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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.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent
2.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent
4.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent
5.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent

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

- | | | | |
|--------------------------------------------|---------------------------------------------|-------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Sleep Issues |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Skin Issues |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Disorders |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lupus | <input type="checkbox"/> Throat Issues |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Menstrual issues | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back Pain - Low | <input type="checkbox"/> Food Sensitivities | <input type="checkbox"/> Migraines | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Back Pain - Mid | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Back Pain – Upper | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Bladder Disorders | <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> Numbness in Arms/Hands | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Numbness in Legs/Feet | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Infertility | <input type="checkbox"/> Sciatica | <input type="checkbox"/> 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?	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekends	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Alcohol:	How often?	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekends	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Exercise:	How often?	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekends	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Caffeine:	How often?	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekends	<input type="checkbox"/> Occasionally	<input type="checkbox"/> 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	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Exercise	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Work/Job Tasks	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentration (Reading)	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other:_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other:_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> 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 _____

