CHIROPRACTIC INTAKE & HISTORY

Creating Wellness
Your Spine. Our Science.

PATIENT INFORMATION

Patient Name _____
LAST NAME
_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ State _____

Home Phone _____

Cell Phone _____

Email _____

Sex ❑ M ❑ F Age _____ Birthday _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

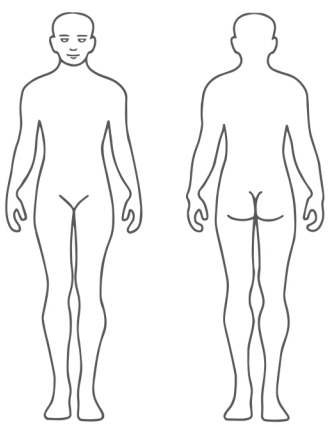
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

0 = NO SYMPTOMS; 10 = INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

❑ Numbness ❑ Sharp

❑ Tingling ❑ Shooting

❑ Stiffness ❑ Burning

❑ Dull ❑ Throbbing

❑ Aching ❑ Stabbing

❑ Cramping ❑ Swelling

❑ Nagging ❑ Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other _____	❑	❑	❑	❑

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

0 = NOT COMMITTED; 10 = VERY COMMITTED

PATIENT WELLNESS ASSESSMENT

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 _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ❑ No ❑ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma/Allergies
- ❑ Back Pain
- ❑ Cardiovascular Issues
- ❑ Cancer
- ❑ Circulation Issues
- ❑ Childhood Illness
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ❑ Elbow/Wrist/Hand Issues
- ❑ Endocrine Issues (Thyroid)
- ❑ Foot/Ankle Issues
- ❑ Gout
- ❑ Headaches / Migraines
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hip Issues
- ❑ Immune Issues
- ❑ Lymphatic Issues
- ❑ Multiple Sclerosis
- ❑ Neck Pain
- ❑ Reproductive Issues
- ❑ Ringing in Ears
- ❑ Scoliosis
- ❑ Shoulder Issues
- ❑ Stroke
- ❑ TMJ Issues
- ❑ Urinary Issues
- ❑ Osteoporosis
- ❑ Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

_____

_____

_____

MEDICATIONS (list)

_____

_____

_____

SUPPLEMENTS (list)

_____

_____

_____

CONSENT

I CONSENT TO A PROFESSIONAL AND COMPLETE CHIROPRACTIC EXAMINATION AND TO ANY RADIOGRAPHIC EXAMINATION THAT THE DOCTOR DEEMS NECESSARY. I UNDERSTAND THAT ANY FEE FOR SERVICE RENDERED IS DUE AT THE TIME OF SERVICE AND CANNOT BE DEFERRED TO A LATER DATE.

CHIROPRACTIC CARE IS RECOGNISED AS BEING AN EFFECTIVE AND SAFE METHOD OF CARE FOR MANY CONDITIONS. HOWEVER, YOU MUST RECOGNISE THAT THERE ARE RISKS ASSOCIATED WITH ALL HEALTH CARE PROCEDURES, INCLUDING ASSESSMENT AND TREATMENT, WHICH YOU SHOULD BE INFORMED ABOUT. PLEASE READ THE FOLLOWING CAREFULLY:

1. I ACKNOWLEDGE THAT I HAVE DISCUSSED WITH THE CHIROPRACTOR THE RARE RISKS ASSOCIATED WITH MY PROPOSED CARE WHICH INCLUDE BUT ARE NOT LIMITED TO; MUSCLE AND JOINT SORENESS OR STRAINS, NAUSEA AND DIZZINESS, FRACTURES, DISC INJURIES INCLUDING DISC ENCROACHMENTS/RUPTURES, CAUSING NERVE IRRITATION AND REFERRED SYMPTOMS, STROKES (OR LIKE EPISODES) AND AN EXACERBATION AND/OR AGGRAVATION OF MY UNDERLYING CONDITION. SUCH RISKS MAY RESULT IN OUTCOMES SUCH AS REFERRAL, FURTHER TESTS, SURGERY, INCAPACITY AND THE LIKE.

2. I ALSO ACKNOWLEDGE THE FOLLOWING ADDITIONAL POTENTIAL RISKS INSOFAR AS MY PROPOSED CARE IS CONCERNED HAVE BEEN EXPLAINED TO ME.

3. I HAVE HAD THE OPPORTUNITY TO DISCUSS THE PROPOSED CARE WITH THE CHIROPRACTOR. I ALSO ACKNOWLEDGE THAT I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE NATURE, EXTENT AND PURPOSE OF THE PROPOSED CHIROPRACTIC CARE AND THAT I HAVE BEEN GIVEN SUFFICIENT TIME TO MAKE A DECISION GIVING CONSENT FOR THE CARE TO PROCEED.

4. I ACKNOWLEDGE THAT I AM AWARE OF AND UNDERSTAND THE POTENTIAL RISKS. I APPRECIATE THAT RESULTS ARE NOT GUARANTEED. I DO NOT EXPECT THE PRACTITIONER TO BE ABLE TO ANTICIPATE ALL POTENTIAL RISKS AND COMPLICATIONS ASSOCIATED WITH THE PROPOSED CARE.

5. I HEREBY ACKNOWLEDGE MY CONSENT TO THE PERFORMANCE OF THE PROPOSED CHIROPRACTIC CARE. I UNDERSTAND THAT I CAN WITHDRAW CONSENT AT ANY TIME.

6. IN VERY RARE CIRCUMSTANCES, SOME TREATMENTS OF THE NECK MAY DAMAGE A BLOOD VESSEL AND LEAD TO STROKE OR RELATED SYMPTOMS (CURRENT STATISTICS BETWEEN 1 IN 2 MILLION TO 1 IN 5.85 MILLION -HALDEMAN, ET AL. SPINE VOL 24-8 1999). OTHER POSSIBLE RISKS INCLUDE STRAIN/INJURY TO A LIGAMENT OR A DISC IN THE NECK (CURRENT STATISTICS E.G. LESS THAN 1 IN 139,000) AND THE LOW BACK (CURRENT STATISTICS E.G. 1 IN 62,000 DVORAK STUDY IN PRINCIPLES & PRACTICE OF CHIROPRACTIC, HALDEMAN 2ND ED.). FOR SOME PATIENTS ESPECIALLY WITH BONE WEAKENING DISEASES, A FRACTURE OF A BONE ALTHOUGH RARE IS POSSIBLE."

PRINT YOUR NAME	DATE	SIGNATURE