Patient Intake Form

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our ***Patient Intake Form***. Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

Patient Information

SSN: _____ Birthday: _____

*First Name: _____ Middle Name: _____ *Last Name: _____

Sex: ◯M ◯F Height: _____ Weight: _____

Married/Civil Union: ◯Married ◯Single Spouse Name: _____ # of Children: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

*Email: _____

Employer Information

Employed: ◯Full Time ◯Part Time ◯Homemaker ◯Unemployed Employer Name: _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Physical Work Duties: _____

History

List current Medications: _____

(name, amounts, frequency, length of use, reason for use)

List current vitamins, minerals, supplements, or herbs: _____

(name, amounts, frequency, length of use, reason for use)

Have you ever:

Broken Bones: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Sprains/Strains: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Hospitalized: ◯Yes ◯No Explain: _____

Surgery: ◯Yes ◯No Explain: _____

Auto Accident: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Struck Unconscious: ◯Yes ◯No Treatment: ◯Yes ◯No Explain: _____

Eating Disorder: ◯Yes ◯No Explain: _____

Stroke: ◯Yes ◯No Explain: _____

Family Health History: _____

Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.

Social History & Life Choices

Alcohol:	◯Daily	◯Weekly	◯Occasionally	◯Never	Caffeine Drinks	◯Daily	◯Weekly	◯Occasionally	◯Never
Diet Food Products:	◯Daily	◯Weekly	◯Occasionally	◯Never	Drugs:	◯Daily	◯Weekly	◯Occasionally	◯Never
OTC Stimulants:	◯Daily	◯Weekly	◯Occasionally	◯Never	Exercise:	◯Daily	◯Weekly	◯Occasionally	◯Never
Homemade Food:	◯Daily	◯Weekly	◯Occasionally	◯Never	Processed Food:	◯Daily	◯Weekly	◯Occasionally	◯Never
Soft Drinks:	◯Daily	◯Weekly	◯Occasionally	◯Never	Tobacco:	◯Daily	◯Weekly	◯Occasionally	◯Never
Water:	◯Daily	◯Weekly	◯Occasionally	◯Never					

Chiropractic Experience

Who referred you to our office? _____

How did you find our office? ☐ Newspaper ☐ Sign ☐ Yellow Pages ☐ Community Event ☐ Mailing

Have you been adjusted by a chiropractor before? ◯Yes ◯No

If yes, what was the reason ? _____

Doctor's Name: _____ Date of last visit _____

Has any member of your family ever seen a wellness chiropractor? ◯Yes ◯No

Reason for this Visit

Describe the reason for this visit: _____

Impact on Life: _____

(Skip this section for wellness services)

◯Wellness ◯Sports ◯Auto ◯Fall ◯Home Injury ◯Job ◯Chronic Discomfort ◯Other

When did this concern begin? _____

Has this concern? ◯Gotten Worse ◯Stayed Constant ◯Come and Gone

Does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain: _____

Has this concern occurred before? ◯Yes ◯No Briefly Explain: _____

Have you seen other doctors for this concern? ◯Yes ◯No Doctor's Name: _____

Type of Treatment: _____

Results: ◯Good ◯Bad ◯Indifferent

Women Only

Are you pregnant? ◯Yes ◯No **Are you taking birth control?** ◯Yes ◯No **Do you have irregular cycles?** ◯Yes ◯No

Are you nursing? ◯Yes ◯No **Do you experience painful periods?** ◯Yes ◯No **Do you have breast implants?** ◯Yes ◯No

Health Checklist

- [ ] Allergies
- [ ] Arteriosclerosis
- [ ] Back Pain
- [ ] Bruise Easily
- [ ] Cold Extremities
- [ ] Depression
- [ ] Dizziness
- [ ] Fatigue
- [ ] Hemorrhoids
- [ ] Irregular Heart Beat
- [ ] Kidney Stones
- [ ] Loss of Smell
- [ ] Pacemaker
- [ ] Prostate Trouble
- [ ] Spinal Curvatures
- [ ] Swollen Joints
- [ ] Ulcers
- [ ] Alcoholism
- [ ] Arthritis
- [ ] Breast Lump
- [ ] Cancer
- [ ] Constipation
- [ ] Diabetes
- [ ] Excessive Menstruation
- [ ] Frequent Urination
- [ ] High Blood Pressure
- [ ] Irregular Menstrual Cycle
- [ ] Loss of Memory
- [ ] Loss of Taste
- [ ] Polio
- [ ] Sciatica
- [ ] Sinus Infection
- [ ] Stroke
- [ ] Thyroid Condition
- [ ] Varicose Veins
- [ ] Anemia
- [ ] Asthma
- [ ] Bronchitis
- [ ] Chest Pain
- [ ] Cramps
- [ ] Digestion Problems
- [ ] Eye Pain or Difficulties
- [ ] Headache
- [ ] Hot Flashes
- [ ] Kidney Infection
- [ ] Loss of Balance
- [ ] Nosebleeds
- [ ] Poor Posture
- [ ] Shortness of Breath
- [ ] Insomnia
- [ ] Swelling of Ankles
- [ ] Tuberculosis
- [ ] Venereal Disease

- [ ] Other: _____

Patient Signature: _____ Date: _____

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ I want the Doctor to select the type of care appropriate for my condition.

☐ Relief Care: Symptomatic relief of pain or discomfort.

☐ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms.

☐ Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

Were you aware that...

Doctors of Chiropractic work with the nervous system?

◯ Yes ◯ No

The nervous system controls all bodily functions and systems?

◯ Yes ◯ No

Chiropractic is the largest natural healing profession in the world?

◯ Yes ◯ No

Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic.

I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

☐ I agree with this statement of authorization *

Name of the Insured : _____

Patient's / Guardian's Signature: _____

Date: _____

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Informed Consent

I will use my hands or a mechanical instrument upon your body in order to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may or may not experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication or contraindication to care.

Patient name (print) _____

Patient signature _____ Date _____

Patient Acknowledgment and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated _____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Informed Consent For Acupuncture Treatment

I _____, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or the patient names below, for whom I am legally responsible) by Dr. Kelsie Rasor or by the doctor serving as a fill-in for her.

I understand, that methods of treatment may include, but are not limited to, acupuncture, moxibustion, Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is generally a safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, dizziness or fainting. Burns are a potential risk of moxibustion. Unusual risks of acupuncture include nerve damage, organ puncture, uncludng lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand the herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I understand I must notify my clinician or a staff member if I am pregnant or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask question. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient signature_____ Date _____

Signature of witness _____ Date _____