

# CHIROPRACTIC INTAKE & HISTORY

## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
LAST NAME

\_\_\_\_\_  
FIRST NAME MIDDLE INITIAL

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_  
zip code

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthday \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered

Social Security Number \_\_\_\_\_

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? \_\_\_\_\_

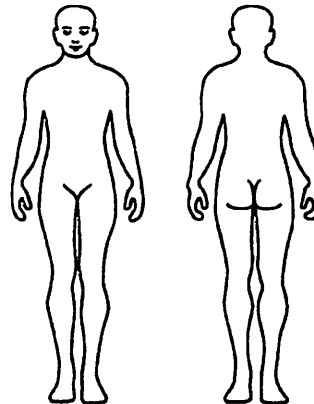
How bad is it? How intense are your symptoms? (circle)

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

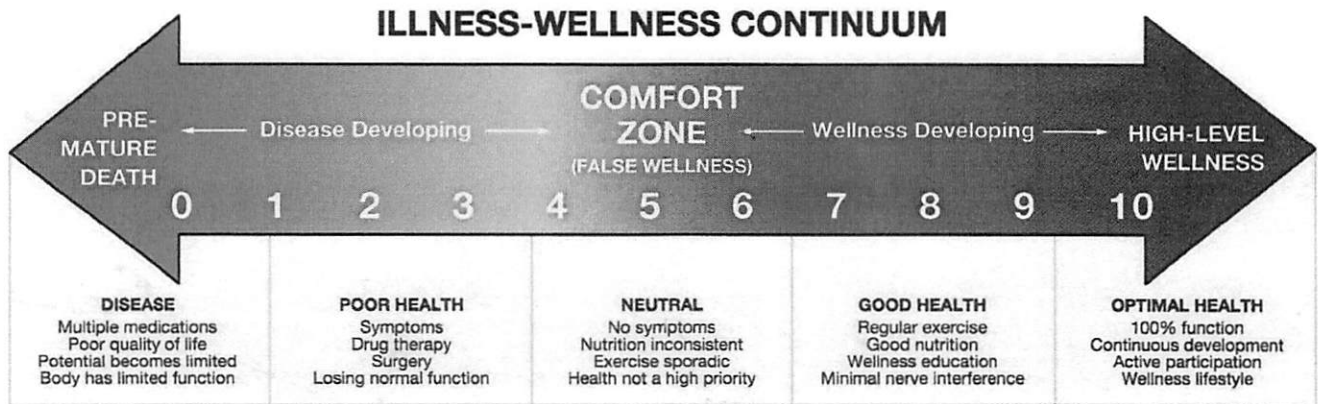
How is this symptom / condition interfering with your life? (check where appropriate)

	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"/>	Energy	<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"/>	Attitude	<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"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<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"/>	Creativity	<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



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? \_\_\_\_\_

## 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   | _____                                    |

## ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

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

MEDICATIONS (list)

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

SUPPLEMENTS (list)

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

**Consent to Care**

I do hereby authorize the doctors of EPIC Life Chiropractic & Wellness to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments, and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable and necessary for my healthcare.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below or other licensed doctors of chiropractic 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, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I authorize the doctors of EPIC Life Chiropractic & Wellness to discuss the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services rendered will be charged and I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of chiropractic there are some risks to treatment including, but not limited 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, and is in my best interest. The doctor will not be held responsible for any health conditions are diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spina structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees previously incurred will be due and payable at that time. I authorize the assignments of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be personally liable for any and all of the unpaid balance due to the Doctor.

I, \_\_\_\_\_, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below to the above names procedure. I intent 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.

Signature \_\_\_\_\_  
(If under age 18) Parent Signature

Date \_\_\_\_\_

**INSURANCE INFORMATION**

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing there services strictly as a convenience for me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credit to my account.

Signature \_\_\_\_\_  
(If under age 18) Parent Signature

Date \_\_\_\_\_