PATIENT INTAKE FORM

DICKSON CHIROPRACTIC

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All answers are confidential.

PATIENT PROFILE

Name: _____ Nick Name: _____

Address: _____ Social Security # _____- ____- _____

City / State / Zip: _____ /_____ /_____ Date of Birth: _____ / _____ / _____

Email: _____ Age: _____

Occupation: _____ Gender: ☐ M ☐ F ☐ Unspecified

Company _____

Cell Phone: _____- _____- _____ Home: _____- _____- _____ Work: _____- _____- _____

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Other

Employment Status

- ☐ Employed
- ☐ Full Time Student
- ☐ Part Time Student
- ☐ Retired

Race / Ethnicity

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Hispanic or Latino
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other: _____

Dominant Hand

- ☐ Left
- ☐ Right
- ☐ Both

Do you currently take medications? ☐ Y ☐ N

1. _____
2. _____
3. _____
4. _____
5. _____

Please provide list if taking more than 5.

Have any known allergies to meds? ☐ Y ☐ N

1. _____
2. _____
3. _____
4. _____
5. _____

WHAT BRINGS YOU IN TODAY?

DICKSON CHIROPRACTIC

☐ No symptoms. I'm here for wellness.

List most important problem / symptom first.

1. _____ 2. _____

Frequency of main problem

- ☐ Occasional 0-25%
- ☐ Intermittent 26-50%
- ☐ Frequent 51-75%
- ☐ Constant 76-100%

Quality of Pain

- ☐ Dull ache
- ☐ Sharp
- ☐ Burning
- ☐ Stiffness
- ☐ Numb / Tingling
- ☐ Radiates

Have you seen other doctors for this problem? ☐ Y ☐ N

If yes, what treatment was received and did it help?

_____

Have you seen a chiropractor before? ☐ Y ☐ N

If yes, when & where? _____

_____

	Feels better	Feels worse	No change	Don't know
In the morning	☐	☐	☐	x
By mid-day	☐	☐	☐	x
By evening	☐	☐	☐	x
At night	☐	☐	☐	x
Sitting	☐	☐	☐	x
Driving	☐	☐	☐	x
Standing	☐	☐	☐	x
Bending	☐	☐	☐	x
Lifting	☐	☐	☐	x
Walking / Moving	☐	☐	☐	x
Lying down	☐	☐	☐	x
Sleeping	☐	☐	☐	x
Work activities	☐	☐	☐	x
Coughing	☐	☐	☐	x
Rest	☐	☐	☐	x
Stress	☐	☐	☐	x
Fatigue	☐	☐	☐	x
Household chores	☐	☐	☐	x
Stretching	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Heat	☐	☐	☐	☐
Ice	☐	☐	☐	☐
Medication	☐	☐	☐	☐
Chiro treatment	☐	☐	☐	☐
Massage	☐	☐	☐	☐

SURGICAL HISTORY

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____
4. _____ Year _____
5. _____ Year _____

Please provide list if more than 5

LIFESTYLE

	Often	Occasional	Never
Caffeine Used	☐	☐	☐
Exercise	☐	☐	☐
Alcohol	☐	☐	☐
Tobacco	☐	☐	☐
Feel Stressed	☐	☐	☐

Performed by clinic staff:

Height _____ ' _____ "

Weight _____ pounds

BMI _____

DICKSON CHIROPRACTIC

Cardiovascular
- [ ] Blood Pressure
- [ ] Cholesterol
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] Stroke
- [ ] Pacemaker
- [ ] Congestive Heart Failure
- [ ] Irregular Heartbeat

Respiratory
- [ ] Asthma
- [ ] Pneumonia
- [ ] Sleep Apnea
- [ ] COPD
- [ ] Emphysema
- [ ] Chronic Cough
- [ ] Tuberculosis

Neurological
- [ ] Seizures
- [ ] Head Injury
- [ ] Multiple Sclerosis
- [ ] Autism
- [ ] Memory Loss
- [ ] Headache / Migraine
- [ ] Parkinson's
- [ ] Carpal Tunnel
- [ ] Loss of Balance
- [ ] Dizziness

Constitutional
- [ ] Weight Loss / Gain
- [ ] Energy Problem
- [ ] Difficulty Sleeping

Ear / Nose / Throat
- [ ] Hearing Loss
- [ ] Ringing
- [ ] Chronic Sinus
- [ ] Frequent Ear Infections

Gastrointestinal
- [ ] Gall Bladder
- [ ] Crohn's Disease
- [ ] Constipation
- [ ] Ulcers
- [ ] Reflux
- [ ] Diarrhea
- [ ] Nausea / Vomiting
- [ ] Poor Appetite
- [ ] Diverticulitis

Allergy / Immunity
- [ ] Hives
- [ ] HIV / AIDS
- [ ] Allergy Shots
- [ ] Chronic Allergies

Allergies
- [ ] Eggs
- [ ] Shellfish
- [ ] Milk / Lactose
- [ ] Peanuts
- [ ] Soy
- [ ] Pets
- [ ] Sulfa
- [ ] Wheat / Gluten
- [ ] Codeine
- [ ] Chemical
- [ ] Seasonal
- [ ] Latex
- [ ] Other:
- [ ] Other:

Genitourinary
- [ ] Frequent Urination
- [ ] Kidney Stones
- [ ] Prostate
- [ ] Frequent Infection
- [ ] Kidney Disease

Eyes
- [ ] Glaucoma
- [ ] Cataracts
- [ ] Double Vision
- [ ] Blindness
- [ ] Detached Retina

Endocrine
- [ ] Thyroid
- [ ] Diabetes
- [ ] Menopause
- [ ] Menstrual Problems

Blood / Lymph
- [ ] Easy Bleeding
- [ ] Easy Bruising
- [ ] Leukemia
- [ ] Blood Clots
- [ ] Hepatitis

Skin
- [ ] Eczema
- [ ] Psoriasis
- [ ] Rashes
- [ ] Shingles

Musculoskeletal
- [ ] Gout
- [ ] Arthritis
- [ ] Joint Stiffness
- [ ] Muscle Weakness
- [ ] Osteoporosis

Psychiatric
- [ ] Depression
- [ ] Anxiety
- [ ] Unusual Stress
- [ ] Bi-Polar Disorder

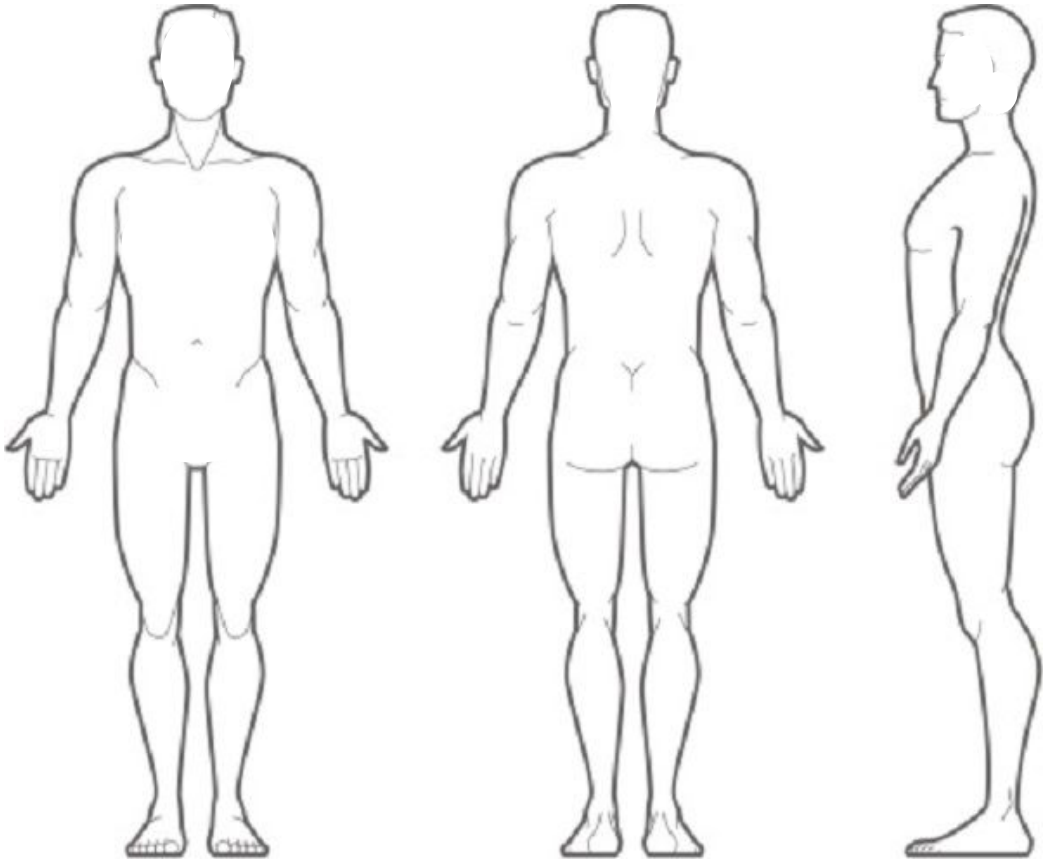
- [ ] None of these symptoms apply to my past health history.

VISUAL ANALOG PAIN SEVERITY SCALE

DICKSON CHIROPRACTIC

Please mark areas where you feel the described sensations including where your symptoms travel.

Aching >>>>>>
Numbness - - - - - - -
Pins / Needles OOOOOO
Burning XXXXXX
Stabbing /////////



1. What is your pain right now?

No Pain — Severe Pain
0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or average pain?

No Pain — Severe Pain
0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level on a “good day”?

No Pain — Severe Pain
0 1 2 3 4 5 6 7 8 9 10

4. What percentage of your day is your pain minimal? _____%

5. What is your pain level on a “bad day”?

No Pain — Severe Pain
0 1 2 3 4 5 6 7 8 9 10

6. What percentage of your day is your pain at its worst? _____%

_____ _____ ____ /____ /____
Print Name Signature Date

DICKSON CHIROPRACTIC

FAMILY HEALTH HISTORY

C = Current Health Problem

P = Past Health Problem

	Father		Mother		Spouse		Brother(s)		Sister(s)		Children	
	C	**P**	**C**	**P**	**C**	**P**	**C**	**P**	**C**	**P**	**C**	**P**
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Auto Accident	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Back Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Disc Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Freq Cold / Flu	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Headache / Migraine	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heartburn	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Trouble	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sinus Trouble	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleeping Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ None of these symptoms apply to my past health history.

OFFICE POLICIES

DICKSON CHIROPRACTIC

INFORMED CONSENT

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, in rare cases, complications such as sprain / strain injuries, irritation of a disc condition, and although rare minor fractures, and possible stroke have been associated with chiropractic adjustments.

Initial here _____

X-RAY CONSENT

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays examination if the doctor has deemed necessary in my case.

Initial here _____

FINANCIAL POLICY

All services rendered are the responsibility of the patient and said patient is ultimately responsible for all payment on services regardless of whether or not this office accepts insurance assignment. Our office will prequalify your insurance coverage. We will give you the best estimate of your coverage for the recommended services. This is not a guarantee of benefits. Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero. Any expenses incurred by this office (collections, court fees, etc.) in the effort to obtain payment on unpaid accounts past 90 days will be added to your balance.

Initial here _____

NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the current Notice of Privacy Practices for this health care facility. It describes your rights to the limited use of protected health information, including your demographic information.

You have the right to request a restriction or disclosure on the use of your PHI (Protected Health Information). This office may or may not agree to your request.

This office utilizes open or common areas for treatment, however, private areas are available upon request. You may refuse to sign this acknowledgement and authorization and revoke this consent to use PHI. This must be done in writing.

Initial here _____

I authorize contact from this office to confirm my appointments, treatment, and billing information by way of:

- ☐ Cell Phone
- ☐ Text
- ☐ Home Phone
- ☐ Email
- ☐ All of the above

_____
Patient Name

_____
Patient or Authorized person's Signature

_____ /_____ /_____
Date

_____
Witness