HLC Chiropractic New Patient Intake Form

Legal Name:____Today's Date:____________________

Nick Name:_________________________Email Address: _______________________________________

Address: ____City/State/Zip______________________

Home Phone:______________________ Work :__________________Cell:_________________________

How would you prefer to receive your appointment reminders ? ❑ Email ❑ Text ❑ Both

Sex: ❑ Male ❑ Female Date of Birth: ____________________

Employment Status: ❑ Employed ❑ Full-time student ❑ Part-time student ❑ Retired ❑ Child

Employer:_______________________________________ Occupation:____________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Other Spouse/Partner Name: _______________

Children: Names and ages ____

How did you hear about our office?

❑ Referral: Name of person that referred you: ____

❑ Website ❑ Google ❑ Facebook ❑ Instagram ❑ Yelp ❑ YouTube ❑ Home Show ❑ Health Fair

❑ Advertisement ❑ Other ____

Health Concerns and Symptoms
❑ I am looking for treatment for symptoms ❑ I am seeking out care to improve my health

Describe any symptoms or health concerns that you are seeking treatment for. ____________________

1°____

2°____

3°____

HLC Chiropractic New Patient Intake Form

Provider:____Date/Time:______________
Name:____Date:___________________

When did your symptoms begin?   1°_______________2°_______________3°________________

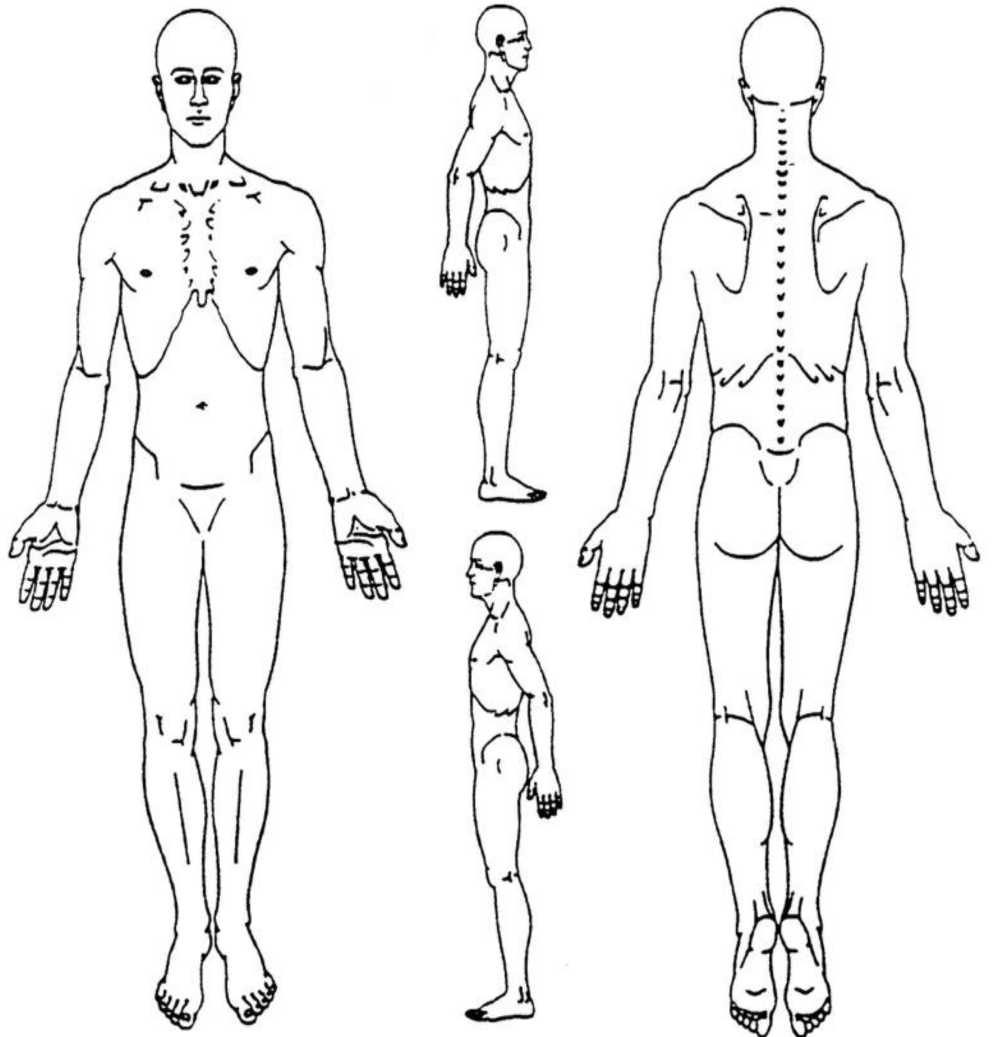
Have you received any advice or treatment for this health concern? ❑ Yes ❑ No

If yes, please describe: ____

____

Please use the key below to show any symptoms that concern you on the symptom diagram.

Symptom	Symbol
Pain	PPP
Numbness	NNN
Tingling	TTT
Burning	BBB
Weakness	WWW
Cramping	CCC



Provider:____Date/Time:____________
Name: ____ Date: _____________________

QUADRUPLE VISUAL ANALOGUE SCALE

Please read instructions carefully. Circle the number that best describes the question being asked. Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache (2) **Neck** (5) **Low Back** (8)

No Pain **0 1 (2) 3 4 (5) 6 7 (8) 9 10** **Worst Pain Possible**

1- What is your pain RIGHT NOW?

No Pain **0 1 2 3 4 5 6 7 8 9 10** **Worst Pain Possible**

2- What is your TYPICAL or AVERAGE pain?

No Pain **0 1 2 3 4 5 6 7 8 9 10** **Worst Pain Possible**

3- What is your pain level AT ITS BEST? (How close to "0" does it get at its best)?

No Pain **0 1 2 3 4 5 6 7 8 9 10** **Worst Pain Possible**

4- What is your pain level AT ITS WORST (How close to "10" does it get at its worst)?

No Pain **0 1 2 3 4 5 6 7 8 9 10** **Worst Pain Possible**

Comments:____

____

Patient Signature:____Date:_____________________
Provider:____Date/Time:________________

Name: ____ Date: _______________________

If this concern/symptom were to go away tomorrow, what would be different about your life?

____

On a scale of 1(worst) to 10 (best), how would you rate your overall health today? ______________

On a scale of 1 to 10, where would you like your health to be? ______________

How long do you think it would take for you to get there? ______________

On a scale of 1 to 10, how important is your health to you? ______________

TRAUMA, MEDICAL, CHIROPRACTIC, HEALTH AND HEALING HISTORY

Have you ever injured your ❑ Head ❑ Neck ❑ Upper Back ❑ Mid-Back ❑ Low Back ❑ Upper Limb ❑ Lower Limb?

Describe any injuries: ____

____

____

____

Have you had ❑ X-Rays ❑ CAT scans ❑ MRI of your spine, neck, or head?

Where and when were they taken? ____

Where there any significant results? ____

Have you ever been ❑ Knocked Unconscious ❑ Broken a Bone ❑ Sprained a Joint ❑ Been in an Automobile Accident ❑ Had a Work Related Injury ❑ Had a Surgery ❑ Been Hospitalized.?

Please Explain ____

____

Provider:____Date/Time:________________
Name: ____ Date: ______________________

List any medications (prescription and non-prescription) that you take currently or have taken in the past 60 days and the reason for taking them. ____

____

____

Have you been treated by any other chiropractors? ❑ Yes ❑ No
If yes, by whom _____________________________ When?________________________________

Why did you go? ____________________________ For how long?___________________________

Where you pleased with the results?____

Does your family receive chiropractic care?____

Which of the following health modalities have you used?
❑ Massage ❑ Yoga ❑ Meditation ❑ Breath Work ❑ Acupuncture ❑ Physical Therapy
❑ Counseling/Psychotherapy ❑ Other ____

LIFESTYLE AND STRESS SURVEY

Was there anything unusual or traumatic about your birth? ❑ Yes ❑ No
If yes, please explain. ____

Was your delivery ❑ C-section ❑ drug-induced ❑ forceps/suction ❑ home birth?
Were you ❑ incubated or ❑ isolated after birth ❑ I don’t know?

Did your mother ❑ smoke ❑ drink alcohol ❑ take medication ❑ prior to ❑ during her pregnancy
❑ I don’t know?

Provider:____Date/Time:_______________
Name: ____ Date: ______________________

What activities do you perform for a prolonged period of time? ❑ Sit in a lounge chair ❑ Stand
❑ Walk ❑ Sit at a desk ❑ Computer Work ❑ Heavy Lifting ❑ Repetitive activity ❑ Telephone work
❑ Drive ❑ Assembly Line ❑ Play a Musical Instrument? _____________________________________

Do you exercise regularly? ❑ Yes ❑ No If yes, what type and how often_______________________

Have you ever played a sport? ❑ Yes ❑ No If yes, what sport? ______________________________

Do you have any injuries related to these activities? ❑ Yes ❑ No If yes, please explain. ___________

____

Do you have trouble getting to sleep? ❑ Yes ❑ No Staying asleep ❑ Yes ❑ No

SOCIAL HISTORY (Check all that apply to you)

Caffeine use:	❑ Occasional	❑ Often	❑ Never
Drink alcohol :	❑ Occasional	❑ Often	❑ Never
Chew Tobacco:	❑ Occasional	❑ Often	❑ Never
Smoke:	❑ Occasional	❑ Often	❑ Never

Other: ____

FAMILY HISTORY (Check all that apply)

Arthritis:	❑ Parent	❑ Sibling	❑ Grandparent
Cancer:	❑ Parent	❑ Sibling	❑ Grandparent
Diabetes:	❑ Parent	❑ Sibling	❑ Grandparent
Heart Disease:	❑ Parent	❑ Sibling	❑ Grandparent
Hypertension:	❑ Parent	❑ Sibling	❑ Grandparent
Stroke:	❑ Parent	❑ Sibling	❑ Grandparent
Thyroid:	❑ Parent	❑ Sibling	❑ Grandparent

Other:____

REVIEW OF SYSTEMS

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past

CONSTITUTIONAL

- ❑ Deny All
- ❑ Chills
- ❑ Drowsiness
- ❑ Fainting
- ❑ Fatigue
- ❑ Fever
- ❑ Night Sweats
- ❑ Weakness
- ❑ Weight Gain
- ❑ Weight Loss

INTEGUMENTARY

- ❑ Deny All
- ❑ Breast Lumps/Pain
- ❑ Change in Nail Texture
- ❑ Change in Skin Color
- ❑ Eczema
- ❑ Hair Growth
- ❑ Hair Loss
- ❑ Hives
- ❑ Itching
- ❑ Numbness
- ❑ Psoriasis
- ❑ Rash
- ❑ Skin Lesions
- ❑ Tingling

ENMT

- ❑ Deny All
- ❑ Bad Breath
- ❑ Dentures
- ❑ Deviated Septum
- ❑ Difficulty Swallowing
- ❑ Discharge
- ❑ Dry Mouth
- ❑ Ear Drainage
- ❑ Ear Pain
- ❑ Frequent Sore Throats
- ❑ Head Injury
- ❑ Hearing Loss
- ❑ Hoarseness
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Nasal Congestion
- ❑ Nose Bleeds
- ❑ Post Nasal Drip
- ❑ Sinus Infections
- ❑ Runny Nose
- ❑ Ringing in Ears
- ❑ TMJ Problems
- ❑ Ulcers in Mouth

MUSCULOSKELETAL

- ❑ Deny All
- ❑ Arthritis
- ❑ Gout
- ❑ Injuries
- ❑ Joint Pain
- ❑ Joint Stiffness
- ❑ Loss of Motion
- ❑ Locking Joints
- ❑ Low Back Pain
- ❑ Mid-Back Pain
- ❑ Muscle Cramps
- ❑ Muscle Pain
- ❑ Muscle Twitching
- ❑ Muscle Weakness
- ❑ Neck Pain
- ❑ Swelling

GASTROINTESTINAL

- ❑ Deny All
- ❑ Abdominal Pain
- ❑ Abdominal Tenderness
- ❑ Belching
- ❑ Black, Tarry Stools
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Jaundice
- ❑ Nausea
- ❑ Rectal Bleeding
- ❑ Stool Changes
- ❑ Vomiting
- ❑ Vomiting Blood

GENITOURINARY

- ❑ Deny All
- ❑ Birth Control
- ❑ Burning on Urination
- ❑ Cramps
- ❑ Erectile Dysfunction
- ❑ Frequent Urination
- ❑ Hesitancy/Dribbling
- ❑ Hormone Therapy
- ❑ Irregular Menstruation
- ❑ Kidney Disease
- ❑ Kidney/Bladder Stones
- ❑ Lack of Bladder Control
- ❑ Prostate Problems
- ❑ Urine Retention
- ❑ Vaginal Bleeding
- ❑ Vaginal Discharge

CARDIOVASCULAR

- ❑ Deny All
- ❑ Angina
- ❑ Chest Pain
- ❑ Chest Tightness
- ❑ Claudication
- ❑ Heart Abnormalities
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Orthopnea
- ❑ Palpitations
- ❑ Shortness of Breath
- ❑ Swelling of Legs
- ❑ Varicose Veins

RESPIRATORY

- ❑ Deny All
- ❑ Asthma
- ❑ Bronchitis
- ❑ COPD
- ❑ Coughing up Blood
- ❑ Difficulty Breathing
- ❑ Dry Cough
- ❑ Pneumonia
- ❑ Productive Cough
- ❑ Reactive Airways
- ❑ Wheezing

EYES

- ❑ Deny All
- ❑ Blindness
- ❑ Blurred Vision
- ❑ Cataracts
- ❑ Change in Vision
- ❑ Colorblindness
- ❑ Detachment of Retina
- ❑ Detachment of Vitreous
- ❑ Double Vision
- ❑ Dry Eyes
- ❑ Eye Pain
- ❑ Eye Strain
- ❑ Far Sightedness
- ❑ Glaucoma
- ❑ Near Sightedness
- ❑ Loss of Central Vision
- ❑ Loss of Peripheral Vision
- ❑ Sensitivity to Light
- ❑ Tearing

NEUROLOGICAL

- ❑ Deny All
- ❑ Change in Concentration
- ❑ Change in Memory
- ❑ Convulsions
- ❑ Dizziness
- ❑ Headache
- ❑ Imbalance
- ❑ Loss of Consciousness
- ❑ Loss of Memory
- ❑ Numbness
- ❑ Seizures
- ❑ Sleep Disturbance Stress
- ❑ Strokes Tremors

PSYCHIATRIC

- ❑ Deny All
- ❑ Agitation
- ❑ Anxiety
- ❑ Behavioral Changes
- ❑ Bipolar Disorder
- ❑ Confusion
- ❑ Depression
- ❑ Eating Disorder
- ❑ Homicidal Thoughts
- ❑ Insomnia
- ❑ Location Disorientation
- ❑ Substance Abuse
- ❑ Suicidal Thoughts
- ❑ Time Disorientation

ENDOCRINE

- ❑ Deny All
- ❑ Cold Intolerance
- ❑ Diabetes
- ❑ Excessive Hunger
- ❑ Excessive Thirst
- ❑ Goiter
- ❑ Hair Loss
- ❑ Heat Intolerance
- ❑ Unusual Hair Growth
- ❑ Voice Changes

BLOOD/LYMPH/IMMUNE

- ❑ Deny All
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Bleeding
- ❑ Blood Clotting
- ❑ Blood Transfusions
- ❑ Bruise Easily
- ❑ Itchy Eyes
- ❑ Lymph Node Swelling
- ❑ Sneezing
- ❑ Food Allergy/Intolerance

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialists of chiropractic, osteopathy, and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures depends on environment, underlying causes, and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of a Vertebral Subluxation Complex (VSC). When such vertebral subluxation complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal neural integrity. It is the chiropractic premise that spinal alignment allows nerve transmission to express efficiently throughout the body and gives the body the best opportunity to express its inherent recuperative powers. Due to complexities of nature, no doctor can promise you specific results. This depends upon many other variables

INFORMED CONSENT

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if they are aware that such care may be contraindicated. Again, it is the responsibility of the patient to make known or to learn through health care procedures whatever he/she is suffering from: latent pathologic defects, illnesses or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to correct specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

We like to advise our patients with neck problems of the following: There are been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists, and chiropractors. The risk of stroke after cervical adjustment is very low at approximately 0.00025%. To put this into perspective, the risk of stroke in the general population 0.00057% and the risk of death from taking aspirin and other anti-inflammatory drugs is 0.04%. In other words, spinal adjusting is 1000x safer. Tests will be performed on you to minimize this risk and an appropriate adjustment technique will be applied. Chiropractic care is considered to be one of the safest and most effective forms of are.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of vertebral subluxation complex. Since there are so many variables, it is difficult to predict the time schedule efficacy of chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care.

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TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy. I have read and understand the foregoing.

Patient Name: ___________________________ Signature: _______________________ Date:____________________
Parent or Guardian: ______________________ Signature:________________________ Date: ___________________
Witness Name: __________________________ Signature:_______________________ Date:____________________

INSURANCE INFORMATION FORM ❑ New Patient ❑ Returning Patient

Legal Name:____Today's Date:____________

Referring Doctor: __________________________Primary Care Doctor______________________

Primary Insurance: ____

Is patient: ❑ Self ❑ Spouse ❑ Child ❑ Other _________________________________

Insured's Name: (If other than self) ____

Insured's DOB: ____________________

Co-pay or Coinsurance for Chiropractic: ________________________

Yearly Deductible: _____________________________

Secondary Insurance: ____

Insured's Name: (If other than self) ❑ Same as Primary ______________________________

Insured's DOB: ❑ Same as Primary ____

RELEASE FORM

I authorize HEALTHY LIFE CENTER to submit requests for fee reimbursement to the above name insurance company for any and all services provided to the above name patient by, HEALTHY LIFE CENTER, and release whatever patient information may be necessary for the submission of such requests. My Health insurance is a contract between me and my insurance. Any amount not paid by my insurance is my responsibility.

To protect your privacy, a consent form signed by the patient is necessary prior to sending information to anyone not listed herein.

Your records are held in strict confidence by HEALTHY LIFE CENTER. Privacy is your right and our duty.

I have read, understood, and agree with the above policy

Patient Signature: ____ Date:_____________________