

# 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?** \_\_\_\_\_

## 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)

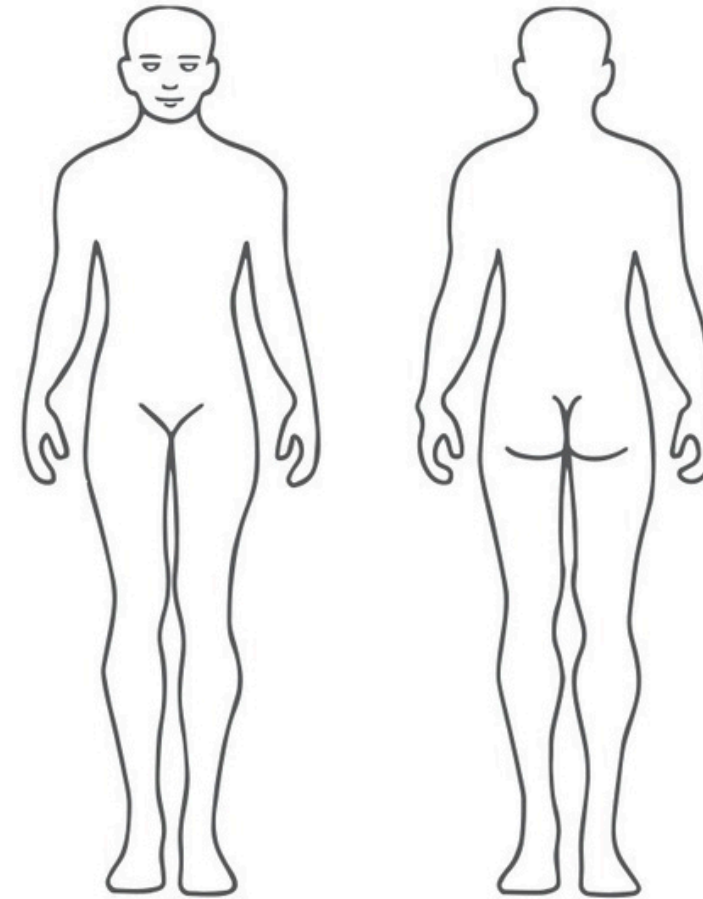
0
1
2
3
4
5
6
7
8
9
10

NO SYMPTOMS INTENSE SYMPTOMS

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

What does it feel like? (check where appropriate)

- |                                    |                                      |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Numbness  | <input type="checkbox"/> Sharp       |
| <input type="checkbox"/> Tingling  | <input type="checkbox"/> Shooting    |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Burning     |
| <input type="checkbox"/> Dull      | <input type="checkbox"/> Throbbing   |
| <input type="checkbox"/> Aching    | <input type="checkbox"/> Stabbing    |
| <input type="checkbox"/> Cramping  | <input type="checkbox"/> Swelling    |
| <input type="checkbox"/> Nagging   | <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

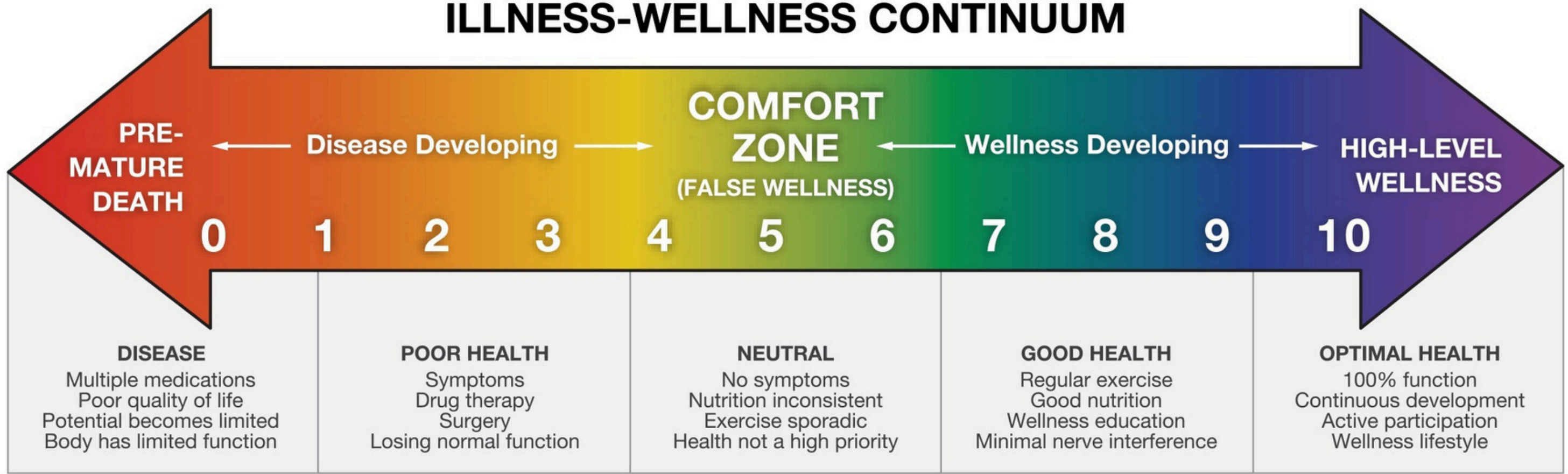
How committed are you to correcting this issue?

0
1
2
3
4
5
6
7
8
9
10

NOT COMMITTED VERY COMMITTED

## PATIENT WELLNESS ASSESSMENT

### ILLNESS-WELLNESS CONTINUUM



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 \_\_\_\_\_

LONG TERM \_\_\_\_\_

## 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? \_\_\_\_\_

## FAMILY CARE OPTIONS

*We offer family plans for the immediate household (Parent, Spouse, Partner, Child).*

I'm interested in learning about family plans.  Yes  No

I have more questions about my PARENT / SPOUSE / PARTNER / CHILD when it comes to chiropractic.  
*circle any that apply*

## HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

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

## SURGERIES

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## ACCIDENTS

Is your condition due to an accident?  Yes  No Date: \_\_\_\_\_

Type of Accident: (circle all that apply) Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Worker's Comp  Other

Attorney Name (if applicable): \_\_\_\_\_

## ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

MEDICATIONS (list)

SUPPLEMENTS (list)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## DISCLOSURE AND CONSENT CHIROPRACTIC ADJUSTMENTS AND CARE

**TO THE PATIENT:** *You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I will have/had the opportunity to discuss with the Doctor, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able 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 which the doctor feels at the time, based on the fact then known, and is in my best interest, I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I also will have an opportunity to ask questions, and all my questions answered fully and satisfactorily. By signing below, I consent to the treatment plan. 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.

Patient Name (PRINT): \_\_\_\_\_ Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights of privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certification.
4. Call out my name in the waiting room to assign me to the correct table for my adjustment.

I acknowledge that I can request your full NOTICE OF PRIVACY PRACTICES (HIPPA) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name (PRINT): \_\_\_\_\_ Signature: \_\_\_\_\_ DATE: \_\_\_\_\_



# Heskett Family Chiropractic Media Release Form

I \_\_\_\_\_, grant permission to Heskett Family Chiropractic hereinafter known as the “Media” to use my image (photographs and/ or video) for use in Media publications including:

- Videos    ● Magazines    ● Emails    ● Recruiting Brochures
- Newsletters    ● Website and / or Affiliates    ● General Publications

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the used of the image.

Please **initial** the paragraph below which is applicable to your present situation:

\_\_\_\_ - **I am 18 years of age** or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

\_\_\_\_ - **I am the parent or legal guardian** of the below named child, I have read this release before signing below, and I fully understand the contents. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

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

Name (Please Print): \_\_\_\_\_

Signature of parent or legal guardian: \_\_\_\_\_  
(If under 18 years of age)

