Patient Intake Information

CONFIDENTIAL HEALTH INFORMATION

Date ____________________

(Legal) First Name (Legal) MI (Legal) Last Name Date of Birth Age

Street ______________________________ Apt. __________

City____________________ State __________ Zip __________ Gender: [ ] M [ ] F

Social Security #:______________ Marital Status: [ ] S [ ] M [ ] W [ ] D Spouse: __________

Occupation: ____________________ Employer: ____________________

Contact Info: Home Ph: __________ Cell Ph: __________ Work Ph: __________

Cell Carrier: __________ Home Email:______________ Work Email:______________

Contact Preference ____Home Ph ____Work Ph ____Cell Ph ____Email Hm ____Email Wk ____Postal Mail

Emergency Contact:________________ Relation:__________ Phone: __________

Who referred you to our office?____________________ Phone: ____________________

Have you ever been treated by a chiropractor? [ ] Y [ ] N If so, when was your last treatment?__________

PATIENT HISTORY

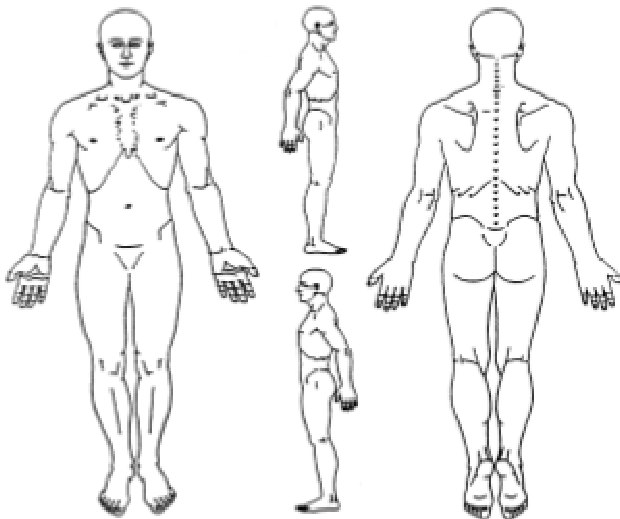
• **Please give a brief description of the problem[s] you are experiencing**:

1.____

2.____

• **When did the problem[s] start?** 1. ____________________ 2. ____________________

• **Where are your symptoms?**



• **What appears to be the initial cause?**

1.______________________________

2.______________________________

• **What does the pain feel like? (Circle all that apply)**

-achy -burning -dull -sharp -stiffness -throbbing

-cramps -nagging -numb -shooting -stabbing -tingling

• **Pain level (*0 = no pain, 10 = worst pain ever felt*):**

currently__________ worst__________ best__________

• **Any pain, numbness, tingling in arms/legs?** [ ] Y [ ] N

What part of the day is it worse? __________ What increases symptoms? __________

What part of the day is it better? __________ What decreases symptoms?__________

PAST HISTORY

- **Musculoskeletal Conditions** (please check all that apply)

[ ] Headaches/Migraines
[ ] Neck Pain/Discomfort
[ ] Shoulder Pain/Discomfort
[ ] Upper Back Pain/Discomfort
[ ] Middle Back Pain/Discomfort
[ ] Low Back Pain/Discomfort
[ ] Hip Pain/Discomfort
[ ] Sciatica
[ ] Elbow Pain/Discomfort
[ ] Wrist Pain/Discomfort
[ ] Knee Pain/Discomfort
[ ] Ankle Pain/Discomfort
[ ] Arthritis
[ ] Fused/Fixated Joints
[ ] Herniated Disc
[ ] Joint Replacement
[ ] Osteoporosis
[ ] Osteopenia
[ ] Inflammation/Swelling; where______________________________

- **Other Conditions**

[ ] Cancer
[ ] Stroke
[ ] High Blood Pressure
[ ] Hernia
[ ] Heart Disease
[ ] Diabetes
[ ] High Cholesterol
[ ] Allergies
[ ] Tumors
[ ] Seizures
[ ] Tuberculosis
[ ] Other______________________________
[ ] AIDS/HIV
[ ] Hepatitis
[ ] Pacemaker

- **Indicate if you have experienced any of the following and mark how recently**

Surgeries [ ] Yes [ ] No -------- [ ] Less than 1 month [ ] 1-6 months [ ] More than 12 months
Falls/Accidents [ ] Yes [ ] No -------- [ ] Less than 1 month [ ] 1-6 months [ ] More than 12 months
Hospitalizations [ ] Yes [ ] No -------- [ ] Less than 1 month [ ] 1-6 months [ ] More than 12 months

If yes to any, list and describe ______________________________

- **Indicate if you use any of the following**

Alcohol [ ] Yes [ ] No Daily Amount ______________
Coffee [ ] Yes [ ] No Daily Amount ______________
Tobacco [ ] Yes [ ] No Daily Amount ______________
Drugs [ ] Yes [ ] No Daily Amount ______________
Soda [ ] Yes [ ] No Daily Amount ______________

- **Daily Activities**

Exercise Frequency ______________
Water intake per day ______________
Average sleep per night ______________

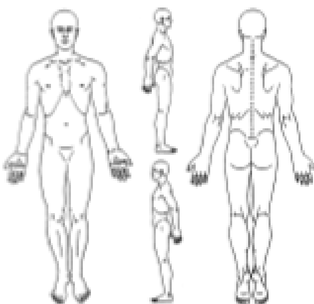
- **Please list all medications and supplements that you are currently taking**

____

____

OFFICE USE ONLY Dr. initials ________

POSTURE



ROM	Csp	Tsp	LB
Flex			
Ext			
Lrot			
Rrot			
LLF			
RLF			

MRS

Upper Extremities

Lower Extremities

ORTHOS

Jacks

Dist

Kemps

SLR

Other

LISTINGS

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Other therapies such as manual therapies, and rehabilitative exercise may be used if deemed necessary. These therapies may be used to decrease inflammation, increase vascular circulation, decrease pain and muscle spasms, improve tissue strength and flexibility. Risks of therapies have previously been explained above.

Iron Mountain Chiropractic, LLC (IMC) does not accept any form of health insurance, including Medicare. Your health insurance is a contract between you and your insurance company and you are expected to pay at the time a service is rendered. Upon request we will provide you with an itemized bill that you may submit to your health insurance company for reimbursement. IMC will not be held responsible if you are not reimbursed by your health insurance company.

We consider the privacy of your health information to be one of the most important elements in our relationship with you. Our responsibility to maintain the confidentiality of your health information is one that we take very seriously. Federal legislation concerning patient privacy requires health care providers, health insurance companies and other health related organizations to bolster their privacy as of April 14, 2003.

Signing below is our Acknowledgement Form and the Notice of Health Information Privacy Practices are offered at request. We are pleased to provide this information to our patients and to comply with the privacy regulations of the federal Health Insurance Portability Accountability Act (HIPAA).

Patient Name:______________________________ Signature:___________________________ Date:__________________

Parent or Guardian:__________________________ Signature:___________________________ Date:__________________

Witness Name:______________________________ Signature:___________________________ Date:__________________