Adult Chiropractic Intake

PATIENT INFORMATION

First Name_______________ MI_____ Last _______________ Birth Date ____/____/____

Address _______________ City _______________ State _____ Zip_____

Home #_______________ Cell #_______________ Email _______________

Can we send you occasional text messages for important reminders? Yes _____ No _____

Gender_________ # of children _____ Single Married Widowed Divorced Partnered

Employer _______________ Occupation _______________

Name of spouse (parent if patient is under 18): _______________

Birth date of spouse (parent if patient is under 18):_______________

How did you hear about our office? Google/Internet Social Media Insurance Person_________ Other_________

Women only: Are you pregnant? No_____ Yes, I'm due:_______________

HOW CAN WE HELP YOU?

What brings you in today? _______________

____

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

____

____

How long has this condition persisted? _______________

Have you seen other doctors for this condition? _______________

Name of previous chiropractor? _______________

***Please circle the areas on the graphic where you are experiencing symptoms ***

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (Check all appropriate boxes)

	NO EFFECT	MILD EFFECT	MODERATE EFFECT	SEVERE EFFECT
WORK	☐	☐	☐	☐
EXERCISE	☐	☐	☐	☐
RECREATION	☐	☐	☐	☐
RELATIONSHIPS	☐	☐	☐	☐
SLEEP	☐	☐	☐	☐
SELF-CARE	☐	☐	☐	☐

	NO EFFECT	MILD EFFECT	MODERATE EFFECT	SEVERE EFFECT
ENERGY	☐	☐	☐	☐
ATTITUDE	☐	☐	☐	☐
PATIENCE	☐	☐	☐	☐
PRODUCTIVITY	☐	☐	☐	☐
CREATIVITY	☐	☐	☐	☐
OTHER _________	☐	☐	☐	☐

FOR OFFICE USE ONLY: INSURANCE: _________ PATIENT NUMBER: _________

HEALTH HISTORY

Please check the appropriate box for any of the following symptoms:

☐ FRACTURED BONES	☐ ALLERGIES	☐ FOOT TROUBLE R OR L	☐ GALL BLADDER PROBLEMS	☐ AIDS / HIV
☐ AUTO ACCIDENTS	☐ SINUS PROBLEMS	☐ ASTHMA	☐ PAIN WITH COUGH, SNEEZE	☐ LIVER TROUBLE
☐ OTHER ACCIDENTS / FALLS	☐ EATING DISORDERS	☐ LUNG PROBLEMS	☐ ULCERS / COLITIS	☐ DIGESTIVE PROBLEMS
☐ BACK CURVATURE	☐ TROUBLE SLEEPING	☐ DIZZINESS	☐ COLON TROUBLE	☐ PAIN / STIFF NECK R OR L
☐ ARTHRITIS	☐ THYROID PROBLEMS	☐ EAR INFECTION	☐ PROSTATE PROBLEMS	☐ MID BACK PAIN / STIFFNESS
☐ DIABETES	☐ LEARNING DISABILITY	☐ BED WETTING	☐ IMPOTENCE	☐ DIARRHEA / CONSTIPATION
☐ SWOLLEN / PAINFUL JOINTS	☐ MOOD CHANGES	☐ HEARING LOSS R OR L	☐ DIFFICULTY BREATHING	☐ HEMORRHOIDS
☐ CONVULSIONS / EPILEPSY	☐ HEADACHE	☐ FAINTING	☐ HEART PROBLEM	☐ HEPATITIS (A, B, C)
☐ SKIN PROBLEMS	☐ HEARTBURN	☐ BLURRED / DOUBLE VISION	☐ RINGING IN EARS R OR L	☐ SHOULDER PAIN R OR L
☐ CANCER	☐ ANEMIA	☐ UPPER BACK PAIN / STIFFNESS	☐ PACEMAKER	☐ KIDNEY PROBLEMS
☐ CHEMOTHERAPY	☐ TREMORS	☐ TROUBLE CONCENTRATING	☐ STROKE	☐ HEAD / SHOULDERS FEEL TIRED
☐ DEPRESSED	☐ ALCOHOL / DRUG ABUSE	☐ LOW BACK PAIN / STIFFNESS	☐ HIGH / LOW BLOOD PRESSURE	☐ RECREATIONAL DRUGS
☐ IRRITABLE	☐ HIP PAIN R OR L	☐ NUMBNESS / TINGLING	☐ VARICOSE VEINS	

For 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
☐ INFERTILITY PROBLEMS ☐ MENOPAUSAL PROBLEMS

ADDITIONAL INFO

Allergies (Please List)	Medications (Please List)	Supplements (Please List)
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

GOALS FOR MY CARE

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for the correction of whatever is malfunctioning in their bodies.

Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

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

On a scale of 1 to 10, with 10 being the highest, rate your level of commitment in helping us solve this problem.

Circle one: 1 2 3 4 5 6 7 8 9 10

Please score the following as one of these options:

0- Not A Goal 1- Immediate Goal 2- Short Term Goal 3- Long Term Goal

______Pain Relief ______Prevent Injury and Disease ______Increase Overall Function
______Weight Loss ______Healthy Nutrition ______Decrease Sickness
______Other: ________________________________

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important each patient understands both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Our philosophy involves "open-bay" adjusting. Should you have personal questions, we do have adequate space for that.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Dynamic Family Chiropractic Policies / Procedures:
(Please Initial Next to Each Line)

_______ 1. All initial services and subsequent fees are payable when services are rendered. (Co-pays, deductibles, etc.) Failure to pay will result with balances being transferred to a collection agency.

_______ 2. X-ray films / discs are the property of Dynamic Family Chiropractic. Once films are used for treatment purposes, they cannot be released. Copies can be made, if necessary with a **$10.00 processing fee** and will be ready for pick-up within **24 hours** of the time requested.

_______ 3. If Medical Records are requested there will be a copy / processing fee of **ten cents per page** and will be ready for pick up within **24 hours** of time requested.

_______ 4. I have read and understand The Notice of Privacy Act (HIPPA forms, behind New Patient Paperwork) and a copy will be provided to me if requested.

_______ 5. I authorize Dynamic Family Chiropractic to use my photograph(s) for education or marketing purposes.

I, ______________________________ have read and fully understand the above statements.
Print Name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Staff Signature Date

DYNAMIC FAMILY CHIROPRACTIC TERMS OF ACCEPTANCE