Patient Intake Form

(Please print clearly)

Today's Date:		**Location:**		
Name:		**Race:**	**Sex: M F**	**R L B Handed**
Street:		**City/State/Zip** :		
Phone H:	**W:**	**C:**	**Email:**	
DOB: mm/dd/yyyy	**Age:**	**Blood type:**	**Ht:**	**Wt:**
Married / Divorced / Single / Widowed / Separated				
Emergency Contact's Name and #:				
Occupation				
Occupational Stresses: (Chemical, physical, psychological, etc.)				
Hobbies/Past-times:		**Denomination/Spiritual Path:**		
Referred by:		**Physician:**	**Phone:**	

Main Concern/health issue:_____

_____

How does it affect your daily living?_____

_____

Please answer all questions as completely and thoroughly as you can. Though some questions may not seem to pertain, they all are very important to help diagnosis and formulate a treatment plan specifically for you and make proper referrals. If needed, list number, then use spaces or back of page to explain more detail.

Recent Exams: (give dates) **Physical:**_____**Eye:**_____
Dental:_____ **Ob/Gyn:**_____ **Specialist:**_____

What is your philosophy of healthcare?_____

Do you have health questions that do not get answered at the doctor's office? Y N_____

_____

_____

Your **Physical** health status now feels: **(poor) 1----------10 (ideal)**

Your **Mental** health status now feels: **(poor) 1----------10 (ideal)**

Your **Daily Work** stress levels now feel: **(poor) 1----------10 (ideal)**

Your **Daily or Social** stress levels feel: **(poor) 1----------10 (ideal)**

Your **Home Life** stress levels now feel: **(poor) 1----------10 (ideal)**

Your ability to handle recent stresses: **(poor) 1----------10 (ideal)**

What special topic/s would you like to ask about at your consultation? _____

_____

_____

Patient Intake Form Name:_____ **Date:**_____

Healthcare: Other Independent or Concurrent Therapies: Past (P) and/or Current (C)

1. ____ Chiropractic
2. ____ Chiro for family, pets
3. ____ Acupuncture
4. ____ Therapeutic Massage
5. ____ Naturopathic
6. ____ Oriental Medicine
7. ____ Nutritional Consult
8. ____ Medical Treatment
9. ____ Specialist
10. ____ Natural Healer
11. ____ Spiritual Healer
12. ____ Energy Work

Diagnostic or Routine Exams: Please list area, Dr. and reason ordered, date and location of exam if known.

13. ____ X-rays
14. ____ MRI
15. ____ CAT Scan
16. ____ Blood draw
17. ____ Ultrasound
18. ____ Upper/lower GI
19. ____ DEXA Scan
20. ____ Breast Exam
21. ____ Prostate Exam
22. ____ Eye Exam
23. ____ Dental Exam
24. ____ Colonoscopy
25. ____ Other_____
26. ____ Other_____
27. ____ Other_____

Medical History: Current = C Past = P (greater than 6 months) include dates if possible for both

Significant Illnesses

28. ____ Allergies
29. ____ Arthritis
30. ____ Asthma
31. ____ Cancer
32. ____ Depression
33. ____ Diabetes
34. ____ Hepatitis A / B / C
35. ____ Heart disease
36. ____ High blood pressure
37. ____ Low blood pressure
38. ____ Lung disease
39. ____ Neurological
40. ____ Psychological
41. ____ Rheumatic Fever
42. ____ Seizures
43. ____ Thyroid disease
44. ____ Vascular disease
45. ____ Other

Illness/Injuries/Surgeries/Hospitalizations:

46. ____ Broken bones
47. ____ Burns
48. ____ Car accidents
49. ____ Concussion
50. ____ Fallen down/upstairs
51. ____ Fallen from any height
52. ____ Fallen on ice
53. ____ Feeling un-coordinated
54. ____ Fevers
55. ____ Flu/colds
56. ____ Frequent accidents
Sports injuries
57. ____ Frequent Illness
58. ____ Frequent Infections
59. ____ Head trauma
60. ____ Hospitalizations
61. ____ Infected wounds
62. ____ Loss of consciousness
63. ____ Psychological
Hospitalization
64. ____ Recreational Injuries
65. ____ Serious cuts
66. ____ Serious Depression
67. ____ Significant trauma
68. ____ Surgeries
69. ____ Transfusions
70. ____ Transplants
71. ____ Tripping/Stumbling
72. ____ Wounds slow to heal

Patient Intake Form Name:_____ **Date:**_____

Childhood

73. ____ Illnesses
74. ____ Traumatic events
75. ____ Immunizations
76. ____ Injuries
77. ____ Other
78. ____ Other

_____
_____
_____

Prescribed/Over the Counter medications and Supplements (Include doses, purpose and duration):

_____
_____
_____

Past Medications and Supplements (3-6 months) _____

Skin and Hair:

79. ____ Rashes
80. ____ Eczema
81. ____ Hair/skin texture change
82. ____ Ulcerations
83. ____ Pimples
84. ____ Purpura
85. ____ Hives
86. ____ Dandruff
87. ____ Itching
88. ____ Loss of hair
89. ____ New moles/growth
90. ____ Other

_____
_____

General: List times of day or any correlating factors

91. ____ Poor appetite
92. ____ Heavy appetite
93. ____ Change in appetite
94. ____ Weight gain
95. ____ Weight loss
96. ____ Cravings salt/sweet/fats
97. ____ Poor sleep
98. ____ Can't fall asleep easily
99. ____ Wake feeling rested
100. ____ Decreased sleep
101. ____ Heavy sleep
102. ____ Insomnia
103. ____ Apnea/Narcolepsy
104. ____ Sudden awakening at night, time_____
105. ____ Hours of sleep/night
106. ____ Day napping ____ amt
107. ____ Night sweats
108. ____ Cold hands/feet
109. ____ Sudden energy drop
110. ____ Strong thirst hot/cold
111. ____ Fatigue
112. ____ Chills
113. ____ Sudden temp changes
114. ____ Localized weakness
115. ____ Tremors
116. ____ Poor circulation
117. ____ Peculiar tastes/smells
118. ____ Night pain
119. ____ Radiating pain
120. ____ Numbness/tingling
121. ____ Pins and needles
122. ____ Sweats easily
123. ____ Excessive sweating
124. ____ Body odor change
125. ____ Stress
126. ____ Bowel/bladder changes
127. ____ Bleed/bruise easily (where?)

_____
_____
_____
_____

Musculoskeletal: List location and type of pain, i.e. sharp, dull, radiating, traveling, etc…

128. ____ Neck Pain
129. ____ Muscle Pain
130. ____ Back Pain
131. ____ Joint Pain
132. ____ Other muscle or joint problems?
133. ____ Irretractable night pain
134. ____ Scar tissue adhesions

_____
_____
_____
_____

Patient Intake Form Name:_____ Date:_____

Head, Eyes, Ears Nose and Throat: List any noticeable correlation and frequency these conditions occur

135.____ Dizziness
136.____ Migraines
Auras, Sounds, Smells
137.____ Headaches
138.____ Vision problems
139.____ Near/Far sighted
140.____ Blurry vision
141.____ Night Blindness
142.____ Eye strain/pain
143.____ Color blindness
144.____ Cataracts
145.____ Glaucoma
146.____ Spots in eyes
147.____ Ringing in ears
148.____ Poor hearing
149.____ Earaches
150.____ Ear Pain
151.____ Ear discharge
152.____ Heavy ear wax
153.____ Nose bleeds
154.____ Sinus problems
155.____ Mucus
156.____ Dry throat/mouth
157.____ Copious saliva (lots)
158.____ Mouth/tongue sores
159.____ Sore throats
160.____ Other

_____
_____
_____
_____

Dental:

161.____ Teeth problems
162.____ Cavities
163.____ Braces
164.____ Bridges
165.____ Fillings/amalgams
166.____ Crowns gold/porcelain
167.____ Tooth pain
168.____ Head pain
169.____ Jaw pain
170.____ Molars
171.____ Extractions
172.____ Surgeries
173.____ Jaw clicks
174.____ Grinding teeth
175.____ Facial pain
176.____ Implants
177.____ Dentures
178.____ Swollen/bleeding gums
179.____ Periodontal Tx
180.____ Sealants
181.____ Fluoride Tx
182.____ Dry mouth
183.____ Other_____
184.____ Other_____

_____
_____
_____

Neurologic:

185.____ Balance problems
186.____ Vertigo
187.____ Nausea
188.____ Vomiting
189.____ Sudden blurry vision
190.____ Loss of consciousness
191.____ Loss of strength
192.____ Weakness limb/body
193.____ Feel un-coordinated
194.____ Stumbling/tripping
195.____ "Running into walls or things"
196.____ Frequently dropping things
197.____ Loss of hand grip
198. ____ Loss of fine motor skills
199.____ Other_____
200.____ Other_____

_____
_____
_____
_____

Cardio Vascular:

201.____ High blood pressure
202.____ Dizziness
203.____ Blood Clots
204.____ Low blood pressure
205.____ Fainting
206.____ Phlebitis
207.____ Chest Pain
208.____ Cold hands/feet
209.____ Difficulty breathing
210.____ Irregular heartbeat
211.____ Hand/feet swelling
212.____ Rapid pulse
213.____ Heaviness in chest
214.____ Other _____
215.____ Other_____

_____
_____
_____

Patient Intake Form Name:_____ Date:_____

Respiratory and Lungs:

216._____Persistent Cough
217._____ Coughing Blood
218._____ Difficulty breathing while lying down
219._____ Asthma
220._____ Production of phlegm Y /N _____Color
221._____ Tight chest
222._____ COPD
223._____ Bronchitis
224._____ Pneumonia
225._____ Asthma
226._____ Other

_____

_____

Genito-Urinary:

227._____ Pain w/urination
228._____Loss of bladder function
229._____Wake to urinate _____ x's/ night; time_____
230._____ Kidney stones
231._____ Frequent Urination
_____ color
_____odor
232._____ Kidney Stones
233._____ Blood in urine
234._____ Venereal disease/STD
235._____ Urgency to urinate
236._____ Impotency
237._____ Prostate problems
238._____ Sexually Active
239._____ Current number of partners
240._____ Other _____

_____

_____

_____

Gastrointestinal:

241._____ Nausea
242._____ Gas/bloating
243._____ Bad breath
244._____ Constipation
245._____ Diarrhea
246._____ Pain or cramps
247._____ Vomiting
248._____ Belching
249._____ Rectal pain
250._____ Bloody stools bright/dark red
251._____ Hemorrhoids
252._____ Sensitive abdomen
253._____ Laxative use: ___wk; type_____
254._____ Bowel Changes
255.Bowel movements
_____Frequency/day/wk
_____Color
_____Odor (foul)
_____Form (loose, compact)
Texture (smooth, segmented)
Other_____
___ International Travel

_____

_____

_____

Gynecology and pregnancy:

256._____ Age of 1st menses
257._____ Flow (describe)
258._____ Period ___ days
259._____ Clots
260._____ Vaginal Sores
261._____ Vaginal discharge
_____odor
_____color
_____appearance
262._____ Irregular Periods
263._____ Last Menses
264._____ Birth Control type and duration _____
265._____ Number of pregnancies
266._____ Number of births
267._____ Live births
268._____ Premature births; duration of pregnancy?_____
269._____ Miscarriages; What month? _____
270._____ Breast Lumps (tender?)
271._____ PMS
272._____ Mood Changes
273._____ Body Changes
274._____ Cramps
275._____ Bloating
276._____ Nausea
277._____ Vomiting
278._____ Menopause _____
279._____ Last PAP_____
280._____ Last Breast Exam
281._____ Last Ob/GYN Appt

_____

_____

_____

_____

_____

_____

Patient Intake Form Name:_____ Date:_____

Appliances or Aids:

282.____ Glasses/Prisms
283.____ Contacts
284.____ Orthotics
285.____ Joint replacement
286.____ Prosthetics
287.____ Implants of any kind
288.____ Braces
289.____ Splints
290.____ Pace Maker
291.____ Hearing Aids
292.____ Other
293.____ Other

_____

_____

Neuropsychological:

294.____ Seizures
295.____ Depression
296.____ Anxiety
297.____ Poor memory
298.____ Foggy thinking
299.____ Bad Temper
300.____ Concussions
301.____ Easily stressed
302.____ Considered/attempted suicide
303.____ Treated for emotional concerns
304.____ Antidepressant medications
305.____ Other neurological or psychological concerns

_____

_____

Lifestyle and Social History:

Stress Screening:

306.____ Can you relax when you want?
307.____ Fall asleep easily?
308.____ Stay asleep all night?
309.____ Have trouble dealing with stress?
310.____ Are you in therapy or counseling? Does it help?
311.____ Is your family safe to express true emotions?
312.____ Are romantic relationships fulfilling?
313.____ Does stress leads to digestive problems?
314.____ Do you abuse food/alcohol/tobacco to deal w/unpleasant feelings?
315.____ Do you vent unpleasant emotions in a satisfying way?
316.____ Do you avoid conflicts at your expense?
317.____ Do you feel your health is out of your hands?
318.____ Have you tried to deal with stress, but couldn't succeed?
319.____ Do you feel capable of resolving your problems, but simply need to know how?
320.____ How much do you love yourself? 0----------100%

_____

_____

_____

_____

Do you find any dysfunction or concern in the following areas?

321.____ Relationship with Family
322.____ Relationships with friends
323.____ Social Skills
324.____ Career
325.____ Work
326.____ Leisure Time
327.____ Hobbies
328.____ Past time activities
329.____ Intimate relationships
330.____ Sex
331.____ Religious Life_____
332.____ Spiritual Path_____
333.____ Childhood Religious teachings
334.____ Past relationships
335.____ Childhood
336.____ School

_____

_____

_____

Patient Intake Form Name:_____ **Date:**_____

Habits: List type and quantities where valid

337.____ Exercise x's/week_____
338.____ Proper diet (Please list typical daily meals)
339.____ Participate in community events
340.____ Sports_____
341.____ Walks_____
342.____ Regular Religious activity
343.____ Regular Spiritual activity
344.____ Seatbelts
345.____ Helmets/Protective gear
346.____ Caffeine/pills/coffee/tea/drinks
347.____ Consume Alcohol
348.____ Crave sugar/salt/fats
349.____ Smoke/chew tobacco
350.____ Recreational drugs use
351.____ Un-protected sex
352.____ Un-necessary risk taking
353.____ Road Rage
354.____ Seek conflict

_____
_____
_____

Nutritional: List typical ounces/servings per week and type

355.____ Drink soda oz/wk_____
356.____ Fruit juices oz/wk_____
357.____ Gatorade oz/wk_____
358.____ Coffee/black tea _____
359.____ Caffeine _____
360.____ Chocolate_____
361.____ Alcohol _____
362.____ health drinks, i.e. Red Bull_____
363.____ Nutritional Shakes_____
364.____ Health bars_____
365.____ Protein powders_____
366.____ Cravings salt/sweet/fats_____
367.____ Meat_____
368.____ Protein _____
369.____ Milk, oz/wk_____
370.____ Dairy, kind _____
_____
371.____ Veg, serving/day_____
372.____ Fruits, serving/day_____
373.____ Vitamins_____
_____
374.____ Supplements_____
_____
375.____ Food Allergies_____
376.____ Other _____
377.____ Other _____

_____
_____
_____
_____

Family History: Medical, psychological, social

378.____ History of Chief Complaint
379.____ Anemia
380.____ Alcoholism
381.____ Allergies
382.____ ALS (Lou Gehrig's)
383.____ Arthritis
384.____ Asthma
385.____ Back/spine problems
386.____ Cancer
387.____ Dementia/Alzheimer's
388.____ Depression
389.____ Diabetes
390.____ Family violence
391.____ Headaches
392.____ Heart Disease
393.____ High blood pressure
394.____ High cholesterol
395.____ Low cholesterol
396.____ Lung disease
397.____ Mental abuse
398.____ Mental illness
399.____ Migraines
400.____ Multiple Sclerosis
401.____ Muscular Dystrophy
402.____ Neglect
403.____ Neuropathy (numbness, tingling, pain, burning)
404.____ Neuromuscular disease
405.____ Parkinson's
406.____ Physical abuse
407.____ Sexual abuse
408.____ Seizures
409.____ Rigid upbringing
410.____ Rigid Religious beliefs
411.____ Stroke
412.____ Suicide (or attempted)
413.____ Thyroid disease
414.____ Tremors
415.____ Vascular disease
416.____ Other_____
417.____ Other_____

_____
_____
_____
_____

Signature_____Date:_____

INFORMED CONSENT

WELCOME. The doctors of chiropractic at this office are honored to be a part of your journey to achieve better health. This consent outlines our practice, policies, and your consent to care.

FUNCTIONAL HEALTH*:* Doctors of chiropractic practicing in a functional health model view health as a continuum from optimal health to hidden imbalances to disease. Rather than treating disease (e.g. cancer, hypothyroid, or multiple sclerosis), we address underlying metabolic, physiologic, and functional imbalances, intervening at root causes. One effect may be the ability to reduce or eliminate the need for medications, which must be done by your prescribing provider. As doctors of chiropractic, we do not prescribe drugs or perform surgery. Therefore all changes to prescription medications must be made by your prescribing provider.

ALTERNATIVES: Alternatives include doing nothing, relying solely on drug therapy, or consulting with other providers. Chiropractic is a branch of the healing arts distinct from other branches (e.g. nursing, osteopathic, or allopathic). I understand that the doctors in this practice are doctors of chiropractic who have post graduate education in functional endocrinology and clinical nutrition, and that diagnosing and treating human diseases or ailments is within the scope of chiropractic practice. Nonetheless, we encourage you to communicate with your other health providers about the care you receive.

RISKS: Nutritional remedial measures and supplements used in our practice are generally considered safe; however, they may involve some risks including, without limit, changes in blood sugar or gastrointestinal upset. They may also interact with certain drugs and may be inappropriate during pregnancy. Chiropractic adjustment involves some risks including, without limit, fractures, disc injuries, dislocations, and sprains/strains. Additionally, hidden conditions may exist that are not detectable through x-ray or physical or neurological exams. This may include spinal tumors, weak or occluded arteries, and aneurysms. Accordingly, there are some people that are at risk for stroke or vascular injuries.

NO GUARANTEE: Every individual responds to care differently and no guarantee or assurance is made as to the results of care in any specific case, as care may not improve your condition or result in reducing medications. We can, however, speak of our experience treating functional imbalances, and the success seen in our office has been excellent. Success includes documented subjective or objective functional improvement.

PAYMENT, INSURANCE, AND REFUNDS: Payment for services is not conditional on response to care. There is no guarantee of insurance coverage. Often, we will not know if an insurer will cover any costs until we send a bill. Any insurance you have is an agreement between you and your insurance carrier and you are responsible for payment of services, whether or not they are covered by insurance. Prorated fees for unused, prepaid services will be refunded if you wish to cancel; however, no refunds are available for any product purchases.

QUESTIONS AND ANSWERS: I have read and fully understand this consent form, and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words.

_____

Signature

Date_____

I understand the informed consent and hereby consent to treatment of my minor child named_____

Child's date of birth_____

_____

Parent or Guardian signature

Date_____

Chief Complaint Worksheet

Patient Name:	**Date:**
Symptom/Complaint:	
Onset (**What** caused it & **When** did it begin?):	
Provoke (What **worsens** the complaint: position, activity, stress, food/drinks, motion, etc.?):	
Palliative (What makes it **better**: ice, OTC, massage, position?):	
Quality (Describe what you feel. Is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, pinpoint/general):	
Radiation (Does the pain travel from one area to another?):	
Reference: What is the worse pain you've ever experienced?	
Severity: At Its Worse: 0 1 2 3 4 5 6 7 8 9 10 Percent of time:	At Its Best: 0 1 2 3 4 5 6 7 8 9 10 Percent of time:
Timing: (Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?	
Possible Social Factor Correlation:	
Possible Hospitalization Correlation:	
Possible Infection Correlation:	
Possible Traumatic Correlation:	
Possible Surgical Correlation:	
Possible Medication Correlation:	
Possible Genetics Correlation:	

Patient Name_____ Date_____

Please mark where you have pain or symptoms. Write down how it feels, such as deep or surface, stabbing or dull, throbbing or constant: