New Patient Intake Forms

Patient Data **Date** ____

Title: (Check one) ☐ Mr. ☐ Mrs. ☐Ms. ☐ Miss ☐ Dr. ☐ Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

I prefer to be called by_____

Address Line _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** ☐ Male ☐ Female

Social Security Number: _____-_____-_____ **Marital Status:** ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Emergency Contact_____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

How did you hear about our office? _____

Patient Name_____ **Date**_____

Medical Conditions: (Check all that apply to you)

□ Arthritis □ Cancer □ Diabetes □ Heart Disease
□ Hypertension □ Psychiatric Illness □ Skin Disorder □ Stroke
□ Other _____

Surgeries: (Check all that apply to you)

□ Appendectomy □ Cardiovascular procedure □Cervical spine □ Hysterectomy
□ Joint Replacement □ Prostate □ Lumbar spine □ Gall Bladder
□ Brain □ Shoulder □ Thoracic spine □ Knee
□ Carpal Tunnel □ Gastro-intestinal □ Uro-genital □ Hernia
□ Other _____

Allergies: (List any allergies)

Social History: (Check all that apply to you)

Caffeine use: □ occasional □ often □ never
Drink Alcohol: □ occasional □ often □ never
Exercise: □ occasional □ often □ never
Tobacco Use: □ occasional □ often □ never
Sleep: Hours per night= _____
Stress Level: High Moderate Low None

Family History: (Check all that apply)

Arthritis: □ Parent □ Sibling
Cancer: □ Parent □ Sibling
Diabetes: □ Parent □ Sibling
Heart Disease □ Parent □ Sibling
Hypertension □ Parent □ Sibling
Stroke □ Parent □ Sibling
Thyroid □ Parent □ Sibling
Other _____

Patient Name_____ **Date**_____

Review of Systems – (Check if you have had trouble with any of the following within the last 3 months)

General:
___ Weight change
___ Fever
___ Chills
___ Night Sweats
___ Weakness
___ Fatigue

Eyes:
___ Vision
___ Pain
___ Discharge

Ears:
___ Hearing
___ Ringing
___ Pain
___ Discharge

Nose:
___ Pain
___ Bleeding
___ Taste

Mouth/Throat:
___ Sores
___ Bleeding
___ Taste

Skin:
___ Rash
___ Itching
___ Hair Changes
___ Nail Changes

Neurologic:
___ Headache
___ Dizziness
___ Fainting
___ Convulsions

G-I:
___ Appetite
___ Abdominal Pain
___ Vomiting
___ Diarrhea
___ Constipation

G-U:
___ Frequent Urination
___ Painful Urination
___ Incontinence

Cardio:
___ Murmur
___ Chest Pain
___ Palpitations
___ Difficulty Breathing
___ Cough
___ Wheezing
___ Blue Extremities
___ Swollen Extremities

Breasts:
___ Mass
___ Pain
___ Discharge
___ Self-exam

Psychologic:
___ Anxiety
___ Depression
___ Moods
___ Memory

Musculoskeletal
___ Neck
___ Upper Extremities
___ Upper Back
___ Lower Extremities
___ Lower Back

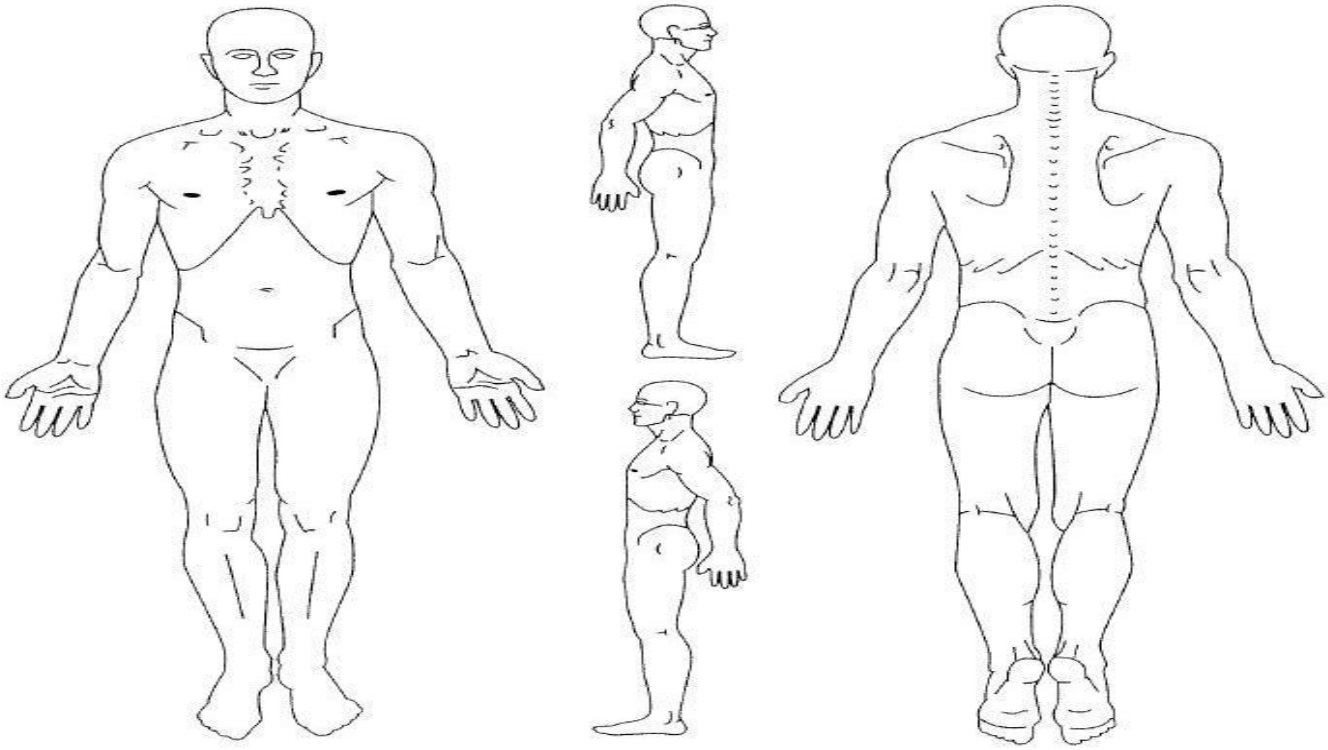
Additional Info:

Please list **ALL** current medications and/or supplements being taken:
_____
_____
_____

Patient Name_____Date_____

Are you pregnant? Yes_____ No _____N/A_____

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10 = the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms in order of severity, with worse symptom being #1: _____
_____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident □ Other_____

How are your symptoms changing?
□ Getting better □ Not changing □ Getting worse

Patient Name **Date**

Activities of Daily Living

Please circle if you have pain or difficulty performing the following:

Bending Carrying Groceries Change Posn–Sit-Stand Climb Stairs
Driving
Extended Computer Use Feeding Household Chores Kneeling
Lift Children
Lifting Pet Care Reading (Concentration) Self Care–Bathing
Self Care–Dressing
Sexual Activities Sleep Static Sitting Static Standing
Walking
Yard Work Other_____

What type of treatment are you looking for?

___ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem

___ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem

___ I am looking to take care of my problem and then go on to "achieve optimal health and wellness"

Cancellation Policy

We are very pleased to participate in your healthcare, and have set aside time for your appointment. We understand that sometimes it is necessary to cancel or change an appointment. In consideration of the others who need care, we ask that if you are unable to keep an appointment with our office, that you please observe our cancellation policy which follows:

Our office requires at least 24 hour notice for all appointment cancelations. If you are unable to provide 24 hour notice, you will be billed a $25.00 charge to your credit card on file for scheduled chiropractic appointments.

Please circle one: Visa Discover MasterCard
Card Number: _____
Expiration Date: _____
Cardholder: _____
Signature: _____
Your credit card will not be charged without notification. It is kept on file only to enforce the cancellation policy.

Please sign stating you agree to the terms and conditions.

Signature _____ Date: _____

Patient Name_____Date_____

Payment/Insurance Information:

Who is responsible for your bill? □ Self □ Health Insurance □ Spouse □ Worker's Comp
□ Auto Insur. □ Medicare □ Medicaid □ Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / ___ / _____ Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? □Yes □No Date: ____/____/____ Time: _____am / pm

If Work is responsible, Please fill out the following:

Employer Data_____

Name _____
Your Occupation _____ Your Job Description _____
Address _____
City _____ State _____ Zip Code _____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date_____

SIGNATURE OF PHYSICIAN: _____Date: _____

COMPLETE CHIROPRACTIC SPORTS & WELLNESS

INFORMED CONSENT FORM

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

One treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the chiropractic procedures.

The material risks inherent in chiropractic treatment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Symptoms may increase and over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. McLaughlin and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient’s Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Dated: _____

_____
Doctor’s Name

_____
Signature

FABQ

Here are some of the things which other patients have told us about their pain. For each statement please circle any number from 0 to 6 to say how much physical activities such as bending, lifting, walking or driving affect or would affect ***your*** back pain.

	Completely Disagree			Unsure			Completely Agree
1. My pain was caused by physical activity.....	0	1	2	3	4	5	6
2. Physical activity makes my pain worse.....	0	1	2	3	4	5	6
3. Physical activity might harm my back.....	0	1	2	3	4	5	6
4. I should not do physical activities which (might) make my pain worse.....	0	1	2	3	4	5	6
5. I cannot do physical activities which (might) make my pain worse.....	0	1	2	3	4	5	6

Name_____ Date_____

Signature_____

FOR OFFICE USE ONLY: **Date_____**

HISTORY OF PRESENT ILLNESS

Onset-

Mechanism-

Previous Care-

Palliative-

Provocative-

Quality-

Radiating-

Site/Severity-

Timing-

Associated Sx's-