Paris Family Chiropractic

Patient Intake Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Called name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:Male Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_

Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*I want appointment reminders send via: Text  Email Voice to HOME / CELL

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

****Single ****Divorced ****Widowed ****Married Name of Spouse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race (circle 1) White Black/African American Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity (circle 1): Declined to State / Hispanic or Latino / Not Hispanic or Latino

Current Doctors name/location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact/relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past chiropractic care? Y/ N Doctor’s name & approx. last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT INSURANCE

PRIMARY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEALTH SPENDING ACCOUNT? Y/ N SECONDARY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY**

Family history- list any **IMMEDIATE** family health issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social history- list any social history (smoking, drinking, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications- list any medications/supplements/vitamins are you currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

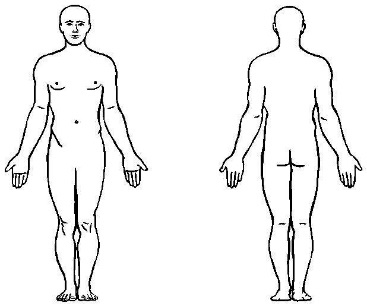
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies: YesNo If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any surgeries? YesNo If yes, list the type and approximate date of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



|  |
| --- |
| OFFICE USE ONLY |
| Height\_\_\_\_\_\_\_\_\_\_\_  Weight\_\_\_\_\_\_\_\_\_\_\_  BP left\_\_\_\_\_\_\_\_\_\_\_\_  right\_\_\_\_\_\_\_\_\_\_\_ |

**PRESENT SYMPOMS**

Mark with “X” any areas of complaint.

Are your present problems due to one of the following? IllnessNo obvious reason Personal injury****

 Motor vehicle accident**** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of injury, illness or onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe the injury, illness, or onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any symptoms you experiencing today: (i.e. neck pain, headache, low back pain, etc.)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1)very mild (2) (3) (4) (5) (6)(7) (8) (9)(10) Remarkable severe

Frequency of pain: constantfrequent intermittentnone

Type of pain: achy dull burning pulling sharp shooting stabbing throbbingtingling

Pain is getting: improved  same worse chronic

Aggravating factors: sitting standing bending lifting twisting other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relieving factors: ice heat NSAID Rx stretching laying down other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1)very mild (2) (3) (4) (5) (6)(7) (8) (9)(10) Remarkable severe

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Type of pain: achy dull burning pulling sharp shooting stabbing throbbingtingling

Pain is getting: improved  same worse

Aggravating factors: sitting standing bending lifting twisting other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relieving factors: ice heat NSAID Rx stretching laying down other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Pain is getting: improved  same worse

Aggravating factors: sitting standing bending lifting twisting other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relieving factors: ice heat NSAID Rx stretching laying down other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Frequency of pain: constantfrequent intermittentnone

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Pain is getting:  improved  same worse

Aggravating factors: sitting standing bending lifting twisting other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relieving factors: ice heat NSAID Rx stretching laying down other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any tests, studies, medications or prior interventions received for **THIS/THESE** issue:

Tests/studies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from any condition other than for which you are now consulting us? YesNo

If yes, what condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| DOCTORS NOTES: |

**REVIEW OF SYSTEMS** Check if you have or have a history of any of the following **DENY ALL**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CONSTITUTIONAL** | **EENMT** | **CARDIOVASCULAR** | **NEUROLOGICAL** | **MUSCULOSKELETAL** |
| Fainting | TMJ problems | Chest pain | Dizziness | Arthritis |
| Fever | Ringing in ears | Heart problems | Headaches | Neck pain |
| Night Sweats | Ear pain | High blood pressure | Numbness/tingling | Decreased motion |
| Weight loss/gain | Blurred vision | Palpitations | Seizures | Joint pain |
| Weakness | Glasses/contacts | Swelling of legs | Slurred speech | Back pain |
|  |  |  | Stroke | Muscle cramps |
|  |  |  | Sleep disturbances | Muscle weakness |
|  |  |  |  | Scoliosis |
|  | | | | |
| **PSYCHIATRIC** | **GASTROINTESTINAL** | **GENITOURINARY** | **RESPIRATORY** | **ALLERGIC** |
| Anxiety | Abdominal pain | Birth control | Asthma | Seasonal |
| Depression | Heartburn | Frequent urination | Shortness of breath | Food |
| Memory loss | Nausea | Hesitancy | Pneumonia | Medication |
|  |  | Prostate problems | Coughing |  |
|  | | | | |
| **ENDOCRINE** | **HEMATOLOGICAL** | **MISC** | **FEMALES ONLY** |  |
| Diabetes | Blood clots | Autoimmune problem | Pregnant Y/ N |  |
| Thyroid problems | Bleeding | History of cancer |  |  |
|  |  | Skin disorder |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DOCTORS NOTES** | | | | | |
| **POSTURE** | | **CROM** | | **LROM** | |
| Ilium | Left / right | Flexion (50⁰) | WNL P | Flexion (90⁰) | WNL P |
| Shoulder | Left / right | Extension(60⁰) | WNL P | Extension(25⁰) | WNL P |
| AHT |  | Lateral Flexion(45⁰) | WNL P | Lateral Flexion(25⁰) | WNL P |
| Antalgia |  | Rotation(80⁰) | WNL P | Rotation(90⁰) | WNL P |
|  | | | | | |

CONSENT TO USE PERSONAL HEALTH INFORMATION

Acknowledgement for consent to use and disclosure of protected health information (PHI)

Your protected health information will be used by Paris Family Chiropractic or may be disclosed to others for the purpose of treatment, obtaining payment, or support the day-to-day health care operations of this office.

Requesting a restriction on the use or disclosure of your information.

* You may request a restriction on the use or disclosure of your PHI, and this office may or may not agree to restrict the use or disclosure of PHI.
* If we agree to your request, the restriction will be binding with this office. Use or disclosure of PHI in violation of an agreed upon restriction will be a violation of the Federal privacy standards.

Revocation of consent - You may revoke this consent to the use and disclosure of your PHI in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below, I give my permission to use and disclose my PHI and acknowledge that I received a copy of the patient notice privacy policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE DATE

CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal and nervous system and the effects of these disorders on general health. The primary treatment given by Doctors of Chiropractic is spinal manipulation (adjustment). The doctor will use her hands and/or a mechanical instrument (Activator/Impulse) on the patient’s body to move joints. This may cause a cavitation (audible “click”), such as when a person “cracks” their knuckles. The patient may feel a sense of movement as well.

Procedures used by Paris Family Chiropractic

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Physical examination | Traction/decompression | Manual therapy | Hot/cold therapy | X-ray |
| Ultrasound therapy | Electrical muscle stimulation | Acupuncture/dry needling | Kinesiotaping | Laser therapy |

In the case where diagnostic x-rays are advisable, I authorize administration of such x-rays necessary to help diagnose my current musculoskeletal condition/illness.

The material risks associated with chiropractic treatment

* Chiropractic utilized very safe, non-invasive procedures to reduce pain, restore range of motion, promote overall body wellness, among other benefits.
* As with any health care procedure, there are certain complication which may arise. Possible complications include, but are not limited to the following: muscle strain, dizziness, nausea, flushing, fractures, disc injuries, dislocations, cervical myelopathy, burns, costovertebral strains and separations. It is not uncommon for a patient to experience temporary soreness after the first few treatments. In rare cases, manipulation of the neck has been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke.

The probability of those risks occurring

* Fractures are rare occurrence and generally result from underlying bone weakness, for which the doctor checks during patient history, examination and/or x-ray. The incidences of stroke are exceedingly rare and are estimated to occur between 1: 1 million – 1:5 million cervical adjustments.

The availability and nature of other treatment options may include the following: self-administer, over the counter analgesics and rest, medical care and prescription drugs such as anti-inflammatories, muscle relaxers and pain killers and/or hospitalization/surgery

There are risk and benefits associated with all the above treatment options, which the patient may wish to discuss with his/her medical doctor.

Remaining untreated may allow for the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Failure to seek care could result in serious medical conditions going unrecognized. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I understand and accept that I have the right to withdraw from or discontinue treatment at any time. Neither the practice of chiropractic or medicine is an exact science, and my care may involve the making of judgements based upon the facts known to the doctor during my course of care. It is not reasonable to expect the doctor to be able to anticipate or explain all the risks and complications, and an undesirable result does not necessarily indicate an error in judgment or treatment. Dr. Craig and Dr. Tester do not guarantee any results with respect to any course of care or treatment.

Do not sign until you have read and understand the above. I have read/have had read to me, the above explanation of chiropractic adjustments and related treatment. I hereby authorize Dr. Craig/Dr. Tester and their assistants, associated and other persons to render care, to perform an examination and to provide an appropriate evaluation and treatment plan to address the complaints, problems and medical history I have provided. I have discussed questions, comments or concerns with the doctor and have had my inquiries answered to my satisfaction. By signing, I state that I have weighted the risks and/or benefits in undergoing treatment and have decided to undergo the recommended treatment. Having been informed of the risks, I hereby give my consent to treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOCTOR/STAFF SIGNATURE DATE