

# Intake Form –

# Health and Fitness Chiropractic PS.

## Box 1

Patient #: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Referred by: \_\_\_\_\_ Cell #: \_\_\_\_\_

Is this for the whole family? family \_\_\_\_\_ : self: \_\_\_\_\_

Primary reason for consulting our office: \_\_\_\_\_ How Long? \_\_\_\_\_

Seen other Chiropractors: **n y** Who: \_\_\_\_\_ #of visits: \_\_\_\_\_Spinal X-rays in last year: **n y** Location of x-rays: \_\_\_\_\_

Name of MD: \_\_\_\_\_ Others seen for this condition: \_\_\_\_\_

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

## Box 2

### GENERAL INFORMATION

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ M / F Driver License # \_\_\_\_\_

SS#: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

E-Mail \_\_\_\_\_ Emergency Contact Name: \_\_\_\_\_ PH: \_\_\_\_\_

Do you have insurance: **n y** Insurance company: \_\_\_\_\_

Ins #: \_\_\_\_\_ Group #: \_\_\_\_\_

Spouses Name: \_\_\_\_\_ Insured DOB: \_\_\_/\_\_\_/\_\_\_

## Box 3

### VISITS SCHEDULED

Visit 1: \_\_\_\_\_ Time: \_\_\_\_\_ Visit 2: \_\_\_\_\_ Time: \_\_\_\_\_ Visit 3: \_\_\_\_\_ Time: \_\_\_\_\_

## Box 4

### AGREEMENTS

Office fees 1st visit/exam **\$100.00** Minimum office visit **\$50.00** Re-exams **\$80.00**X-ray fees range from **\$60.00** to **\$300.00**(depending on the number taken)

#### Informed consent to chiropractic care.

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures and if necessary diagnostic x-rays on me by the doctor of chiropractic at the above named office and/or anyone authorized by the same office. I further understand and am informed that, assign all health care, there are some slight risks to treatment and do not expect the doctor to be able to anticipate or explain all risks and combinations; and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the Facts then known, is in my best interest. I have read this consent and intend this consent form to Cover the entire course of my care for this condition and any care in the future.

Signature: \_\_\_\_\_

Print: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**Over 70%** of our patients bring in their child to get adjusted. If you would like to have your child and or spouse checked for subluxations check the box below, and they can receive a complimentary new patient exam if scheduled in 2 weeks of your starting care. This exam is at no cost to you and does not obligate them to receive future care. We have several convenient and affordable family plan payment options should family members decide to receive care.

 **I would like my family member to be checked for subluxation in the next 2 weeks!!**

## Box 5

### For Office Use Only

Work: (focus, production, time loss) \_\_\_\_\_

Relationships: (spouse, kids, fellow workers) \_\_\_\_\_

Play: ( What they love to do and anger) \_\_\_\_\_

Everyday: (shopping, watching TV, sleeping) \_\_\_\_\_

Level of challenge:

1 \_\_\_\_\_ 5 \_\_\_\_\_ 10

Short term goal: \_\_\_\_\_ Long term goal: \_\_\_\_\_

## Box 1

## Begin Here

### Family History

Health challenges always involve life style choices. Most challenges begin early in life (sometimes before birth) and accumulate without any signs or symptoms until permanent damage has been done.

This history is divided into 4 parts. (check if applies)

1. Your personal history
2. Your spouse's history
3. Your children's history
4. Your family's current health attitudes

## Box 2

## Your Personal Family History (blood relatives only)

loss of energy  recurrent complaints  misses work  takes medicines   
plays sports  overweight  underweight  irritable  mood swings  headaches  loss of  
sleep  under stress  any accidents  surgery  cancer  TB  scoliosis  diabetes   
nervous disorders  stroke  high blood pressure  heart problems  osteoporosis   
Other challenges or medications: \_\_\_\_\_

## Box 3

## Your Spouse's Personal Family History

Any history of: loss of energy  recurrent complaints  misses work  takes medicines   
plays sports  overweight  underweight  irritable  mood swings  headaches  loss of  
sleep  under stress  any accidents  surgery  cancer  TB  scoliosis  diabetes   
nervous disorders  stroke  high blood pressure  heart problems  osteoporosis

### Personal Health Profile

lost consciousness  low energy  recurrent complaints  misses work  any medicines   
plays sports  overweight  underweight  irritable  mood swings  headaches  loss of  
sleep  under stress  any accidents  surgery  cancer  TB  scoliosis  diabetes   
nervous disorders  stroke  high blood pressure  heart problems  osteoporosis   
Other challenges or medications: \_\_\_\_\_

## Box 4 Name: \_\_\_\_\_ Children's History Age: \_\_\_\_\_

difficult birth  eating disorder  vaccine reaction  on aspirin, Tylenol, Advil   
overactive  on Ritalin  fatigued  falls  miss school  asthma  daydreamer   
ear infections  under stress  recurrent infections  plays sports  irritable  anger   
weight problem  lost consciousness  surgery  allergies  mood swings  frequent colds   
Other challenges or medications: \_\_\_\_\_

## Box 5

## Your Family Health Attitudes:

Do you now buy or have you ever bought:

bottled water  yes  no vitamins  yes  no supplements  yes  no  
health magazines  yes  no health club membership  yes  no

Have you ever:

had your children checked for scoliosis  yes  no  
had your nervous system checked for function level  yes  no  
had your teeth checked regularly  yes  no been a runner  yes  no  
been massaged  yes  no worried about your diet  yes  no  
felt you were under stress  yes  no been concerned about your immune system  yes  no  
been concerned about your children's immune system  yes  no

**Name:** \_\_\_\_\_ **Children's History** **Age:** \_\_\_\_\_  
difficult birth  eating disorder  vaccine reaction  on aspirin, Tylenol, Advil   
overactive  on Ritalin  fatigued  falls  miss school  asthma  daydreamer   
ear infections  under stress  recurrent infections  plays sports  irritable  anger   
weight problem  lost consciousness  surgery  allergies  mood swings  frequent colds   
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weight problem  lost consciousness  surgery  allergies  mood swings  frequent colds   
Other challenges or medications: \_\_\_\_\_

# Your Life Review –

*Health and Fitness Chiropractic Inc.*

## Box 1

### Begin Here

If you have enjoyed regular chiropractic wellness care (weekly), please go to box 2.

If this is for pain based care, please go to box 3 and complete the information questionnaire.

## Box 2

### Welcome to our Office

If you have already experienced the tremendous benefits of regular Chiropractic adjustments and wish to continue the chiropractic wellness experience, welcome to our office and together let's keep the world healthy.

GO TO BOX 4.

## Box 3

### Current Health Challenge Information

Describe the pain: sharp  dull  travels  constant

Since the onset is the pain: worse  better  the same  on & off

Is there anything that makes it worse: standing  sitting  lying  motion

Are any of your systems involved: digestive  cardiovascular  respiratory   
elimination  reproductive

Does the pain cause you to: lose sleep  be short tempered  miss work   
miss play  lose focus

Any other facts about your current problem or pain: \_\_\_\_\_

Please check all your warning signs even if not seemingly related to your complaint.

1

- frequent colds  anxiety
- cold hands/feet  ulcers
- bowel problems
- restless sleep
- nervousness
- high BP  tight muscles
- accelerated aging
- heart palpitations
- poor expressions of emotions

2

- ADD  hypoglycemia
- poor concentration
- cognitive worry
- irritability  impulsivity
- distraction  low energy
- disorganization
- incontinence
- muddledness
- poor awakening
- low pain threshold

3

- headaches  seizures
- narcolepsy  PMS
- sleep walking
- hot flashes
- allergies
- bi polar disorders
- eating disorders
- bed wetting
- mood swings
- panic attacks

4

- fevers  fatigue
- MS
- Epstein-Barr syndrome
- Fibromyalgia
- depression
- Rheumatoid arthritis
- Chronic fatigue syndrome
- Auto-immune system disorders

List current medications: \_\_\_\_\_

## Box 4

### Injury History

Hospital birth: yes  no  Play any sports? yes  no  What sports: \_\_\_\_\_

Ever broken a bone? \_\_\_\_\_ Did you: fall as a child yes  no  Ever been knocked out. yes  no

Ever been in any motor vehicle accidents? (please note type and year, even if not apparently injured)

Any surgeries? \_\_\_\_\_

## Box 5

### Agreements

The statements made on this form are accurate, to the best of my recollection, and I agree to allow this office to do an examination of me for further evaluation.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_