NEW PATIENT INTAKE

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. Please complete all pages of this form as accurately and completely as possible. Some information may not appear to be related to your problem, however, experience has proven that providing comprehensive information is essential to getting you better as quickly as possible. Whatever additional information you provide will be helpful in evaluating your condition.

Name ______________________ **Today's Date** ____________

Address ______________________ **Sex** ☐ **M** ☐ **F** **Birth date** __________ **Age** ______

City ______________________ **State** ________ **Zip** ________ **Occupation** ____________

Home Phone ______________ **Cell Phone** ______________ **Work Phone** ______________

SS # ____ / ____ / ____ **No. of children & ages** ______________

Marital Status (check one) ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐ **Separated** ☐ **Significant Other**

E-Mail ______________________ **Employer** ______________

Are you presently under a doctor's care? ☐ **Yes** ☐ **No** **Who & what for?** ______________

Insurance company ______________________ **ID #** ______________

What is the purpose of this appointment? ______________________________

What was the initial cause? ______________________________

When did it begin ____________ **Have you had the same or similar symptoms in the past?** ☐ Yes ☐ No

What makes it worse ______________________________

What makes it better ______________________________

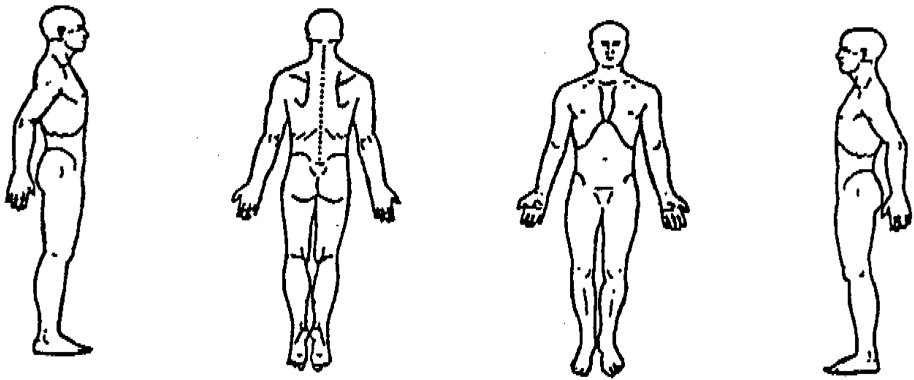
Which daily activities are affected by this problem?

☐ Work ☐ Sitting ☐ Stretching ☐ Recreation ☐ ____________
☐ Sleep ☐ Standing ☐ Social Life ☐ Relationships
☐ Walking ☐ Bending ☐ Sex ☐ Emotional

What have you done about it? ______________________________

What are your health goals? ______________________________

Please indicate the areas of problem(s) on the appropriate figures below:



Pain Key:
^^^ Ache === Numbness
xxx Burning /// Stabbing
ooo Pins & needles

How often do you experience your symptoms?

☐ Constantly (76-100% of the time)
☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time)
☐ Intermittently (0-25% of the time)

Please put a mark on the scale to show how bad your usual discomfort has been recently.

No discomfort	0	1	2	3	4	5	6	7	8	9	10	Worst possible discomfort

PAST HISTORY

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping cough
- ☐ Anemia
- ☐ Measles
- ☐ HIV positive

- ☐ Mumps
- ☐ Small pox
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart disease
- ☐ Thyroid
- ☐ Allergies

- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental disorders
- ☐ Lumbago
- ☐ Eczema
- ☐ Psoriasis

DO YOU USE:

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ Former smoker?
- ☐ Pot
- ☐ White sugar

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint pain ☐ Stiffness
- ☐ Walking problems
- ☐ Difficulty chewing or ☐ Clicking jaw
- ☐ General stiffness

NERVOUS SYSTEM

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion or ☐ Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Tingling or ☐ Cold extremities
- ☐ Stress

GASTROINTESTINAL

- ☐ Poor or ☐ Excessive appetite
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gall bladder problems
- ☐ Weight trouble
- ☐ Abdominal cramps (not menstrual)
- ☐ Gas or ☐ Bloating after meals
- ☐ Heartburn
- ☐ Black or ☐ Bloody stools
- ☐ Colitis

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of sleep
- ☐ Fever
- ☐ Headache ☐ Migraines

GENITO-URINARY

- ☐ Bladder trouble
- ☐ Painful or ☐ Excessive urination
- ☐ Discolored urine
- ☐ Prostate or ☐ Sexual dysfunction

CARDIO-VASCULAR

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Heart problems
- ☐ Lung problems or ☐ Congestion
- ☐ Varicose veins
- ☐ Ankle swelling
- ☐ Stroke

EYES EARS NOSE THROAT

- ☐ Vision problems
- ☐ Dental problems
- ☐ Sore throat
- ☐ Ear aches
- ☐ Hearing difficulty
- ☐ Stuffed nose

FEMALE ONLY

- ☐ Menstrual irregularity
- ☐ Menstrual cramps
- ☐ Vaginal pain or ☐ Infection
- ☐ Breast pain or ☐ lumps

Are you pregnant? ☐ Yes ☐ No

Date of last period: ____________

MEDICATION or VITAMINS YOU TAKE?

- ☐ Birth control pills ____________
- ☐ Aspirin/Tylenol ____________
- ☐ Ibuprofen ____________
- ☐ Pain killers ____________
- ☐ Muscle relaxant ____________
- ☐ Blood pressure ____________
- ☐ Diabetic ____________
- ☐ Thyroid ____________
- ☐ Heart ____________
- ☐ Hormones ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________

MAJOR SURGERY OR OPERATIONS:

- ☐ Tonsils
- ☐ Appendix
- ☐ Gall bladder
- ☐ Hernia
- ☐ Heart
- ☐ Other ____________
- ☐ **Pacemaker**
- ☐ Back
- ☐ Neck
- ☐ Hysterectomy
- ☐ Prostate

FAMILY HISTORY

The following members have a same or Similar problems as I do:

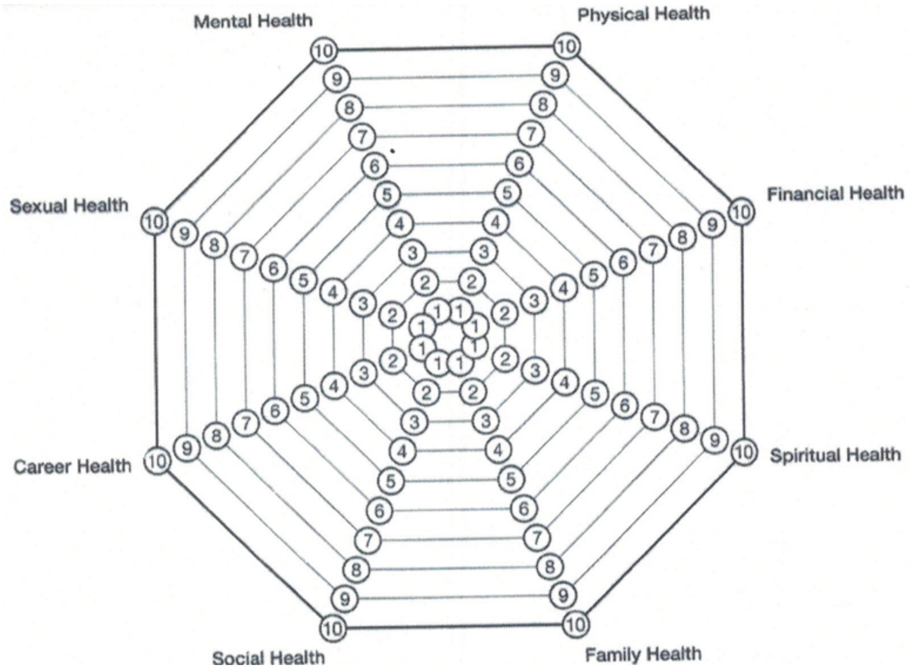
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Child

Name____________________

Web of Wellness

Health and wellness are a balance of many factors that affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram choose your level of satisfaction in each of the areas by shading in the appropriate circle. With "1" the center of the web being extremely satisfied and "10" extremely dissatisfied and "5" being neutral



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

Not committed Looking for relief	0	1	2	3	4	5	6	7	8	9	10	Very Committed Willing to do what it takes

Describe other conditions that you would like us to help you with, if any.

____

____

____

Medications & Supplements

Please list ALL medications, vitamins, minerals, or herbs currently take. Inlcude all Rx or OTC items, inhalers and patches.

ITEM	DOSAGE	REASON FOR TAKING	HOW LONG?

Name______________________________

Cancellation Policy

Our office generally runs on a “no wait” schedule when patients come in on time. If we are running late, we try to call patients to give them notice and expect the same consideration.

Our office policy requires at least 24 hours notice of cancellation of a booked appointment.

The missed appointment fee is $40. (Your insurance does not cover missed appointments). Fee must be paid in full prior to or at the time of your next scheduled appointment.

I have read and understand the Cancellation Policy and agree to be as courteous as possible in making and canceling appointments.

INITIAL HERE__________

Informed Consent for Treatment

I voluntarily consent to participate in therapy performed at the Center.

I understand that treatment may include, but not limited to, chiropractic, acupuncture, hydrocolon therapy, hypnotherapy, laser therapy, electrical stimulation, ultrasound, traction, massage, biopuncture, cupping, moxibustion, gua sha, tuina, nutritional counseling, herbal, homeopathic and food supplements.

I understand that certain modalities may be contraindicated in pregnancy, weakened state or fatigued and that I will inform the office if my condition changes.

I understand that under certain conditions such as nausea, dizziness or fainting may occur. I understand that bruising, hematomas, bleeding and/ temporary soreness may occur from acupuncture. No guarantees or assurances have been made regarding the results of these treatments or procedures.

I have not withheld any information about my medical history and except as stated, I am in good health.

By voluntarily signing below I verify that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of treatment, and have had an opportunity to ask questions. 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.

To be completed by the patient or patient’s representative, (e.g. if the patient is a minor or is physically or mentally incapacitated)

INITIAL HERE__________

Name_____________________________________

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to use and disclosure of my Protected Health Information (PHI) for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the practice's diagnosis or treatment of me may be conditioned upon by my consent as evidenced by my signature on this document.

For purposes of this consent, PHI means any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health condition; the provision of health care to me; or past, present, or future payment for the provision of health care services to me; and that either indemnifies me from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my PHI for the purposes of treatment, payment of healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my PHI.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance to this consent.

INITIAL HERE__________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office any outstanding charges for professional services rendered will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of natural, non-invasive methods such as spinal adjustments, massage, nutrition or acupuncture.

Patient's Name ____________________

Patient's signature **X** ____________________ Date ____________

Guardian's signature (if patient is a minor) ____________________

FUNCTIONAL OUTCOME ASSESSMENT – For Neck & Back Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.
For each item below, please circle the number that most closely describes your condition right now.

1. Pain Intensity

0 1	2 3	4 5 6	7 8	9 10
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0 1	2 3	4 5 6	7 8	9 10
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0 1	2 3	4 5 6	7 8	9 10
No pain No restriction	Mild pain No restrictions	Moderate pain Need to go slowly	Moderate pain Need some assistance	Severe pain Need 100% assistance

4. Travel (driving, etc)

0 1	2 3	4 5 6	7 8	9 10
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0 1	2 3	4 5 6	7 8	9 10
Can do usual work plus unlimited extra work	Can do usual work: no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0 1	2 3	4 5 6	7 8	9 10
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of Pain

0 1	2 3	4 5 6	7 8	9 10
No pain	Occasional pain 25% of the day	Intermittent pain 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day

8. Lifting

0 1	2 3	4 5 6	7 8	9 10
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0 1	2 3	4 5 6	7 8	9 10
No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with any walking

10. Standing

0 1	2 3	4 5 6	7 8	9 10
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name ______________________ **Total Score** __________