CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____ (LAST NAME)

_____ (FIRST NAME) (MIDDLE INITIAL)

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age ___ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer/School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

INSURANCE INFORMATION

Primary Insurance Name _____

Policy # _____

Group # _____

Insured SS # _____

Insured/Subscriber Name _____

Date of Birth _____

Secondary Insurance Name _____

Policy # _____

Group # _____

Insured Social Security Number _____

Insured/Subscriber Name _____

Date of Birth _____

HOW CAN WE HELP YOU?

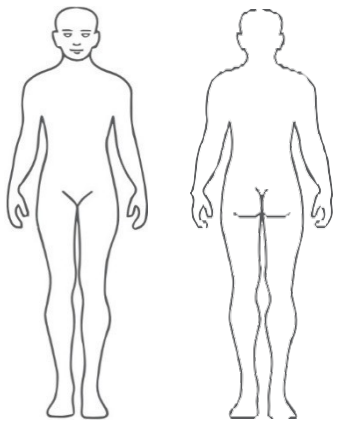
What brings you in today? _____

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

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Sharp

☐ Tingling ☐ Shooting

☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing

☐ Aching ☐ Stabbing

☐ Cramping ☐ Swelling

☐ Nagging ☐ Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
	☐	☐	☐	☐		☐	☐	☐	☐

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10

PATIENT WELLNESS ASSESSMENT

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONGTERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS Please list all below

HEALTH & ILLNESS

Please check the box beside any condition you've experienced

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other

CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. The primary treatment provided by Doctors of Chiropractic is spinal manipulative therapy, also referred to as an adjustment. A Doctor of Chiropractic uses his/her hands and/or a mechanical instrument on the patient's body in such a way as to move the patient's joints. This may cause an audible "pop" or "click", such as when a person "cracks" his knuckles. The patient may feel a sense of movement as well.

Other procedures commonly used by Doctors of Chiropractic include the following:

physical examination, postural analysis, vital signs , bracing and support applications, ultrasound therapy, hot/cold therapy, diagnostic studies, manual therapy , laser therapy traction/decompression, electrical muscle stimulation, acupuncture/dry needling

The material risks associated with chiropractic treatment

Chiropractic treatment utilizes very safe, non-invasive procedures performed in chiropractic offices to reduce pain, restore range of motion, and promote overall body wellness, among other various benefits. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Possible complications include but are not limited to the following: muscle strain, dizziness, nausea, flushing, fractures, disc injuries, dislocations, cervical myelopathy, burns, costovertebral strains and separations. It is not uncommon for patients to experience temporary soreness after the first few treatments. In rare cases, manipulation of the neck has been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke.

The probability of those risks occurring

Fractures are rare occurrences and generally result from underlying weakness of the bone for which the Doctor of Chiropractic checks during the taking of the patient's history, and during examination and X-ray. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options may include the following:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain-killers
- Hospitalization/Surgery

There are risks and benefits associated with all the above treatment options, which the patient may wish to discuss with his/her medical doctor.

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Failure to seek care could result in serious medical conditions going unrecognized. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that Dr. McCartney will advise me of any material risks in this regard.
2. Neither the practice of chiropractic nor the practice of medicine is an exact science, and my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, and an undesirable result does not necessarily indicate an error in judgment or treatment.
4. Dr. McCartney does not guarantee any results with respect to any course of care or treatment.

I have read, or have had read to me, the above explanation of chiropractic adjustment and related treatment. I hereby authorize~~,~~ Dr. McCartney and his/her assistants, associates and other appropriate persons to render care, to perform an examination and to provide an appropriate evaluation and treatment plan to address the complaints, problems, and medical history I have provided. I have discussed any questions, comments, or concerns with Dr. McCartney and have had my inquiries answered to my satisfaction. By signing below, I state that I have weighed the risks and/or benefits in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____	_____
Patient's Name	Patient's Signature
_____	_____
Date	Parent/Guardian Signature (if patient is a minor)

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____ , have received a copy of this office's Notice of Privacy Practices.
I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
Conduct, plan and direct my treatment and follow-up among the health care providers who may be
directly and indirectly involved in providing my treatment.
Obtain payment from third-party payers.
Conduct normal health care operations such as quality assessments and accreditation.

_____
Patient

_____
Signature

_____
Date

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

□ Individual refused to sign
□ Communications barriers prohibited obtaining the Acknowledgment
□ An emergency prevented us from obtaining Acknowledgment
Other (Please Specify) _____

_____ _____
Staff signature Date