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CHIROPRACTIC NEW PATIENT INTAKE

Patient Information

Patient name

_____

Today's date _____ Age _____

Date of birth _____

Address_____

City _____ State ____ Zip_____

Gender: ☐ Male ☐ Female ☐ Other _____

Height_____ Weight _____

Marital status: ☐ Single ☐ Married ☐ Partnered

☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Have you ever seen a chiropractor before? ☐ Yes ☐ No

When was your last adjustment?

_____

How many children do you have?

_____

Family members treated here:

_____

Occupation:

_____

Employer/School:

_____

Employer/School address:

_____

Employer/School phone: (_____)

_____

Spouse's/Partner's name:

_____

Spouse's/Partner's employer:

_____

Who referred you?

_____

Will you be using health insurance? ☐ Yes ☐ No

Insurance Provider:

_____

Insurance ID _____

Group No. _____

Contact Information

Home phone (_____)

_____

Cell phone (_____)

_____

E-mail address

_____

May we contact you via: ☐ Home phone ☐ Cell ☐ Work phone ☐ Email

In case of emergency please contact:

Name

_____

Relationship

_____

Home phone (_____)

_____

Work/Other phone (_____)

_____

Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, on me (or on the patient named on this form for whom I am legally responsible) by a Doctor of Chiropractic at Inner Movement Wellness & Acupuncture.

I have had an opportunity to discuss with the Doctor of Chiropractic and/or office or clinic personnel the nature and purpose of chiropractic adjustment and other procedures. I understand that results are not guaranteed. I understand that, as in the practice of medicine, there are risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure based on the facts then known and in my best interests.

I have read, or have had read to me, the above consent. I have had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Treating Doctor: _____

Patient/Guardian Signature: _____

Date:_____

Patient Condition

What is your major complaint (be as specific as possible)? _____

_____

When did your condition/symptoms/pain first appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Since onset: ☐ Getting worse ☐ Staying the same ☐ Slow to improve

When is it worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ All the time

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily routines ☐ Other: _____

How long has it been since you really felt good? _____

Other doctors seen for this condition: ☐ MD ☐ DC ☐ DO ☐ DDS ☐ Other: _____

Is your condition accident related? ☐ Yes ☐ No If so: ☐ Work ☐ Auto ☐ Other: _____

Date of accident: ____ / ____ / _____ Location: _____

Do you have an attorney advising you? ☐ Yes ☐ No *If so, attorney/firm: _____

Does the condition/symptom/pain radiate? ☐ Yes ☐ No

If yes, where and how frequently?

_____

How long/often does the radiation occur/last? _____

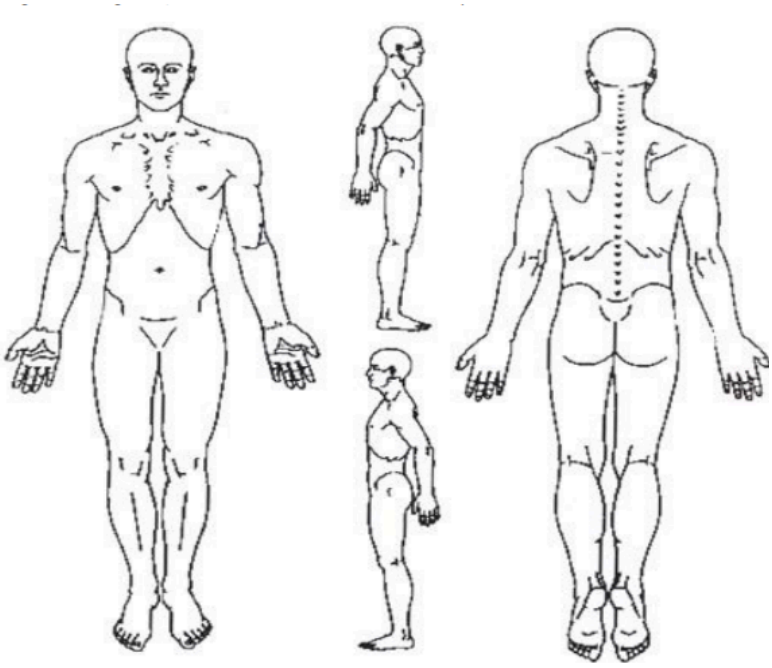
Do you have: ☐ Numbness ☐ Tingling ☐ Weakness Describe: _____

List and mark severity of your condition/symptoms/pain:

Body Part: Level of Pain (0-10):
Body Part: Level of Pain (0-10):
Body Part: Level of Pain (0-10):
Body Part: Level of Pain (0-10):

Type of Pain: ☐ sharp ☐ dull ☐ aching ☐ throbbing ☐ numbness ☐ shooting ☐ burning ☐ tingling Other:

Mark all areas where your condition, symptoms, and/or pain occur.



What activities or positions aggravate your condition?

☐ bending ☐ coughing ☐ getting up/down ☐ driving ☐ lifting ☐ lying down ☐ reaching ☐ sitting

☐ sneezing ☐ standing ☐ straining at stool ☐ turning head ☐ twisting ☐ walking Other:_____

What activities or positions relieve your condition?

☐ heat ☐ ice ☐ lying down ☐ medication ☐ sitting ☐ standing ☐ stretching Other:_____

Have you ever had this condition before? ☐ Yes ☐ No If yes, when? _____

Were you treated for this condition or a similar one before? ☐ Yes ☐ No If yes, when/by whom? _____

Health History

Do you have any allergies? (food, contact, environment) _____

List prescribed medications, over-the-counter medications, vitamins, herbs, and supplements:

_____

When was your last: Physical examination? _____ Blood/lab work? _____ X-ray study? _____

Injuries/Fractures (broken bones) you have had and when? _____

_____

Surgeries you have had and when?

_____

Have you had or do you have any of the following conditions or diseases? Please check yes or no for each one below.

Anxiety ☐ Yes ☐ No Arthritis ☐ Yes ☐ No Asthma ☐ Yes ☐ No Bleeding Disorder ☐ Yes ☐ No Blurred Vision ☐ Yes ☐ No Bowel/Bladder Problems ☐ Yes ☐ No Buzzing in Ears ☐ Yes ☐ No Cancer ☐ Yes ☐ No Carpal Tunnel ☐ Yes ☐ No Celiac Disease (Gluten) ☐ Yes ☐ No Chest Pains ☐ Yes ☐ No Chronic Fatigue ☐ Yes ☐ No Cold Hands or Feet ☐ Yes ☐ No Colitis/Diverticulitis ☐ Yes ☐ No Compression Fractures ☐ Yes ☐ No Connective Tissue Issues ☐ Yes ☐ No COPD (Bronchitis/Emphysema) ☐ Yes ☐ No	Cushing's Disease ☐ Yes ☐ No Cystic Medial Necrosis ☐ Yes ☐ No Depression ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Digestive/Bowel Problems ☐ Yes ☐ No Dizziness or Vertigo ☐ Yes ☐ No Fibromuscular Dysplasia ☐ Yes ☐ No Fibromyalgia ☐ Yes ☐ No Fusions (Spinal, Joint, etc.) ☐ Yes ☐ No Gout ☐ Yes ☐ No Heart Disease ☐ Yes ☐ No Hepatitis (A, B, C, etc.) ☐ Yes ☐ No Herpes ☐ Yes ☐ No High Blood Pressure ☐ Yes ☐ No Hip Replacement ☐ Yes ☐ No HIV/AIDS ☐ Yes ☐ No Kidney Disease ☐ Yes ☐ No	Knee Surgery ☐ Yes ☐ No Liver Disease ☐ Yes ☐ No Marfan Syndrome ☐ Yes ☐ No Multiple Sclerosis ☐ Yes ☐ No Osteoporosis/Penia ☐ Yes ☐ No Parkinson's Disease ☐ Yes ☐ No Prosthesis ☐ Yes ☐ No Rotator Cuff Problem ☐ Yes ☐ No STI/STD ☐ Yes ☐ No Shoulder Surgery ☐ Yes ☐ No Spinal Surgery ☐ Yes ☐ No Stroke/TIA ☐ Yes ☐ No Thyroid Problems ☐ Yes ☐ No Tuberculosis ☐ Yes ☐ No Concussions ☐ Yes ☐ No Other:_____ ☐ Yes ☐ No

Are there any conditions that run in your family? ☐ Yes ☐ No If yes, what condition(s) and which family members?

For Women Only

Do you currently or have you ever used birth control? ☐ Yes ☐ No If yes, what brand(s), dosage, when, and for how long?

Do you currently or have you ever taken hormone replacement medication? ☐ Yes ☐ No If yes, what brand(s), dosage, when, and for how long?

Are you currently pregnant, or do you think you may be pregnant? ☐ Yes ☐ No If yes, for how many weeks? _____

Personal and Social Health History

How many hours per week do you typically work/attend school? ☐ <20 hrs ☐ 20 hrs ☐ 30 hrs ☐ 40 hrs ☐ 40+ hrs
What are your typical duties and postures (sitting, standing, lifting, etc.)? _____
Do you exercise? ☐ Yes ☐ No If yes, how often and what type? _____
How would you rate your eating habits? ☐ Excellent ☐ Pretty good ☐ Could be better ☐ Needs improvement
Do you follow a specific nutritional program? ☐ Yes ☐ No If yes, what type? _____
Would you like help with your diet or have a nutritional program developed for you? ☐ Yes ☐ No
Habits? Tobacco: Packs/Day _____ Alcohol: Drinks/Week _____ Caffeine: Cups/Ounces/Day _____
Other habits? _____
How well do you sleep? ☐ Excellent ☐ Pretty good ☐ Restless ☐ Can't Sleep How many hours daily? _____
Do you feel well rested in the morning? ☐ Yes ☐ No
How is your energy overall? ☐ Full power ☐ OK ☐ Low ☐ Generally fatigued
How do you feel your immune system is? ☐ Strong ☐ OK ☐ Low
In your own words, what do you think chiropractors do? _____
What do you hope to receive from our program? _____
Other than the current condition(s) for which you are here today, are there any other conditions that you would like to have checked by the doctor? ☐ Yes ☐ No If yes, please describe: _____

Please add any comments here:_____

Under penalty of perjury, I attest that my answers to the above questions are complete and true:

Signature: _____ Date: _____