



Adult Chiropractic Intake form

Welcome to our office!! The following information is confidential. It will be used to complete your history and understand your condition, so please be as accurate as possible while completing this form. If you have any questions about this form, please ask at the front desk.

PATIENT INFORMATION

Date ____/____/____

Patient Name _____
 LAST FIRST MI

Address _____

City _____ State _____ Zip _____

Email _____

Cell Phone (____) _____ Work Phone (____) _____

Home Phone (____) _____ Best time to reach you _____

Date of birth ____/____/____ Age _____ Sex Male Female

Married Single Dating Divorced Widowed

Occupation _____ Employer/School _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Primary Phone (____) _____ Secondary Phone (____) _____

REFERRAL INFORMATION

How did you hear about us? Facebook Family/Friend (Whom may we thank for referring you? _____)
 Internet Search Primary Physician Staff Other _____

Can we send them a thank you note for referring you to us? Yes No



PATIENT CONDITION

Current Health Concern: _____ When did this condition start? ____ / ____ / ____

Rate your pain on a severity scale from 1 (least) to 10 (severe) _____

Mark an X on the picture where you have symptoms.

Describe your symptoms Sharp Dull Aching Throbbing Burning Stabbing Swelling
 Numbness Tingling Stiffness Other _____

How often do you have this pain? Constant Frequently Intermittent Occasionally

Does this condition interfere with: Work Family Sleep Daily Activities

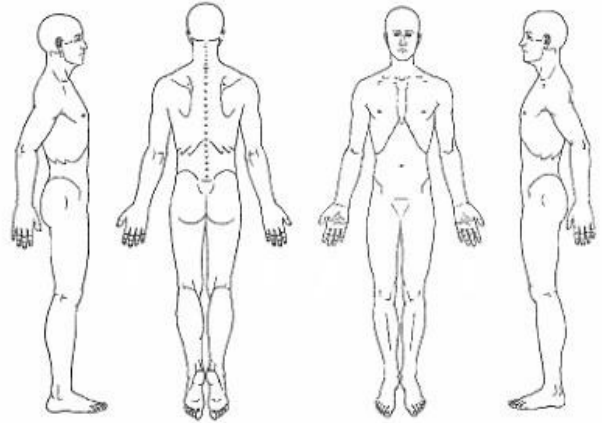
Sitting Standing Walking Bending Lying down

Have you experienced this problem before? No Yes

Please Explain _____

Have you sought treatment for this condition before? No Yes

Please Explain _____



What are your goals during and after treatment?

1. _____

2. _____

3. _____

4. _____

PREVIOUS TREATMENT

Family Medical Doctor: _____

Date of last visit ____ / ____ / ____

Previous Chiropractic Care No Yes Name: _____

Date of last visit ____ / ____ / ____

What treatment have you already received for you condition? Acupuncture Chiropractic Massage

Medications Physical Therapy Surgery None Other _____

Previous Diagnosis _____

Last X-Rays Taken ____ / ____ / ____



PREVIOUS INJURIES

Please describe any injuries or surgeries (e.g., slips/falls, head injuries, broken bones, dislocation, surgeries, auto accidents)

HEALTH HISTORY

Please mark any of the following conditions that you have been diagnosed with or experience

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Allergies (List: _____) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mood swings, irritability |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pinched nerve |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Fever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Breast Lump (s) | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Balance problems* | <input type="checkbox"/> Pelvic inflammatory Disease | <input type="checkbox"/> Seizures/convulsions |
| <input type="checkbox"/> Blood pressure – High - Low | <input type="checkbox"/> Fractures | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Temperature intolerance* |
| <input type="checkbox"/> Cancer* | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cholesterol – High – Low | <input type="checkbox"/> Heart problems* | <input type="checkbox"/> Thyroid problems* |
| <input type="checkbox"/> Congenital Disease* | <input type="checkbox"/> Hernia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Herniated Disc* | <input type="checkbox"/> Tumor (s)* |
| <input type="checkbox"/> Diabetes – Type I – Type II | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Unexplained weight-loss |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Visual problems* |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Ear infection | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Vertigo/dizziness |
| <input type="checkbox"/> Body pain* | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Pain with bowel movement | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Numbness legs or arms* |
| <input type="checkbox"/> UTI | <input type="checkbox"/> Chronic yeast infection | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Liver problems* | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Increase PMS |
| <input type="checkbox"/> Polycystic Ovary Syndrome (POS) | <input type="checkbox"/> Painful menstrual cycles | <input type="checkbox"/> Changes in menstrual cycle |

OTHER(s) _____

*Explain _____

Are you taking any medications or drugs? Yes No

Please List _____

Are you taking any vitamins/supplements/herbs/minerals? Yes. No

Please List _____



SOCIAL HISTORY

Mark all that applies

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor
- Other _____

HABITS

- Smoking Packs/day _____
- Alcohol Drinks/week _____
- Caffeine Cups/day _____
- High Stress Level
Reason _____

FAMILY HISTORY (*any parents, siblings, grandparents, aunts & uncles have the following?*)

Mark all that applies

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hight blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Uterine cancer | <input type="checkbox"/> Cancer (other) _____ | | |
| <input type="checkbox"/> Other _____ | | | |

Office Policies

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. _____(initials)

In the event that you are not able to keep your scheduled appointment, please give 24 hours' notice prior to canceling. Canceling with less than 24 hours' notice or missing an appointment will result in. being charged the cost of the appointment _____(initials)

NOTICE OF PRIVACY PRACTICE We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us or the law authorizes or compels us to do so. You may see your records to get information about it by contacting our office at (360) 352-8112. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information. _____(initials)

Family Chiropractic
204 Pinehurst Dr. SW #103
Tumwater, WA 98501

Dr. Betsy Burgos Diaz

Informed Consent

The Doctor of Chiropractic evaluates the patient using standard examination and testing procedures. If your history and examination indicate the need, you will receive further diagnostic tests or a referral to a specialist. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. Adjustments are usually performed by hand but may also be performed by hand-guided instruments or equipment. In addition to adjustments, other treatments used by chiropractors include soft tissue manipulation, nutritional recommendations, and exercise. Please list any preferences here _____

I have read the previous information regarding the risk of chiropractic care, and my doctor has verbally explained the risks (if any) and suggested alternatives when those risks exist. I understand the purpose of care and have been explained the treatment, the frequency of care, and alternatives to this care. All my questions have been answered to my satisfaction. I agree to this plan of care, understanding any perceived risk(s) and alternatives to this care for the above minor patient. By signing, I give consent for examination, tests, and procedures for the above minor patient. _____ (initials)

By signing, I have read and understood the Office Policies and Informed Consent:

Print Patient Name _____

Print Parent/Guardian Name _____

Parent/Guardian Signature _____ **Date** ____ / ____ / ____