Adult New Patient Intake

Name _____ Age _____ Birth Date ____/____/_____

Soc. Sec. # _____-_____-_____ Home Phone _____Cell Phone _____

Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____ Email _____

Marital Status: M W D S Spouse's Name: _____ Children # and Ages: _____

Whom may we thank for referring you to our office? _____

Have you ever been to a chiropractor? YES / NO When was your last adjustment? _____

Do you have insurance you would like file? YES / NO Is this due to an auto or work related accident? YES / NO

Your Health Summary

Please ☑ all the symptoms you are currently experiencing, or have had in the past, even if they do not seem related to your current problem.

☐ Headaches/Migraines	☐ Leg/Foot pain	☐ Neck pain	☐ Frequent colds
☐ Shoulder/Arm pain	☐ Heartburn/Reflux	☐ Mid back pain	☐ Sinus problems
☐ Numbness/Tingling in arms	☐ Recurrent colds/Flu	☐ Sleeping problems	☐ Asthma/Wheezing
☐ Numbness/Tingling in legs	☐ Hearing disturbances	☐ Loss of smell	☐ Allergies
☐ Low Energy/Fatigue	☐ Low back pain	☐ Loss of taste	☐ Infertility
☐ Constipation/Diarrhea	☐ Sexual dysfunction	☐ Tension/Stress	☐ Dizziness
☐ Menstrual Irregularity	☐ Heart problems	☐ Upper back pain	☐ Fainting
☐ Frequent/Difficulty urinating	☐ TMJ/Pain/Clicking	☐ Depression	☐ Nausea

Other symptoms: _____

List any medications you are taking: _____

_____

This office conforms to the current HIPPA guidelines. You may request a copy of your HIPPA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____.

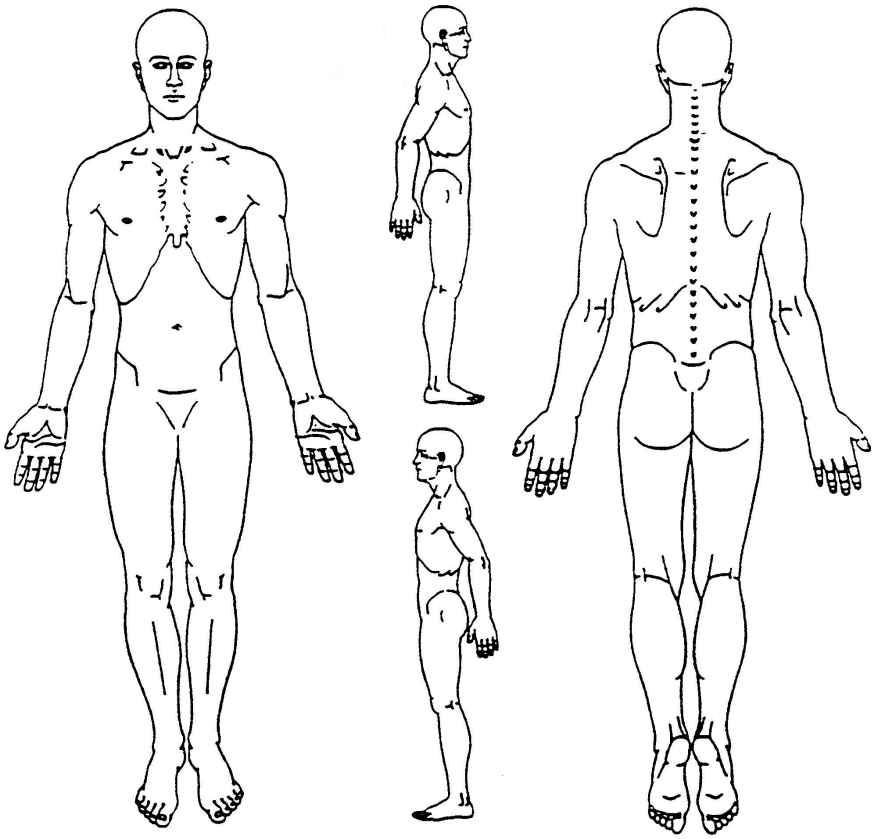
I understand that I am responsible for payment to Belrichard Family Chiropractic for services performed. If filing insurance; I authorize the release of any information necessary to process the claim, and that payment of medical benefits be made directly to Belrichard Family Chiropractic. I am responsible for payment should my insurance company deny payment, or make payment directly to me. By signing below you certify the accuracy of your medical history and further certify that you present to Belrichard Family Chiropractic for evaluation and treatment of a health related condition and for no other purpose.

Patient Signature _____ Date _____

PAIN DIAGRAM

Please draw the location of your pain or discomfort on the images below. Use the symbols show to represent the type(s) of pain you are experiencing.

D = Dull
B = Burning
N = Numb
S = Sharp/Stabbing
T = Tingling (pins & Needles)
C = Cramping



On the scale below, please draw a **X** on the line representing your pain or discomfort:

Rate the pain you have right **NOW**:

No Pain — Unbearable pain

Rate your pain at its **BEST** in the past week:

No Pain — Unbearable pain

Rate your **AVERAGE** pain in the past week:

No Pain — Unbearable pain

Rate your **WORSE** pain in the past week:

No Pain — Unbearable pain

Functional Rating Index

For use with Neck and/or Back Problems only.
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 one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

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

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

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

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

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

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 _____
PRINTED

_____ _____
Signature Date

FAMILY HEALTH HISTORY

Patient Name _____ Date _____

Please review the symptoms and conditions listed below, and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave the spaces that do not apply blank.

	Father Age____	**Mother** Age____	**Spouse** Age____	**Brother**(s) Age____ Age____		**Sister**(s) Age____ Age____		**Children** Age____ Age____ Age____		
First Name										
Condition										
Allergies										
Anxiety										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Gassy/Bloating										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Low Energy										
Migraine										
Neck Pain										
Nervousness										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Other:										
Other:										
Other:										

Informed Consent to Chiropractic Care

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health,the recommended care, and treatment to be provided. You can then make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed so that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation. The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. 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.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiological examination (x-rays). After that further treatments deemed necessary the the findings will be performed.

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, fractures, disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical 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.

Patient Name: _____ Signature: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____

Relationship to Patient: _____