Back in Action Chiropractic LLC

Patient Intake Form *PLEASE PRINT CLEARLY*

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our Patient Intake Form. Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

DATE _____

PERSONAL INFORMATION

FIRST NAME _____ MIDDLE_____

LAST NAME_____

GENDER ☐ Male ☐ Female

SOCIAL SECURITY # _____-____-_____

DATE OF BIRTH (MM/DD/YYYY) _____/_____/_____

HEIGHT _____ WEIGHT _____

MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

SPOUSE'S NAME _____

NUMBER OF CHILDREN _____

EMERGENCY CONTACT _____

RELATIONSHIP _____

PHONE (_____) _____-_____

CONTACT INFORMATION

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 (_____) _____-_____ PROVIDER _____

WORK PHONE (_____) _____-_____

ADDRESS _____

_____

CITY _____ STATE _____

ZIP _____

PRIMARY COMPLAINT INFORMATION

What is the purpose of your visit? ☐ Chronic Discomfort ☐ Consultation ☐ Injury ☐ New Condition ☐ Second Opinion

What is the reason for this visit? ☐ Auto accident (job related) ☐ Auto accident (personal) ☐ Chronic or acute pain ☐ Home injury ☐ Job-related (but not auto-related) ☐ Slip and fall (away from home) ☐ Sports injury ☐ Wellness ☐ OTHER _____

Date of scheduled appointment _____ When did this condition begin? _____

How long have you had this condition? ☐ 5 days or less ☐ More than 5 days but less than 30 days ☐ More than 30 days

What caused this condition? ☐ Of unknown origin ☐ After a fall ☐ After a long drive ☐ After a long flight ☐ After a poor night's sleep ☐After a slip ☐ After lifting an object ☐ After reaching or overarching ☐ After performing household chores ☐ After performing yard work ☐ After sitting in one place for too long ☐ Associated with prolonged or chronic illness ☐ OTHER

Where is the discomfort?

Head ☐ Front of head ☐ Right side of head ☐ Back of head ☐ Left side of head

Neck ☐ Front of neck ☐ Right side of neck ☐ Back of neck ☐ Left side of neck

Back ☐ Right mid back ☐ Central mid back ☐ Left mid back ☐ Right low back ☐ Central low back ☐ Left low back ☐ Upper back

Trunk ☐ Abdomen ☐ Back of ribs ☐ Chest ☐ Right side of ribs ☐ Front of ribs ☐ Left side of ribs

(Continued on next page)

Upper Extremity

☐ Front of right upper extremity ☐ Front of left upper extremity ☐ Rear of right upper extremity ☐ Rear of left upper extremity
☐ Front of right shoulder ☐ Front of left shoulder ☐ Rear of right shoulder ☐ Rear of left shoulder ☐ Front of right upper arm
☐ Front of left upper arm ☐ Rear of right upper arm ☐ Rear of left upper arm ☐ Front of right elbow ☐ Front of left elbow
☐Rear of right elbow ☐ Rear of left elbow ☐ Front of right wrist ☐ Front of left wrist ☐ Rear of right wrist ☐ Rear of left wrist
☐ Front of right hand ☐ Front of left hand ☐ Rear of right hand ☐ Rear of left hand

Lower Extremity

☐ Front of right lower leg ☐ Front of left lower leg ☐ Rear of right lower leg ☐ Rear of left lower leg ☐ Front of right hip
☐ Front of left hip ☐ Rear of right hip ☐ Rear of left hip ☐ Front of right thigh ☐ Front of right knee ☐ Rear of right thigh
☐ Rear of right knee ☐ Front of left thigh ☐ Front of left knee ☐ Rear of left thigh ☐ Rear of left knee ☐ Front of right leg
☐Front of right ankle ☐ Rear of right leg ☐ Rear of right ankle ☐ Front of left leg ☐ Front of left ankle ☐ Rear of left leg
☐ Rear of left ankle ☐ Top of right foot ☐ Top of left foot ☐ Bottom of right foot ☐ Bottom of left foot
☐ Right side of right foot ☐ Right side of left foot ☐ Left side of right foot ☐ Left side of left foot
☐ **Other**

Does the discomfort radiate/travel? ☐ Yes ☐ No

Describe the quality of the discomfort. Choose all that apply:
☐ Aching ☐ Annoying ☐ Burning ☐ Deep ☐ Diffuse ☐ Dull ☐ Heavy ☐ Intolerable ☐ Pulling ☐ Sharp ☐ Shock-like ☐ Shooting
☐ Stabbing ☐ Stiffness ☐ Throbbing ☐ Tightness ☐ Tingling ☐ 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

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? ☐ Employment ☐ Homemaking ☐ Lifting
☐ Personal care (washing, dressing, etc.) ☐ Sitting ☐ Sleeping ☐ Social life ☐ Standing ☐ Traveling and/or driving ☐ Walking

What aggravates this condition? Choose all that apply:
☐ Almost any movement☐ Athletic activity and/or exercise☐ Bathing ☐ Bending☐ Caring for family☐ Carrying☐ Changing positions
☐ Climbing stairs ☐ Computer use☐ Concentrating☐ Cooking☐ Coughing and/or sneezing☐Daily child or pet care☐ Driving☐ Eating
☐ Falling or staying asleep☐ Getting in or out of car☐ Getting out of bed☐ Getting up from lying down ☐ Getting up from sitting
☐ Grocery shopping
☐ Household chores☐ Lifting☐ Looking over shoulder☐ Love life☐ Lying down ☐ Pulling ☐ Pushing ☐ Reaching ☐ Reading
☐ Repetitive motions ☐ Resting ☐ Running ☐ Self care (dressing, bathing, etc.) ☐ Shaving ☐ Sitting ☐ Squatting☐ Standing ☐ Stress
☐ Stretching ☐ Talking on telephone ☐ Turning ☐ Twisting ☐ Unknown ☐ Walking ☐ Working ☐ Yard work ☐ OTHER

What improves this condition? Choose all that apply: ☐Nothing ☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs
☐ Massage ☐ Over-the-counter medications ☐ Physical Therapy ☐ Prescription medication ☐ Re-direct attention ☐ Rest
☐Stretching ☐ Work ☐ OTHER

What treatment have you received for this condition up to now? ☐None ☐ Acupuncture ☐ Chiropractic care ☐ Craniosacral therapy
☐ Homeopathic medicine ☐ Hypnosis ☐ Injection therapy ☐ Medical care ☐Naturopathic medicine ☐ Nutritional supplements
☐ Occupational therapy ☐ Osteopathic medicine ☐ Over-the-counter medications ☐ Physical therapy ☐ Prescribed medications
☐ Psychotherapy ☐ Reiki ☐ Surgery ☐ 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 ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself ☐ Driving a car ☐ Exercising
☐ Getting in or out of car
☐ Getting to sleep ☐ Grocery shopping ☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing ☐ Staying asleep
☐ Using a computer ☐ Walking ☐ Yard work ☐ OTHER

****** For additional complaints, please reprint pages 1-2 and fill them out accordingly. ******

REVIEW OF SYSTEMS

Musculoskeletal ☐ No additional musculoskeletal complaints ☐ Osteoporosis ☐ Back problems ☐ Arthritis ☐ Hip disorders ☐ Scoliosis
☐ Knee injuries ☐ Joint or muscle pains/stiffness ☐ Foot/ankle pain ☐ Cramping ☐ Shoulder problems ☐ Swelling, redness deformity of joint(s) ☐ Elbow/wrist pain ☐ Fractures ☐ Poor posture ☐ Implants, plates, pins or screws ☐ Gout ☐ Neck pain

Neurological ☐ No additional neurological complaints ☐ Anxiety and/or panic ☐ Pins and needles ☐ Depression ☐ Numbness ☐ Memory issues
☐ Loss of smell or taste ☐ Sleeping issues ☐ Temporary loss of vision ☐ Headache ☐ Difficulty concentrating ☐ Dizziness ☐ Stroke ☐ Weak muscles ☐ Epilepsy or seizures

Head, Eyes, Ears, Nose & Throat ☐ No complaints ☐ Headaches or migraines ☐ Dental problems ☐ Eye or vision problems ☐ Gum problems
☐ Eyeglasses or contact lenses ☐ TMJ problems ☐ Eye surgery ☐ Sore throat ☐ Cataracts ☐ Postnasal drip ☐ Glaucoma ☐ Swollen lymph nodes ☐ Nose congestion or sinus trouble ☐ Ear or hearing problems ☐ OTHER

Cardiovascular ☐ No cardiovascular complaints ☐ Chest pain or tightness ☐ Rheumatic fever ☐ Palpitations ☐ Leg pain upon walking
☐ Swollen legs or feet ☐ Blood clots ☐ High blood pressure ☐ Varicose veins ☐ Low blood pressure ☐ Dizziness ☐ High cholesterol or triglycerides ☐ Excessive bruising ☐ Heart attack ☐ Coronary artery disease ☐ Heart murmur ☐ Congenital heart defects ☐ OTHER

Respiratory ☐ No respiratory complaints ☐ Persistent cough ☐ Blood in sputum ☐ Wheezing ☐ Asthma ☐ Shortness of breath ☐ Apnea ☐ Snoring issues ☐ Emphysema ☐ Tuberculosis ☐ Hay fever ☐ Pneumonia ☐ OTHER

Gastrointestinal ☐ No gastrointestinal complaints ☐ Abdominal pain ☐ Black or bloody stool ☐ Nausea or vomiting ☐ Colon cancer or colon polyps
☐ Bloating ☐ Hemorrhoids ☐ Heartburn ☐ Food sensitivities ☐ Ulcer ☐ Constipation ☐ Difficulty swallowing ☐ Severe diarrhea ☐ Jaundice
☐ Irritable Bowel Syndrome ☐ Liver disease ☐ Crohn's disease ☐ Gallbladder problems ☐ Gastric reflux ☐ Pancreatitis ☐ Collitis ☐ Change in bowel habits ☐ OTHER

Genitourinary ☐ No genitourinary complaints ☐ Painful or frequent urination ☐ Sexual dysfunction ☐ Blood in urine ☐ Incontinence ☐ Kidney stones ☐ Urinary infections ☐ OTHER

Endocrine ☐ No endocrine complaints ☐ Feeling hot or cold all the time ☐ Hyperparathyroidism ☐ Thyroid problems ☐ Testosterone deficiency ☐ Diabetes ☐ Cushing's syndrome ☐ Increase urination ☐ Steroid treatments ☐ Excessive thirst ☐ Hyperthyroidism ☐ OTHER

Dermatological & Bleeding ☐ No skin or bleeding complaints ☐ Skin trouble or rashes ☐ Skin cancer ☐ Flushing ☐ Skin pigmentation issues
☐ Change in hair or nails ☐ Blood in stool ☐ Excessive acne ☐ Easy bruising ☐ Eczema ☐ Gum bleeding ☐ Psoriasis ☐ OTHER

EMPLOYMENT INFORMATION

Regular Work Status ☐ Employed ☐ Part-Time Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____ Occupation _____

Supervisor Name _____ Supervisor Phone (_____)_____-_____ Extension _____

Physical Work Duties

_____

What is the purpose of your visit? ☐ Wellness ☐ Complaint ☐ Injury ☐ Other

SOCIAL HISTORY & LIFE CHOICES

Alcohol
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Drinks & Products
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Diet Food Products
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Drugs
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Energy Products or Over-the-Counter Stimulants
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Exercise
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Fresh & Homemade Foods
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Preprocessed, Packaged, & Restaurant Food
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Soft Drinks
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Tobacco
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Water
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

CHIROPRACTIC EXPERIENCE

How did you hear about us? Choose all that apply.
☐ Advertisement ☐ Another Provider ☐ Attorney ☐ Community Event ☐ Employee ☐ Existing Patient ☐ Friend ☐ Internet ☐ Local Merchant ☐ Mailing ☐ Newspaper ☐ Phone Book/Yellow Pages ☐ Physician ☐ Provider Manual ☐ Sign ☐ Other _____

If you were referred by someone, please let us know their name.

REFERRING PHYSICIAN _____ REFERRING PATIENT _____

If you found out about our office from an advertisement, where did you see it? _____

If you found out about our office from a phone or professional directory, what was it? _____

Have you been adjusted by a chiropractor before? ☐ Yes ☐ No

If yes, 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

AUTHORIZATION

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office. 1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. 2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions. 3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office. 4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented. 5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them. 6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures. 7. If the patient refuses to sign this consent for the purposes of treatment, payment, and health care operations the chiropractic physician has the right to refuse to give care. I have and understand how my Patient Health Information will be used and I agree to these policies and procedures.

☐ **I agree with this statement of authorization.**

SIGNATURE _____ **DATE** _____