Patient Intake Form

Patient Information

*First Name: __________

Middle Name: __________

*Last Name: ________________

Gender:

Female / Male

Date of Birth: ______________

Social Security #: _______________

Height:

Feet _____

Inches _____

Weight: __________

Marital Status: _________

Spouse's Name: ______________

Number of Children: __________

Emergency Contact: __________

Relationship: _____________

Phone: ____________________

*Email: _______________________

(We will **NOT** share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

Home Phone: _______________

Cell Phone: _________________

Work Phone: ________________

Country: _________________

Address Line 1: _________________

Address Line 2: _________________

City: _____________________

State/Province/Region: __________

Zip/Postal Code: __________

Complaint Information

What is the purpose of your visit? ______________________

What is the reason for this visit? ________________________

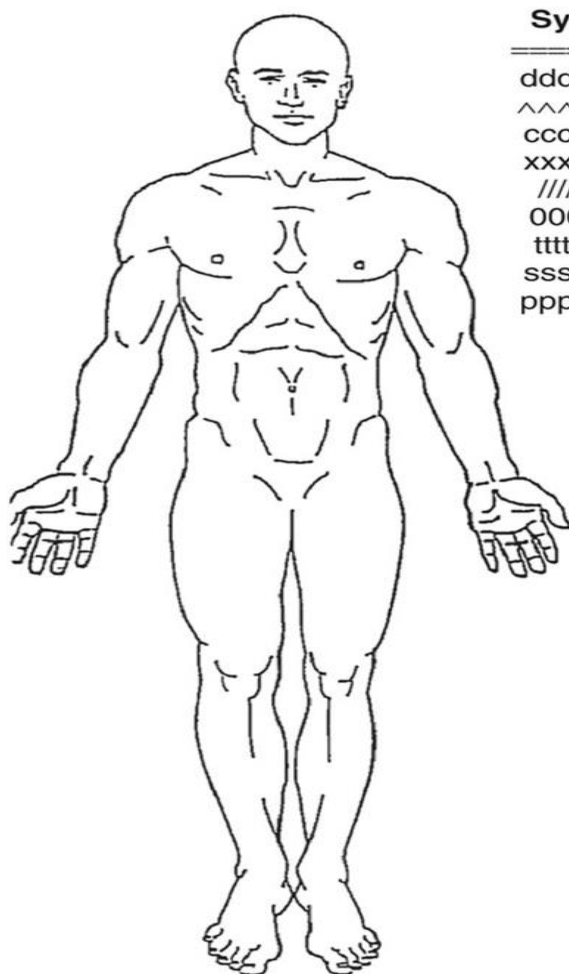
Date of scheduled appointment ___________________________

When did this condition begin? ___________________________

How long have you had this condition? __________________________

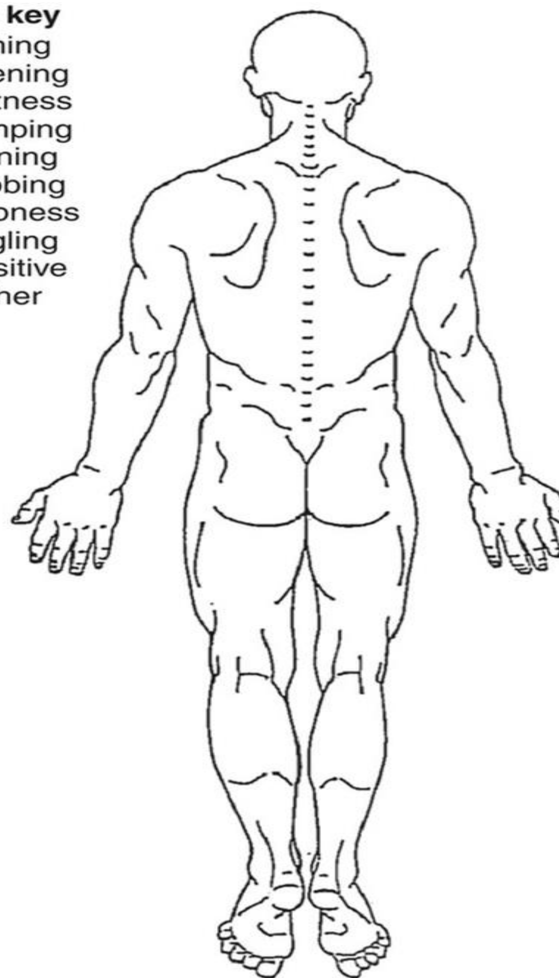
What caused this condition? ___________________________________

Where is the discomfort? _____________________________________



Symptom key

=====	Aching
dddd	Stiffening
^^^^	Tightness
cccc	Cramping
xxxx	Burning
////	Stabbing
000	Numbness
ttttt	Tingling
ssss	Sensitive
pppp	Other



Does the discomfort radiate/travel?

Yes or No

Describe the quality of the discomfort. Choose all that apply.

Aching Sharp Annoying Shock-like Burning Shooting Deep

Stabbing Diffuse Stiffness Dull Throbbing Heavy Tightness

Intolerable Tingling Pulling OTHER ___________

Describe the onset of the discomfort. Choose only one:

Gradual Insidious Recent Spontaneous Sudden Traumatic Unknown

Describe the intensity of the discomfort. Choose only one.

Mild Mild to moderate Moderate Moderate to severe Severe

Rate the severity of your discomfort on a scale of 1-10 where 1 is the least severe and 10 is the most severe.

1 2 3 4 5 6 7 8 9 10

Least severe <----------------------------> Most severe

How often do you feel this discomfort? Choose only one.

Constant Frequent Intermittent On and off Random Recurring

How has this complaint changed since the onset?

Improved Stayed the same Worsened

What activity is most significantly affected by this discomfort?
____

What aggravates this condition? Choose all that apply.

Almost any movement Love life Athletic activity and/or exercise

Lying down Bathing Pulling Bending Pushing Caring for family

Reaching Carrying Reading Changing positions Repetitive motions

Climbing stairs Resting Computer use Running Concentrating

Self care (dressing, bathing, etc.) Cooking Shaving Coughing and/or sneezing

Sitting Daily child or pet care Squatting Driving Standing Eating

Stress Falling or staying asleep Stretching Getting in or out of car

Talking on telephone Getting out of bed Turning Getting up from lying down

Twisting Getting up from sitting Unknown Grocery shopping Walking

Household chores Working Lifting Yard work Looking over shoulder

OTHER ___________

What improves this condition? Choose all that apply.

Nothing Chiropractic adjustment Prescription medication Cold packs

Exercise Rest Heat packs Stretching Massage Work

Over-the-counter medications OTHER___________

What treatment have you received for this condition up to now?

None Acupuncture Occupational therapy Chiropractic care

Osteopathic medicine Craniosacral therapy Over-the-counter medications

Homeopathic medicine Physical therapy Hypnosis Prescribed medications

Injection therapy Psychotherapy Medical care Reiki

Naturopathic medicine Surgery Nutritional supplements

OTHER_________________

Were any diagnostic tests performed to assess this condition (including X-rays, MRIs, etc.)?

Yes No Unsure

Have you ever had any previous episodes of this condition?

Yes No

In what ways does this condition affect your life and your ability to function? Choose all that apply.

Bending over Looking over shoulder Caring for family Love life

Climbing stairs Lying down Concentrating Reaching overhead

Dressing myself Rising out of chair or bed Driving a car

Showering or bathing Exercising Sitting Getting in/out of car

Standing Getting to sleep Staying asleep Grocery shopping

Using a computer Household chores Walking Lifting objects

Yard work

Do you have an additional complaint?

If yes ____

Employment Information

Regular Work Status: ____________________

Employer Name: _______________________

Employer Address: ______________________

Employer City: ________________________

Employer State: _________

Employer Zip: ___________

Occupation: ________________

Occupational Activities: (Circle one that best describes your job description)

Administration Business Owner Clerical/Secretary Computer User

Heavy Equipment operator Daycare/Childcare Construction Health Care

Food Service Industry Medium Manual Labor Manufacturing

Home Services Heavy Manual Labor Light Manual Labor

Executive/Legal Housekeeper Other ________________

Personal Health History

Date of Last Physical Exam: ___________________

Name of Family Physician or Physician Seen: ______________________

Physician Phone: _______________________

Physician City: ______________________

Physician State: ______________________

Physician Zip: _______________

Please list any health conditions that you have been treated for in the last year:

(condition, cause, current/resolved) * Separate details with "," comma*

____

____

On the next page please indicate any current symptoms you are experiencing or have experienced recently:

Review of Systems

General
- Weight Change
- Fatigue
- Fever/Chills

Skin
- Skin Changes
- Pruritis
- Rash
- Hair Loss or Growth

HEENT & Neck
- Headache
- Vision Change
- Glasses/Contacts
- Diplopia
- Blurring
- Scotoma
- Eye Pain
- Photophobia
- Hearing Loss
- Tinnitus
- Vertigo
- Ear Pain
- Ear Discharge
- Epistaxis
- Nasal Discharge
- Nasal Obstruction
- Sinusitis
- Teeth/Dentures
- Abnormal Taste
- Sore Mouth or Tongue
- Gums
- Sore Throat
- Speech Difficulty
- Hoarseness
- Neck Swelling
- Neck Pain
- Stiff Neck
- Goiter
- Masses or Nodes

Breasts
- Sores
- Breast Masses
- Breast Pain
- Breast Discharge

Respiratory
- Shortness of Breath
- Cough
- Dyspnea
- Wheezing
- Hemoptysis

Cardiovascular
- Chest Pain
- Orthopnea
- PND
- Edema
- Claudication
- Cyanosis
- Syncope

GI
- Anorexia
- Nausea or Vomiting
- Hematemesis
- Dysphagia
- Heartburn
- Abdominal Pain
- Jaundice
- Changed Bowel Habits
- Diarrhea
- Constipation
- Melena
- Hematochezia
- Rectal Pain
- Tenesmus
- Flatulence

Gynecological
- Age of Menarche
- Menstrual Cycle
- Last Menstrual Period
- Age of Menopause
- Dysmenorrhea
- Menorrhagia
- Metrorrhagia
- Dyspareunia
- Contraception
- Pelvic Pain
- Sexual Dysfunction
- Vaginal Discharge

Genitourinary
- Polyuria
- Hesitancy
- Frequency
- Urgency
- Dysuria
- Oliguria

Genitourinary (cont.)
- Anuria
- Hematuria
- Proteinuria
- Pyuria
- Nocturia
- Decreased Stream
- Erectile Dysfunction

Neuro
- Seizures
- Paralysis
- Muscle Weakness
- Paresthesia
- Dizziness
- Tremor
- Gait
- Incoordination
- Headache
- Syncope

Muscular
- Backache
- Joint Pain
- Stiffness
- Atrophy

Hem/Lymph
- Lymphadenopathy
- Bleeding
- Easy Bruising
- Infections

Endocrine
- Goiter
- Heat or Cold Intolerance
- Diaphoresis
- Polydypsia
- Polyuria
- Polyphagia

Psychiatric
- Anxiety
- Depression
- Mood
- Sleep Disturbances
- Memory Change
- Suicidal Ideation
- Homicidal Ideation
- Hallucinations (A/V)

Are you pregnant, or have you had any signs of pregnancy? (Female Only)

No Yes

Are you planning to get pregnant in the next 12 months? (Female Only)

No Yes

List current medications: (name, amounts, frequency, length of use, reason for use)

Separate details with "," comma

____
____
____

List current vitamins, minerals, supplements, or herbs:

(name, amounts, frequency, length of use, reason for use)

____
____

Family Health History

Please list diagnosed health conditions and untimely deaths.(condition, relationship to you) (Family members include: Parents and siblings and maternal and paternal grandparents/aunts/uncles)

(Example: arthritis, cancer, diabetes, heart disease, kidney disease, high cholesterol, etc.)

____
____
____
____
____

Chiropractic Experience

Who referred you to our office? __________________________

Where did you hear about us? Please select all that apply.

Sign Community Event Walk-in Other____________________

Have you been adjusted by a chiropractor before?

Yes No

If yes any specific ways? ____________________

What was the reason for those visits? _________________________

Doctor's Name: ______________________

Approximate date of last visit: ____________________________
Has any member of your family ever seen a wellness chiropractor?

Yes No

At iConnect Family Chiropractic we want to make the greatest impact on our community. If you have an organization where you would like an educational talk on chiropractic please indicate below:
____
____

If you know someone who may benefit from chiropractic and would like the doctor to reach out, specify below:

Name: ________________

Phone Number: ______________ or Email: ___________________________

PAYMENT POLICY

Thank you for choosing iConnect Family Chiroprctic as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. We do **NOT (**at this time) participate with any insurance company. Full payment must be rendered at the time of service.
2. An itemized bill can be generated for possible reimbursement from 3rd party payers upon request and all services do go toward your deductible.

3. Medicare Patients- We are currently a non-participating provider with Medicare. Unfortunately we are unable to provide care until Medicare accepts our application.
4. **MISSED APPOINTMENT**. Our policy is to charge for a full visit after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment**.

Our practice is committed to providing the best care to our patients. Our prices are representative of the usual and customary charges for our area.
I have read and understood the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party

____

Date ___________________________

Informed Consent (Please Read and Sign)

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. 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 upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care, physical therapy; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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

Name of Patient:____

Signature of Patient:____

Date____

Name Printed of Guardian/Parental and Relationship to Patient:___________________________

Guardian/Parental Signature:____

Date:____