DC Chiropractic, P.L.L.C.

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New Practice Member Intake Form

First Name: _____ Last Name: _____ Nickname: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: __/__/___ Age: _____ Sex: Male/ Female Status: Single/ Married/ Divorced/ Widowed

Social Security #: _____-_____-_____ Job Description _____

Home Phone: (__)___-_____ Cell Phone: (__)___-_____ Work Phone: (__)___-_____

Type of Insurance: ( ) Work Comp ( ) Auto ( ) MA ( ) Medicare ( ) Private: _____

How were you referred to our office? (Please check off)-

( ) Family/Friend ( ) Yellow pages ( ) Lecture ( ) Drive by ( ) Coupon ( ) Mail ( ) Screening
Where? _____

Whom may we thank for referring you to our office?

Name: _____ Phone: (___) -_____ Relationship: _____

Your Health Profile

Please rate your overall health status:

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your health objectives? _____

_____

Name/Address/Phone of the last doctor who put you on a health development program?

_____

Were you able to stay on the program? Y How long? _____

What were your results? _____

Are you healthier today than you were 5 years ago? Yes/ No / Not sure

If so, what did you do to improve your health? _____

_____

If not, why do you think your health declined? _____

_____

Will you be healthier 5 years from now than you are today? Y N Not Sure

If so, what are you planning to do to improve your health and if not, what could you do to improve your health rather than have it continue to decline? _____

_____

After making these changes in your life, how do you expect your health to be 5 years from now?

_____

Have you had previous chiropractic care? Yes/ No

If yes, what was the doctor's name? _____

What was the approximate date of your last visit? _____

What was the duration of your 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 this world? ___Yes ___No

--If Chiropractic care starts at birth, you can achieve a higher level

of health throughout life? ___Yes ___No

What other wellness professionals are currently parts of your health care team?

( ) Massage Therapist ( ) Acupuncturist ( ) Naturopath ( ) Homeopath

( ) Other: _____

How many Medical Doctor's office visits did you and your family have last year?

( ) None ( ) Less that 5 ( ) More than 5 ( ) More than 10

Is your current condition the result of a **recent**: ( ) auto accident? ( ) work related injury

What was the date of injury? _____

If so, please inform the front desk staff immediately to obtain additional necessary paperwork.

Please describe below, in the following 2 sections, your primary, secondary and additional reasons, if any, for seeking care in our office:

Primary Complaint (List one only): _____

When did you first experience this problem? _____

How did this problem first begin? _____

_____

How often do you experience this problem? (Please Circle One)

<25% (Intermittent) 26-50% (Occasional) 51-75% (Frequent) >76% (Constant)

Please grade the severity of this problem (with 10 being worst):

Now 1 2 3 4 5 6 7 8 9 10

On Average 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?

_____ Burning _____ Stabbing _____ Aching _____ Sharp

_____ Tingling _____ Numb _____ Other: _____

Please describe the location of the pain. _____

_____

Does this problem cause pain to travel to any other area? Y N If yes, where? _____

_____

Is this problem: In the AM: ( ) worse? ( ) better?

In the PM: ( ) worse? ( ) better?

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)?

_____

_____

Have you seen any other doctors for this problem? Y N If yes, who? _____

_____

What treatment was given? _____

Secondary Complaint -- if any (List one only): _____

When did you first experience this problem? _____

How did this problem first begin? _____

_____

How often do you experience this problem? (Please Circle One)

<25% (Intermittent) 26-50% (Occasional) 51-75% (Frequent) >76% (Constant)

Please grade the severity of this problem (with 10 being worst):

Now 1 2 3 4 5 6 7 8 9 10

On Average 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?

_____ Burning _____ Stabbing _____ Aching _____ Sharp

_____ Tingling _____ Numb _____ Other: _____

Please describe the location of the pain. _____

_____

Does this problem cause pain to travel to any other area? Y N If yes, where? _____

_____

Is this problem: In the AM: ( ) worse? ( ) better?

n the PM: ( ) worse? ( ) better?

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)?
_____

_____

Have you seen any other doctors for this problem? Y N If yes, who? _____

_____

What treatment was given? _____

How effective was the care? _____

Lifestyle/Social History

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

Do you smoke? Y/ N If yes, how much? _____

Do you drink alcohol? Y /N If yes, how much? _____

Do you drink coffee? Y/ N If yes, how much? _____

Do you drink tea? Y /N If yes, how much? _____

Daily water intake: ( ) None ( ) 1-2 ( ) 3-4 ( ) 5+

Daily servings of vegetables: ( ) None ( ) 1-2 ( ) 3-4 ( ) 5+

Daily servings of fruits: ( ) None ( ) 1-2 ( ) 3-4 ( ) 5+

How regularly do you exercise? ( ) never ( ) occasionally ( ) ___x/week ( ) daily

What kind of exercise do you do? _____

How many hours of sleep do you get on average? _____

What position do you regularly sleep in? Back Side Stomach

On a scale of 1-10 please rate your stress level (1=none and 10=extreme):

Occupational 1 2 3 4 5 6 7 8 9 10

Personal 1 2 3 4 5 6 7 8 9 10

Women Only

Pregnancies and outcomes:

Date of pregnancy Outcome

_____ _____

_____ _____

_____ _____

_____ _____

When was your last period? _____

Are you pregnant? ( ) Yes ( ) No ( ) Not sure

Medical History

Please list the cause of death (including cancer, heart disease, stroke or diabetes) and age of any immediate family members (parents or siblings):

Relationship Cause of Death Age of death

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgeries:

Date Type Reason for surgery

_____ _____ _____

_____ _____ _____

_____ _____ _____

Previous injuries or trauma (please give type and date): _____

_____

Medications (including over the counter drugs):

Medication & Dosage Reason for taking

_____ _____

_____ _____

_____ _____

_____ _____

Nutritional Supplements you are currently taking:

Supplement & Dosage Reason for taking

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: _____

Stress History

Please indicate whether you have **ever** experienced stress in any of the following areas.

our answers will enable us to determine which factors have contributed to your present health ondition/concerns.

Childhood

Repeated/Prolonged Antibiotic Use ___Yes ___No

Car Accident ___Yes ___No

Childhood Illness ___Yes ___No

Fall/Jump from a Height < 3 feet ___Yes ___No

Fall/Jump from a Height > 3 feet ___Yes ___No

Head Trauma ___Yes ___No

Inhaler Use ___Yes ___No

Prescription Medications ___Yes ___No

Surgery ___Yes ___No

Vaccinations ___Yes ___No

Youth Sports ___Yes ___No

Other Traumas (physical or emotional) _____

Adulthood

Alcohol Consumption ___Yes ___No

Repeated/Prolonged Antibiotic Use ___Yes ___No

Car Accident ___Yes ___No

Coffee Drinker ___Yes ___No

Drug Use/Abuse ___Yes ___No

Fall/Jump from a Height ___Yes ___No

Head Trauma ___Yes ___No

Home Environment Stress ___Yes ___No

Inhaler Use ___Yes ___No

Prescription Medications ___Yes ___No

Smoker ___Yes ___No

Surgery ___Yes ___No

Contact Sports ___Yes ___No

Extreme Sports ___Yes ___No

Workplace Stress ___Yes ___No

Other Traumas (physical or emotional)_____

Please **CHECK AND EXPLAIN any of the following you have had in the last**

2 MONTHS AND/OR EVER RECEIVED TREATMENT FOR:

MUSCULO-SKELETAL: Check and Explain

____Low Back Pain ____Pain Between Shoulders ____Neck Pain ____Arm Pain ____Joint Pain/Stiffness ____Walking Problems ____Difficult Chewing/Clicking Jaw ____General Stiffness

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GENITO-URINARY: Check and Explain

____Painful/Excessive Urination ____Discolored Urine ____Bladder Trouble

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____

CARDIO-VASCULAR- RESPIRATORY: Check and Explain

____Chest Pain ____Short Breath ____Blood Pressure Problems ____Irregular Heartbeat ____Heart Problems ____Lung Problems/Congestion ____Varicose Veins ____Ankle Swelling ____Stroke

Symptom Date Last Experienced Treatment Received

_____ _____ _____

_____ _____ _____

_____ _____ _____

NERVOUS SYSTEM: Check and Explain

____Nervous ____Numbness ____Paralysis ____Dizziness ____Forgetfulness ____Confusion/Depression ____Fainting ____Convulsions ____Cold/Tingling Extremities ____Stress ____Hearing Difficulty

Symptom Date Last Experienced Treatment Received

_____ _____ _____

_____ _____ _____

_____ _____ _____

EYES, EARS, NOSE, THROAT: Check and Explain

____Vision Problems ____Dental Problems ____Sore Throat ____Ear Aches ____Stuffed Nose

Symptom Date Last Experienced Treatment Received

_____ _____ _____

_____ _____ _____

GENERAL: Check and Explain

____Fatigue ____Allergies ____Headaches ____Fever

Symptom Date Last Experienced Treatment Received

_____ _____ _____

MALE / FEMALE: Check and Explain

____Menstrual Irregularity ____Menstrual Cramps ____Vaginal Pain/Infection ____Breast Pain/Lumps ____Prostate/Sexual Dysfunction ____Other: _____

Symptom Date Last Experienced Treatment Received

_____ _____ _____

_____ _____ _____

GASTRO-INTESTINAL: Check and Explain

____Poor/Excessive Appetite ____Excessive Thirst ____Frequent Nausea ____Vomiting ____Diarrhea

____Constipation ____Hemorrhoids ____Liver Problems ____Gall Bladder Problems ____Weight Trouble
____Abdominal Cramps ____Gas/Bloating after Meals ____Heartburn ____Black/Bloody Stools ____Colitis

Symptom Date Last Experienced Treatment Received

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please **check and explain any of the following illnesses you have ever had:**

____Cancer ____Diabetes ____Mental Disorders ____Pneumonia ____Heart Disease ____Rheumatic Fever ____Small Pox ____Pleurisy ____Polio ____Chicken Pox ____Arthritis ____Tuberculosis ____Epilepsy ____Whooping Cough ____Anemia ____Mumps ____Measles ____Thyroid Disorder

Symptom Date Last Experienced Treatment Received

_____ _____ _____

_____ _____ _____

Which best describes your reason for consulting our office?

_____ I have a specific concern and require help with this concern.

_____ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.

_____ I want to be healthier five years from now than I am today.

Patient's Signature _____ Date _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare 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 that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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.

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 only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions.

However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend you seek the services of another healthcare provider.

We do not offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements. *(Print Name)*

Consent to evaluate and adjust a minor child

I, _____ being the parent of legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. All questions regarding the doctor's objectives pertaining to my/ my child's care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient/Guardian Signature _____ Date _____

Authorization to Release Medical Information

I authorize the release of medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature _____ Date _____

Agreement for Payment of Services

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED** TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY REPSONSIBLE FOR THE PAYMENT **OF MY ACCOUNT.** It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

Patient Signature _____ Date _____