



**New Patient Intake Forms**

**Patient Data**

**Date** \_\_\_\_\_

**Title:** (Check one)     Mr.     Mrs.     Ms.     Miss     Dr.     Other \_\_\_\_\_

**First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_ **Last Name** \_\_\_\_\_

**I prefer to be called by** \_\_\_\_\_

**Address Line** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Work Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Cell Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Email** \_\_\_\_\_

**Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_    **Sex:**     Male     Female

**Social Security Number:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_    **Marital Status:**     Single     Married     Other

**Employment Status:**     Employed     Unemployed     FT Student     PT Student     Other \_\_\_\_\_

**Emergency Contact**

**Contact Name** \_\_\_\_\_    **Relationship to Patient** \_\_\_\_\_

**Contact Home Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_    **Cell Phone** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Payment/Insurance Information:**

Who is responsible for your bill?     Self     Health Insurance     Spouse     Worker's Comp

Auto Insurance     Medicare     Medicaid     Other \_\_\_\_\_

**Health Insurance Carrier:** \_\_\_\_\_ **Insurance Card ID #** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Policy Holder's Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_    **Primary Care Physician** \_\_\_\_\_

**Worker's Compensation Injury / Auto / Personal Injury:**

Have you filed an injury report with your employer?     Yes     No    **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_    **Time:** \_\_\_\_\_ am / pm

How did you hear about our office? \_\_\_\_\_

**INFORMED CONSENT FORM**

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

**The nature of the chiropractic adjustment**

One treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

**Analysis / Examination / Treatment**

As a part of the analysis, examination, and treatment, you are consenting to the chiropractic procedures.

**The material risks inherent in chiropractic treatment**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

**The probability of those risks occurring**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. 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**

Other treatment options for your condition may include:

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

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**The risks and dangers attendant to remaining untreated**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Symptoms may increase and over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

**PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW:**

**I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. McLaughlin and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved 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.**

Dated: \_\_\_\_\_  
Patient's Name: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Signature of Parent or Guardian (if a minor): \_\_\_\_\_

Dated: \_\_\_\_\_  
Doctor's Name: \_\_\_\_\_  
Signature: \_\_\_\_\_

**CANCELLATION POLICY**

We are very pleased to participate in your healthcare, and have set aside time for your appointment. We understand that sometimes it is necessary to cancel or change an appointment. In consideration of the others who need care, we ask that if you are unable to keep an appointment with our office, that you please observe our cancellation policy which follows:

**Our office requires at least 24 hour notice for all appointment cancellations. If you are unable to provide 24 hour notice, you will be billed a \$25.00 charge to your credit card on file for scheduled chiropractic or massage appointments.**

Please circle one:      Visa      Discover      MasterCard      American Express

Card Number: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_  
Cardholder: \_\_\_\_\_  
Signature: \_\_\_\_\_

Your credit card will be kept on file to enforce the cancellation policy and to collect on delinquent accounts 30 days past due.

*Please sign stating you agree to the terms and conditions.*

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**HIPAA Privacy Practices**

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name \_\_\_\_\_  
Patient's Signature \_\_\_\_\_  
Date \_\_\_\_\_

Consent to Treat a Minor: (Minor's Printed Name) \_\_\_\_\_

Guardian / Spouse's Signature Authorizing Care \_\_\_\_\_

Date \_\_\_\_\_

**SIGNATURE OF PHYSICIAN:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medical History**

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

- Arthritis                       Cancer                       Diabetes                       Heart Disease                       Hypertension
- Psychiatric Illness               Skin Disorder                       Stroke                       Other

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

- Appendectomy                       Cardiovascular procedure                       Cervical spine                       Hysterectomy
- Joint Replacement                       Prostate                       Lumbar spine                       Gall Bladder
- Brain                       Shoulder                       Thoracic spine                       Knee
- Carpal Tunnel                       Gastro-intestinal                       Uro-genital                       Hernia                       Other

**Allergies:** (List any allergies)

\_\_\_\_\_  
\_\_\_\_\_

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

- Caffeine use:     occasional     often     never                      Drink Alcohol:     occasional     often     never
- Exercise:         occasional     often     never                      Tobacco Use:      occasional     often     never
- Sleep: Hours per night \_\_\_\_\_
- Stress Level: High   Moderate   Low   None

**Family History:** (Check all that apply)

- |   |  |
|---|--|
| Arthritis: <input type="checkbox"/> Parent <input type="checkbox"/> Sibling   | Cancer: <input type="checkbox"/> Parent <input type="checkbox"/> Sibling       |
| Diabetes: <input type="checkbox"/> Parent <input type="checkbox"/> Sibling    | Heart Disease <input type="checkbox"/> Parent <input type="checkbox"/> Sibling |
| Hypertension <input type="checkbox"/> Parent <input type="checkbox"/> Sibling | Stroke <input type="checkbox"/> Parent <input type="checkbox"/> Sibling        |
| Thyroid <input type="checkbox"/> Parent <input type="checkbox"/> Sibling      | Other _____  |

**Review of Systems** – (Check if you have had trouble with any of the following within the last 3 months)

**General:**

- \_\_\_ Weight change
- \_\_\_ Fever
- \_\_\_ Chills
- \_\_\_ Night Sweats
- \_\_\_ Weakness
- \_\_\_ Fatigue

**Skin:**

- \_\_\_ Rash
- \_\_\_ Itching
- \_\_\_ Hair Changes
- \_\_\_ Nail Changes

**Cardio:**

- \_\_\_ Murmur
- \_\_\_ Chest Pain
- \_\_\_ Palpitations
- \_\_\_ Difficulty Breathing
- \_\_\_ Cough or Wheezing
- \_\_\_ Blue or Swollen Extremities

**Eyes:**

- \_\_\_ Vision
- \_\_\_ Pain
- \_\_\_ Discharge

**Neurologic:**

- \_\_\_ Headache
- \_\_\_ Dizziness
- \_\_\_ Convulsions
- \_\_\_ Fainting

**Breasts:**

- \_\_\_ Mass
- \_\_\_ Pain
- \_\_\_ Discharge
- \_\_\_ Self-exam

**Ears:**

- \_\_\_ Hearing
- \_\_\_ Ringing
- \_\_\_ Pain
- \_\_\_ Discharge

**G-I:**

- \_\_\_ Appetite
- \_\_\_ Abdominal Pain
- \_\_\_ Vomiting
- \_\_\_ Diarrhea
- \_\_\_ Constipation

**Mouth/Throat:**

- \_\_\_ Sores
- \_\_\_ Bleeding
- \_\_\_ Taste

**Psychologic:**

- Anxiety
- Depression
- Moods
- Memory

**Nose:**

- Pain
- Taste
- Bleeding

**G-U:**

- Frequent Urination
- Painful Urination
- Incontinence

**Musculoskeletal:**

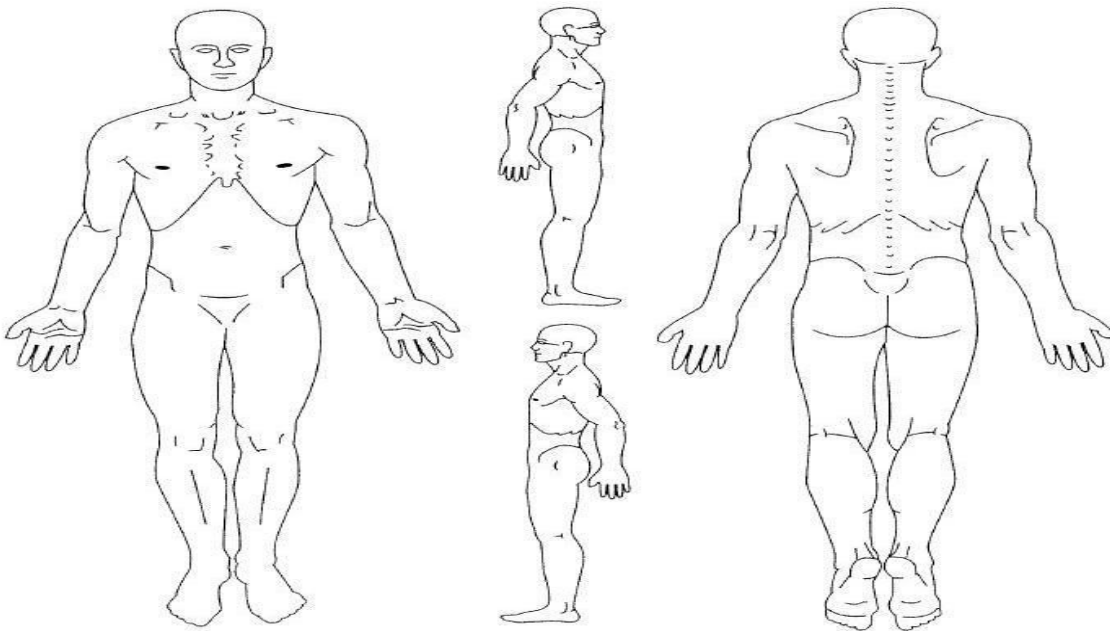
- Neck
- Upper Extremities
- Upper Back
- Lower Extremities
- Lower Back

**Additional Info:**

Please list ALL current medications and/or supplements being taken: \_\_\_\_\_

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10 = the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms in order of severity, with worse symptom being #1: \_\_\_\_\_

Are your symptoms a result of:  Motor Vehicle Accident  Work related Accident  Other \_\_\_\_\_

How are your symptoms changing?

- Getting better
- Not changing
- Getting worse

**Activities of Daily Living**

**Please circle if you have pain or difficulty performing the following:**

Bending    Carrying Groceries    Change Position–Sit-Stand    Climb Stairs    Driving    Feeding    Walking    Sleep  
Extended Computer Use    Household Chores    Kneeling    Lift Children    Lifting    Yard Work  
Pet Care    Reading    Self Care/Bathing    Self Care/Dressing    Sexual Activities    Static Sitting    Static Standing  
Other \_\_\_\_\_

**What type of treatment are you looking for?**

I am looking for the most minimal amount of care to “patch up the symptoms” of my problem

I am looking to resolve my symptoms and then go on to “fix the cause” of my problem

I am looking to take care of my problem and then go on to “achieve optimal health and wellness”

***FOR OFFICE USE ONLY***

**HISTORY OF PRESENT ILLNESS**

**Date** \_\_\_\_\_

**Onset-**

**Mechanism-**

**Previous Care-**

**Palliative-**

**Provocative-**

**Quality-**

**Radiating-**

**Site/Severity-**

**Timing-**

**Associated Sx's-**