Chiropractor Intake Form

Title: (Circle one) □ Mr. □ Mrs. □Ms. □ Miss □ Dr. Date of Birth _____/_____/_____

First Name:_____Middle Initial:_____Last Name:_____

Address:_____City:_____State:_____Zip Code:_____

Cell / Home Phone:_____ Email:_____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Other

How did you hear about our office? _____

Emergency Contact

Contact Name:_____ Relationship to Patient: _____

Contact Home Phone:_____ Contact Cell Phone: _____

Primary Care Physician:_____ Primary Care Physician Phone:_____

Employer Data

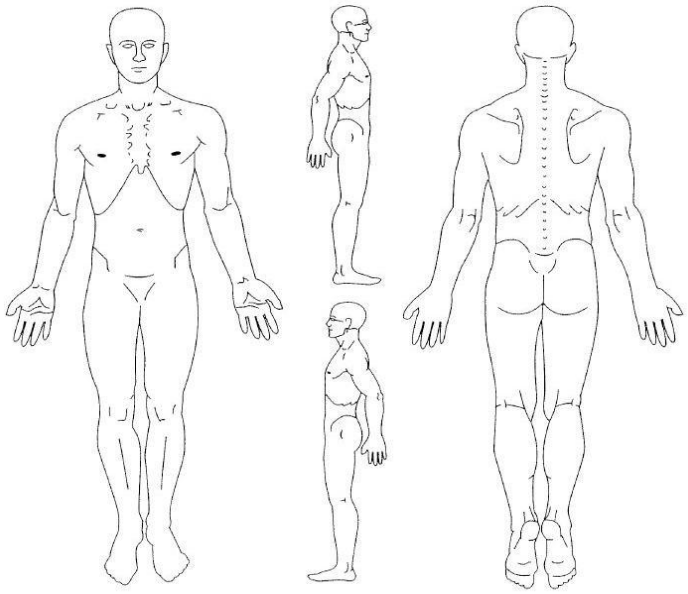
Employment Status: □ Employed □ Unemployed □ Student □ Other_____

Employer _____Your Occupation _____

Chief Complaint

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Sharp T=Tingling A=Dull/Ache

1. When did your complain start? _____
2. Briefly describe your chief complaint?
_____
3. What happened/mechanism of injury?
_____
4. What daily activities are being affected?
_____
5. Does anything make your symptoms BETTER?
_____
6. Does anything make your symptoms WORSE?
_____
7. What is the goal you would like to achieve from your visit?
_____
8. How often do you experience your symptoms?
□ Constantly □ Frequently □ Occasionally □ Intermittently



Average Pain Intensity

No Pain Worst Pain
0 1 2 3 4 5 6 7 8 9 10

ADVANCED HEALTH CHIROPRACTIC

Patient Name:_____Date_____ Dr. Initials: _____

Medical Conditions: *(Circle all that apply to you)*

□ Arthritis	□ Cancer	□ Diabetes – Type I /II	□ Heart Disease
□ Hypertension	□ Psychiatric Illness	□ Skin Disorder	□ Stroke
□ Fibromyalgia	□ Asthma	□ Osteoporosis	□ Other_____

Surgeries: *(Circle all that apply to you)*

□ Appendectomy	□ Joint Replacement	□ Uro-genital	□ Knee: RT / LT
□ Hysterectomy	□ Cardiovascular procedure	□ Prostate	□ Hernia
□ Joint Replacement	□ Gall Bladder	□ Breast Augmentation	□ Spine:_____
□ Brain	□ Shoulder: RT / LT	□ Carpal Tunnel: RT / LT	□ Other:_____

Social History: *(Circle all that apply to you)*

Caffeine use:	□ occasional	□ often	□ never
Drink Alcohol:	□ occasional	□ often	□ never
Exercise:	□ occasional	□ often	□ never
Drink Water:	□ <64 oz/day	□>64 oz/day	□ never
Cigarettes:	□ <1 pack/day	□ >1 pack/day	□ never
Sleep:	□ <8 hours/night	□ >=8 hours/night	□ Insomnia

Family History: *(Circle 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

Allergies: *(Circle all that apply to you)*

□ Mold	□ Chemical
□ Seasonal	□ Wheat/Glutens
□ Milk or Lactose	□ Animal
□ Other:_____	

***Women: Are you Pregnant?**

□ No □ Yes

If so, how many weeks:_____

Prescriptions / Medications / Supplements:

(Name, Dosage, Frequency, Purpose)

_____

_____

Review of Systems – *(Check box if you have had trouble with any of the following)*

Cardiovascular

□ Poor Circulation	□ Heart Disease
□ Chest Pain	□ High Cholesterol
□ Irregular Heart Beat	□ Swelling in legs

Respiratory

□ Asthma	□ Cold/Flu
□ Cough	□ Emphysema
□ Short Breath	□ Wheezing

Hematologic

□ Excessive Bruising
□ Cancer
□ Clotting Factors

Eyes / Ear / Nose / Throat

□ Glaucoma	□ Double Vision
□ Dizziness	□ Hearing Loss
□ Sore Throat	□ Bleeding Gum
□ Loss of Vision	□ Blurred Vision

Neurologic

□ Stroke	□ Carpal Tunnel
□ Headache	□ Numbness
□ Head Injury	□ Vertigo
□ Parkinson's	□ Sciatic

Musculoskeletal

□ Pain:_____
□ Gout
□ Joint Stiffness
□ Muscle Weakness

Genitourinary/Gastrointestinal:

□ Kidney Disease	□ Burning Urination	□ Frequent Urination	□ Blood in Urine	□ Kidney Stones
□ Gall Bladder Pain	□ Diarrhea	□ Constipation	□ Ulcers	□ Bloody Stools

ADVANCED HEALTH CHIROPRACTIC

Patient Name:_____Date_____ Dr. Initials: _____

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and chiropractic procedures including various modes of physical therapy, and if necessary diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible:_____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Advanced Health Chiropractic and/or other licensed Doctors of Chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Brandon Pounds and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Further, I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels are in the best interests at the time, based upon the facts then known. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my doctor. I intend this consent from to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Authorization and Release of Information:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorized and request my insurance company to pay directly to Advanced Health Chiropractic, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for medical services/supplies rendered.

I agree to be responsible for payment on all medical services/supplies rendered on my behalf or my dependents

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

Date:_____/_____/_____

To be completed by the patient's representative, if necessary, *(e.g. if the patient is a minor or is physically or mentally incapacitated)*

_____
Print Name of Representative

_____
Signature of Representative

Date:_____/_____/_____

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