MISSION -CHIROPRACTIC & WELLNESS-

1580 King Ave., Suite 204
Columbus, OH 43212
info@getmissionchiropractic.com
www.getmissionchiropractic.com

ADULT INTAKE FORM

PATIENT INFORMATION

First: ________________________________MI ________ Last:___________________________ DOB _____/______/______ Sex: M / F

Address:____City______________________________State:________Zip:____________

Email: ____ Home Phone: ____

Cell Phone: _________________________Cell Provider:__________________________ □Yes! I want to opt in for text reminders

Occupation: ____ Employer:____

Marital Status: □ Single □ Married □ Divorced □ Widowed Spouses Name:_______________________________

Do you have children? □YES □NO If yes, please list names/ages:____

How did you hear about us? □ Screening/Event □ Online Search □ Social Media □ Referral :________________________

List The Health Concerns That Brought You Into This Office

Health Concern (list according to severity)	Rate Severity 0= no pain – 10=unbearable	When did this problem begin?	Have you had this condition in the past?	Did problem begin with injury?	Are problems constant or intermittent?
1.			□Yes □ No	□Yes □ No	□Constant □ Intermittent
2.			□Yes □ No	□Yes □ No	□Constant □ Intermittent
3.			□Yes □ No	□Yes □ No	□Constant □ Intermittent
4.			□Yes □ No	□Yes □ No	□Constant □ Intermittent
5.			□Yes □ No	□Yes □ No	□Constant □ Intermittent

*PLEASE MARK **"P"** FOR **PREVIOUS** HEALTH CONCERNS or MARK **"C"** FOR **CURRENT** HEALTH CONCERNS:

____ADD/ADHD
____Allergies
____Anxiety
____Arm Pain
____Asthma
____Back Pain - Low
____Back Pain - Mid
____Back Pain – Upper
____Bladder Disorders
____Chest Pain
____Chronic Fatigue
____Disc Problems
____Dizziness
____Ear Infections
____Epilepsy
____Fibromyalgia
____Food Sensitivities
____Gastric Reflux
____Headaches
____Heart Disorder
____Hip Pain
____Infertility
____Knee Pain
____Leg Pain
____Liver Disease
____Lupus
____Menstrual issues
____Migraines
____Neck Pain
____Nervousness
____Numbness in Arms/Hands
____Numbness in Legs/Feet
____Sciatica
____Sleep Issues
____Skin Issues
____Stomach Disorders
____Throat Issues
____Thyroid Problems
____TMJ
____Ulcers
____Vertigo
____Arthritis
____Sexual Dysfunction
____Prostate Problems

____Constipation ____Irritable Bowel ____Shoulder Pain ____Blood Pressure H/L

____Depression ____Kidney Problems ____Sinus Issues ____Other:____________

Have you seen other doctors for these concerns? □ Yes □ No **If so, which type?** □ Chiropractor □ Medical Doctor

□Other ____

Additionally, list Doctor's name and approximate date of the visit: ____

____

Please check the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each. Score the pain with **0 being no pain** and **10 being worst possible pain.**

Location of pain:________________________________

1. **How would you rate your pain RIGHT NOW?**

   0 1 2 3 4 5 6 7 8 9 10

2. **What is your TYPICAL or AVERAGE pain?**

   0 1 2 3 4 5 6 7 8 9 10

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

   0 1 2 3 4 5 6 7 8 9 10

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

   0 1 2 3 4 5 6 7 8 9 10

The human body is designed to be healthy. The primary system in the body, which coordinates health and function, is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Many of the common health challenges that adults experience have their origins during the developmental years, starting at birth. Layers of damage to the spine and nervous system occur as a result of various traumas, toxins, and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system – a condition called Vertebral Subluxation. Please answer the following questions to give us a better understanding about your state of wellness and factors which may be contributing to vertebral subluxation and *impeding your body's ability to heal.*

Have you ever been involved in an auto accident? □Yes □ No If yes, when? ________________________________

Have you ever been knocked unconscious? □Yes □ No If yes, explain: ____________________________________

Have you ever fractured a bone? □Yes □ No If yes, please list: ____

Please describe any other traumas you have undergone: ____

____

Please check any condition you have currently, or have had in the past:

☐Stroke ☐Cancer ☐Heart Disease ☐Spinal Surgery

☐Seizures ☐Spinal Bone Fracture ☐Scoliosis ☐Diabetes: Type________

Please list all hospitalizations and surgical operations you have undergone with the corresponding year: _______________

____

Please list all medications you are currently taking (over the counter / prescription and dosage):____________________

____

Social History:

Smoking:	How often?	☐Daily	☐Weekends	☐Occasionally	☐Never
Alcohol:	How often?	☐Daily	☐Weekends	☐Occasionally	☐Never
Exercise:	How often?	☐Daily	☐Weekends	☐Occasionally	☐Never
Caffeine:	How often?	☐Daily	☐Weekends	☐Occasionally	☐Never

What are your primary health goals you're hoping to achieve through your visits at Clear Health Chiropractic?

____

____

Activities of Daily Living

Please identify how your current health concerns are affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Lifting/Carrying Objects	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Sit to stand	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Climbing Stairs	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Driving	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Extended Computer Use	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Exercise	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Household Chores	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Lifting Children	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Dressing	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Sexual Activity	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Sleep	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Sitting	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Standing	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Work/Job Tasks	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Walking	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Washing/Bathing	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Yard Work	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Concentration (Reading)	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Other:____________________	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform
Other:____________________	□No Effect	□Painful (can do)	□Painful (limits)	□Unable to Perform

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________________ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature____________________________ Date_____________________

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature________________________________ Date______________________

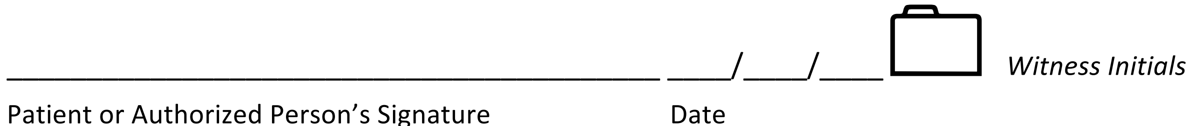
MISSION
-CHIROPRACTIC & WELLNESS-

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Mission Chiropractic and Wellness have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.



____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

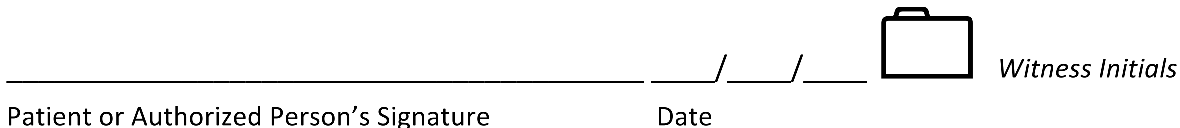
REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

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. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.



____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

Please **circle** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individuation complain and indicate the score of each complaint.

EXAMPLE:

No pain____Worst Possible is 10

1 2 3 4 5 6 7 8 9 10

1) How would you rate your pain RIGHT NOW?

____

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

____

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain its best? _______%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain its worst? ______%

Practice Member Name:____ Date:_____________________

Score: Q1______ +Q2_______ +Q4 ________= ___________/3x10= ____________ (Low Intensity = <50; High Intensity = >50)