_____

_____

_____

_____

_____

FOR OFFICE USE ONLY **(Clinical Comments)**

Examiner's Name:_____ Examiner's Signature: _____ Date:_____
Physician/Provider Name: _____ Physician/Provider Signature:_____ Date:_____