Chiropractic Health intake

Name ________________________________ SSN ________________

Address ________________________________ Date of Birth __________

City ____________________ State ______ Zip ________ Phone ____________________

Email ________________________________ Marital Status: Single Married Divorced Widow

Occupation ________________________________ Employer ____________________

Do you primarily: sit stand perform repetitive tasks other______________

Spouse Name __________________________ Spouse Employer ____________________

How many children? _____ Names and ages of children ________________________________

____

How were you referred to our office? ________________________________

Have you seen a chiropractor before? Y N If yes, who and when ________________________

Do you feel your previous chiropractic care was effective? Y N Please explain ____________

____

Have you had x-rays of your spine in the past 2 years? Y N Where taken? ________________

Do you currently wear the following: mouthguard/bite splint C-PAP heel lift orthotics

Circle any insurance coverage that may be applicable in this case:

Health Insurance Health Sharing Medicare Auto Accident/Personal Injury HRA/Flex

Terms of Acceptance: Our goals are to provide a detailed assessment of your current health status and provide you with resources to achieve health. Health is defined as a state of complete physical, mental, and social well-being not merely the absence of disease or infirmity. Chiropractic has only one goal: To restore the health of the body by removing spinal nerve impingements (also called joint fixations or chiropractic subluxations) which may be contributing or causing certain health conditions. To do this, we perform a procedure called a chiropractic manipulative treatment (CMT) or chiropractic adjustment and in most cases will also give advice for home care and nutrition to help your body heal and recover. We do not offer to diagnose or treat any disease as we only diagnose and offer treatment for chiropractic subluxations or musculoskeletal conditions.

HIPAA Notice: I understand and agree to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. If you would like to have a more detailed description of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA notice posted in the waiting room. The following person(s) have my permission to receive my personal health information: ________________________________

Authorization and Release: I authorize payment of insurance benefits directly to this office. I authorize the doctor to release all information necessary to communicate with my insurance company, attorney, adjuster, healthcare providers, or payors to secure the payment of benefits. I understand that I am responsible for all costs of care regardless of insurance coverage or settlement. I give an assignment of health care lien against any claims or a third party to this office up to the owed balance for treatment. I also understand that if I suspend or terminate my recommended care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I have read and understood the information above in Terms of Acceptance, HIPAA Notice, and Authorization and Release.

Print Patient Name ________________________________ Date ____________

Signature ____

Please fill out separate sections for each condition:

Condition 1: ____**How often does it occur?** ________

When did it start? ____________ **Have you had it in the past?** Y N **Have you missed work/school?** Y N

Is this pain: Constant Intermittent Certain Motions Only **Auto Accident/Work Injury?** Y N

Type of pain: Dull/Ache Throbbing Sharp/Stabbing Burning Tight/Stiff/Pressure

Pain rating: 0 1 2 3 4 5 6 7 8 9 10 **Does pain travel anywhere?** _______________________

What makes it better: ____ **Worse:** ___________________

What other treatments have you had for this condition? _______________________________________

Condition 2: ____**How often does it occur?** ________

When did it start? ____________ **Have you had it in the past?** Y N **Have you missed work/school?** Y N

Is this pain: Constant Intermittent Certain Motions Only **Auto Accident/Work Injury?** Y N

Type of pain: Dull/Ache Throbbing Sharp/Stabbing Burning Tight/Stiff/Pressure

Pain rating: 0 1 2 3 4 5 6 7 8 9 10 **Does pain travel anywhere?** _______________________

What makes it better: ____ **Worse:** ___________________

What other treatments have you had for this condition? _______________________________________

Condition 3: ____**How often does it occur?** ________

When did it start? ____________ **Have you had it in the past?** Y N **Have you missed work/school?** Y N

Is this pain: Constant Intermittent Certain Motions Only **Auto Accident/Work Injury?** Y N

Type of pain: Dull/Ache Throbbing Sharp/Stabbing Burning Tight/Stiff/Pressure

Pain rating: 0 1 2 3 4 5 6 7 8 9 10 **Does pain travel anywhere?** _______________________

What makes it better: ____ **Worse:** ___________________

What other treatments have you had for this condition? _______________________________________

Condition 4: ____**How often does it occur?** ________

When did it start? ____________ **Have you had it in the past?** Y N **Have you missed work/school?** Y N

Is this pain: Constant Intermittent Certain Motions Only **Auto Accident/Work Injury?** Y N

Type of pain: Dull/Ache Throbbing Sharp/Stabbing Burning Tight/Stiff/Pressure

Pain rating: 0 1 2 3 4 5 6 7 8 9 10 **Does pain travel anywhere?** _______________________

What makes it better: ____ **Worse:** ___________________

What other treatments have you had for this condition? _______________________________________

Have you ever been in a car accident or had any falls/injuries? ____

____

____

Primary Care Physician

Name ____ Phone # ____________________

Address ____ Last Visit _____________

City ________________ State ____ Zip ________

Do you have any of the following conditions in your health history or family health history?

Self	Family		Self	Family	
___	_____	Arthritis	___	_____	Liver/Kidney Issues
___	_____	High Cholesterol	___	_____	Diarrhea/Constipation/Digestive issues
___	_____	High Blood Pressure	___	_____	Low Blood Pressure
___	_____	Diabetes	___	_____	Hypoglycemia
___	_____	Cancer	___	_____	Auto-immune conditions
___	_____	Asthma/Hay Fever	___	_____	Insomnia
___	_____	Osteopenia/Osteoporosis	___	_____	Anemia
___	_____	Vitamin D Deficiency	___	_____	Headaches
___	_____	Depression/Anxiety	___	_____	Alcoholism/Drug Addiction
___	_____	Emphysema	___	_____	Autism or Sensory/Learning disorder
___	_____	Bedwetting	___	_____	Growing Pains or Muscle Cramps
___	_____	Scoliosis	___	_____	Seizures or Epilepsy
___	_____	Genetic Disorder/Mutation	___	_____	Vaccine adverse reaction
___	_____	Hormone Imbalance	___	_____	Menstrual Issues/Fertility Problems
___	_____	Heart troubles	___	_____	Difficulty Urinating
___	_____	Cold or color change in hand/feet	___	_____	Joint Pain/Swelling

Please list all medications/supplements you are currently taking.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Please circle activities affected by your current condition:

Bathing/Showering	Bending	Brushing teeth	Carrying or Lifting or Reaching
Movement/Exercise	Changing positions	Climbing stairs	Computer usage
Cooking	Dressing/socks	Caring of family/pets	Eating
Driving Running/Sports	Getting out of bed	Chores/Yard Work	Laying down
Reading	Sexual activities	Sleeping	Sneezing/Coughing
Sitting	Standing	Work	

Males Only:

Have you ever had a prostate exam? Y N

Have you ever had your PSA tested? Y N

Do you have any issues with urinating? Y N

Do you have any issues with your prostate? Y N

Do you have any issues with erectile dysfunction? Y N

Have you ever taken testosterone before? Y N

Have you been diagnosed or think you might have low testosterone levels? Y N ____________________

Do you have any issues with libido? Y N

Females Only:

Do you currently have menstrual cycles? Y N When was your last cycle? ________________________

Any chance you could be pregnant today? Y N

Have you had a hysterectomy? Total Hysterectomy Partial Hysterectomy No

Do you have any issues with hormone imbalance or libido? Y N

Do you experience hot flashes? Y N

Trying/Pregnant Only:

Are you currently pregnant or trying to get pregnant? _________________ How Many Weeks ___________

When is your due date? ___________ What type of provider are you using? Midwife Ob/Gyn Other

Where do you plan on delivering? _______________ Do you have a birth plan? Yes No

Is this your first pregnancy? Y N If No, how many previous pregnancies? Vaginal ___ Csection ___

Miscarriages? Yes No D&C Natural Miscarriage

Have you had any complications or long term issues? ____

Lifestyle

How many hours of sleep per night? ____ Do you feel refreshed upon waking? _____

What position do you sleep in? Back Belly Side Other__________

How old is your mattress? ________ Do you feel like your mattress is supportive for you? Y N

Do you use a pillow? Y N How old is your pillow? ______ Do you feel your pillow is supportive? Y N

How many glasses of water do you drink daily? ____

How many alcoholic beverages do you consume per week? ______

How many caffeinated beverages (including coffee, soda, tea, energy drinks) do you consume daily? ___

How many times do you eat out per week? _____

Are you currently recording your food intake or calorie intake? Y N

Are you currently using any weight loss products, programs, or a special diet? _______________________

How many servings or grams of protein do you consume daily? ___

How many servings of fruits and vegetables do you consume daily? ___

Do you have any food allergies? ____

Do you smoke or use tobacco products? Y N If yes, how many times or cigarettes per day? ____

Number of hours commuting per week? ____

Number of hours spent at desk or computer per week? ____

Number of hours spent on smart devices/tablet per week? _____

What is your current stress level? 0 1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, what is your commitment level to making changes? 0 1 2 3 4 5 6 7 8 9 10

How many times per week do you perform cardiovascular exercise? ____

How many times per week do you perform resistance training or weight lifting? ____

Do you experience pain that prevents you from exercise or pain after exercise? ______________________

Are you at your ideal weight? Y N If no, what is your desired weight? ______