

Initial Intake Form

Name: _____ Date: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SS#: _____ Date of Birth: _____ Age: _____ Sex: M F

E-Mail Address: _____ Occupation: _____

Marital Status: Married Single Divorced Widowed Separated

Name of Spouse: _____ Spouse's Employer: _____

Names and Ages of Children: _____

How were you referred to our office? _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

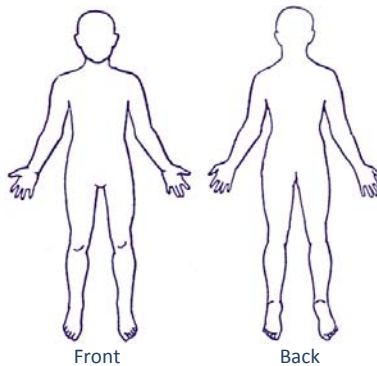
Insured Person's Name: _____ Date of Birth: _____ Relationship: Self Spouse Other

Current Health History

Reason for your appointment: _____

WHEN and HOW did this condition begin? _____

Please indicate on the diagram the type of discomfort you are experiencing: X = Sharp Pain, O = Dull Pain (Muscle Spasm), Z = Numbness/Tingling, B = Burning



Is this discomfort: Localized Radiating Constant Comes and goes

At its worst, is your condition: Mild Moderate Severe

When is your condition worst? Check all that apply: Morning Evening Sitting Standing Moving Lying down

Is there anything that makes your condition better? _____

Have you ever had this problem before? If yes, please explain: _____

Have you ever received treatment for this condition? If yes, who was your physician? _____

Current Primary Physician Phone #: _____ Is it ok if we contact this physician? Yes No

Current Medications: Pain killers Muscle Relaxers Anti-inflammatories Antidepressants Anti-psychotic
Anxiety Blood Pressure Cholesterol Insulin Sleeping pills Birth control Blood thinners

Are you pregnant? Yes No Date of the first day of your last period: _____

Do you smoke? Yes No

Do you drink alcohol? Yes No How much, how often? _____

Do you drink coffee? Yes No How much, how often? _____

Has your condition affected your: Home life Work Recreation Sleep

Do you sleep : On your back On your side On your stomach

Is your condition: Getting worse Getting better Staying the same

Do you have any concerns about getting treatment here? _____

Have you ever been in an automobile accident? No Past year 2-5 years 5-10 years 10+ years

Surgeries: Back/Neck Gall Bladder Appendectomy Tonsillectomy Heart Hysterectomy Hernia

Other: _____

Broken bones: _____

Have you ever been diagnosed with:

Cancer Yes No

HIV Yes No

Stroke Yes No

Hepatitis Yes No

Herniated discs Yes No

Migraines Yes No

Lyme's Disease Yes No

Other: _____

Depression Yes No

Anxiety Yes No

Epilepsy Yes No

Fibromyalgia Yes No

Asthma Yes No

GURD Yes No

Kidney stones Yes No

Restless leg syndrome Yes No

Hearing difficulty Yes No

Diabetes Yes No

Vertigo Yes No

Insomnia Yes No

IBS Yes No

Shingles Yes No

Have you ever been to a chiropractor? Yes No If yes, date of last treatment: _____

Were you satisfied with your care? Yes No If no, why were you unsatisfied? _____

Missed Appointment Policy

I understand that in order to maximize my results with chiropractic care, I must be on time for my appointments.

I understand that there is a \$25 fee for each missed appointment. This includes any and all appointments made by me, including my spouse or children.

Please call before your appointment if you need to cancel or reschedule. If we are not notified before your appointment, you will be responsible for your missed appointment fee if you decide to continue care.

Print name

Signature

Date

Terms of Acceptance

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

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: the 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: the state of optimal physical, mental and social well-being and 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 bodies innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnose either vertebral subluxation or neuromuscular conditions. However, during the course of a chiropractic spinal examination we encountered 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 another healthcare provider.

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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation. However, we may use other procedures to help your body holds the adjustments.

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

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

Therefore, I accept chiropractic care on this basis.

(Signature)

(Date)

Consent to evaluate and adjust a minor child

I, _____, being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy release

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor and her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of the first day of my last menstrual cycle: _____

(Signature)

(Date)

Consent for Purposes of Treatment, Payment, and Health Care Operations.

I acknowledge that Back to Health Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Back to Health Chiropractic's "Notice of Privacy Practices" prior to signing this document. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Back to Health Chiropractic. The "Notice of Privacy Practices" for Back to Health Chiropractic is also provided on request at the main administration desk of this practice. The "Notice of Privacy Practices" also describes my right and Back to Health Chiropractic's duties with respect to my protected health information.

Back to Health Chiropractic reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices". I may obtain a revised" Notice of Privacy Practices" by calling the office and requesting a revised copy sent in the mail, or ask for one at the time of my next appointment.

I have the right to revoke its consent in writing, except to the extent that Back to Health Chiropractic has taken action in reliance on this consent.

Patient Acknowledgment

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Signature of Patient or Personal Representative

Date

Print name of patient Or Personal Representative

Description of Personal Representatives Authority