# CHIROPRACTIC INTAKE & HISTORY

CREEKSIDE CHIROPRACTIC
Better Health - Better Posture

## PATIENT INFORMATION

Date: ______________

Patient Name ____________________________________
LAST NAME
____________________________________
FIRST NAME MIDDLE INITIAL

Address ____________________________________

City&Zip______________________State ____________

Cell Phone ____________________________________

SSN ____________________________________

Email ____________________________________

Sex ☐ M ☐ F Age ___ Birthday____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School ____________________________________

Occupation____________________________________

Spouse's Name ____________________________________

Spouse's Employer ____________________________________

Spouse's Occupation ____________________________________

**IN CASE OF EMERGENCY, CONTACT**

Name____________________________________

Relationship____________________________________

Contact Number ____________________________________

**Who may we thank for referring you?** ____________________

## HOW CAN WE HELP YOU?

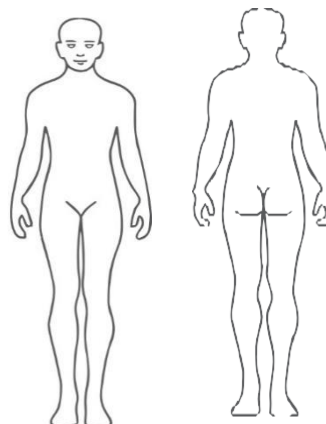
What brings you in today? ____________________________________

When did your symptoms start and what are they?____________________________________

How bad is it? How intense are your symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Sharp

☐ Tingling ☐ Shooting

☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing

☐ Aching ☐ Stabbing

☐ Cramping ☐ Swelling

☐ Nagging ☐ Other __________________

## HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

☐ AIDS/HIV
☐ Alcoholism
☐ Anxiety
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma/Allergies
☐ Back Pain
☐ Cardiovascular Issues
☐ Cancer

☐ Circulation Issues
☐ Childhood Illness
☐ Depression
☐ Diabetes
☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
☐ Elbow/Wrist/Hand Issues
☐ Endocrine Issues (Thyroid)
☐ Foot/Ankle Issues
☐ Gout

☐ Headaches / Migraines
☐ Heart Disease
☐ Hepatitis
☐ Hip Issues
☐ Immune Issues
☐ Lymphatic Issues
☐ Multiple Sclerosis
☐ Neck Pain
☐ Reproductive Issues

☐ Ringing in Ears
☐ Scoliosis
☐ Shoulder Issues
☐ Stroke
☐ TMJ Issues
☐ Urinary Issues
☐ Osteoporosis
☐ Other ______________
______________________

Do you smoke? ☐ Yes ☐ No How much? / How often? ____________ Do you drink alcohol? ☐ Yes ☐ No How much? / How often?______________

## SURGERIES MEDICATIONS & MOTOR VEHICLE CRASHES

| SURGERIES | MEDICATIONS (list) | MOTO VEHICLE CRASHES (list) |
|---|---|---|
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |

## CERVICAL SPINE (NECK) **Please indicate: (N) = Now (P) = Past or both if applicable**

____ Neck Pain
____Pain in shoulders/arms/hands
____Numbness/tingling in arms/hands
____Hearing Disturbances
____Weakness in grip
____Dizziness
____Visual Disturbances
____Coldness in hands
____Sinusitis
____Allergies/Hay Fever
____Recurrent Colds/ Flu
____TMJ / Jaw Clicking
____Headaches
____Low Energy / Fatigue

Please Explain: ______________________________________________

______________________________________________

## THORACIC SPINE (Middle Back) **Please indicate: (N) = Now (P) = Past or both if applicable**

____ Middle Back Pain
____Shortness of Breath
____Pain on Deep Inspiration / Expiration
____ Asthma/Wheezing
____Pain in Ribs
____ Heart Palpitations
____Heart Murmurs
____Tachycardia
____Heart Attacks / Angina
____Recurrent Lung Infection /Bronchitis
____Indigestion /heartburn
____Nausea
____Ulcers /Gastritis
____Reflux
____Tired /Irritable after eating

Please Explain: ______________________________________________

______________________________________________

## LUMBAR SPINE (Low Back) **Please indicate: (N) = Now (P) = Past or both if applicable**

____ Pain in hips / legs/ feet
____Numbness / Tingling in legs / feet
____Frequent / difficulty urinating
____ Constipation / Diarrhea
____ Recurrent Bladder infections
____Muscle Cramps in legs and feet
____Menstrual irregularities / Cramping
____ Low Back Pain
____ Pain with laughing, coughing or sneezing
____Sexual Dysfunction
____Coldness in legs and feet
____Weakness / Injuries in hips/ knees

Please Explain: ______________________________________________

______________________________________________

## EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? __________ Who? ____________________

How did you respond to treatment?______________________________________________

Reason for visit(s):______________________________________________

Did they take before and after X-rays? ____________ Did they recommend a home health care program? ____________

Last treatment date? ____________________ How long where you treated?____________________

# HIPPA (Health Insurance Portability & Health Care Information)

## Re: Appointment Calls, Open Room Adjusting & Health Care Information

Dr. Brown and his staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this is made by phone and you are not home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decided to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subjected to re-disclosure by anyone that has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style, with other patients in the same room. Occasionally comments about your symptoms, improvements or lack thereof may be discussed during your office visits.

This office videotapes and audiotapes doctor-patient communications and treatment in the treatment area. The tapes are used, generally, for training and quality assurance purposes. By signing this form, you are giving us permission to video and audiotape communications you have with any staff of Creekside Chiropractic.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (#164.524)

This authorization will expire seven years after the date in which you last received services at Creekside Chiropractic.

I authorize Creekside Chiropractic to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

**Patient Signature** ___________________________________ **Date** _________________________

**Name Printed** ______________________________________

## Authorization to Release Information to Physician

At Creekside Chiropractic we believe it is important that all of your physicians work together for your benefit. By signing this release you are authorizing us to release reports and information to your doctors regarding your treatment at Creekside Chiropractic.

**Patient Signature** ___________________________________ **Date** __________________________

# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes cause by arterial dissections have been associated with over 72 every day activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headaches. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:________________________Signature:_______________________________ Date:

Parent or Guardian:__________________ Signature:_______________________________ Date:

Witness Name:_______________________Signature:_______________________________ Date: