Patient Intake Form

Patient Information

Name: ____ Date: ____________________________

Address: ____

City / State / Zip: ____

Home Phone: (   )___________________________ Work Phone: (   )_________________________

Cell Phone:(   )___________________________ Email:_____________________________________

Birth Date: _______________ Age: _____ Sex: __ M __ F

Occupation: ______________________________ Employer's Name: ______________________________

Work Address: ____

City / State / Zip: ____

Marital Status: __ S __ M __ D __ W Spouse's Name: __________________________ # of Children: ____

How were you referred to this office? ____

Emergency Contact

Name: ____ Relation: ____________________________

Home Phone: (   )___________________________ Work Phone: (   )_________________________

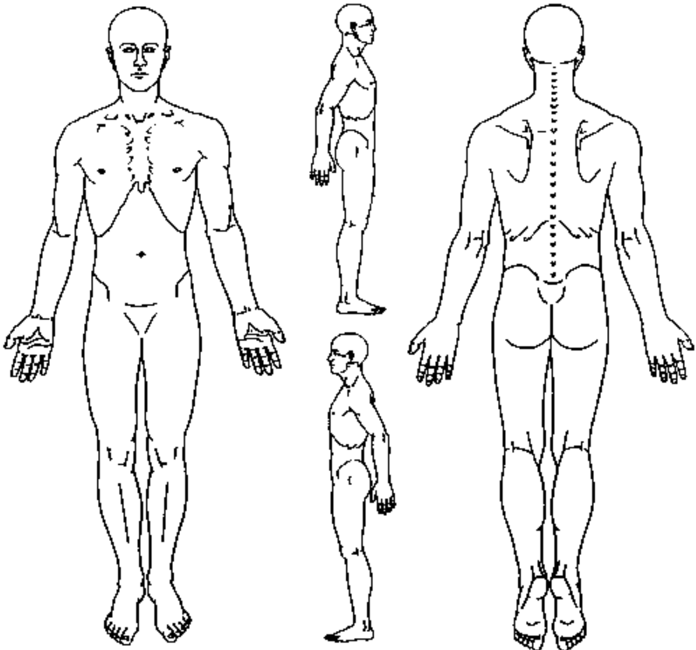
Address: ____

City / State / Zip: ____

Major Complaint Information

Using the symbols provided in the Symptom Index box below, mark the areas on the illustrations to the right where you are experiencing symptoms, followed by a number from 1 to 10 indicating the extent of the pain. (1 = mild, 10 = severe)

Symptom Index	
D	**Dull, nagging ache**
B	**Burning**
S	**Sharp / Stabbing**
N	**Numbness / Tingling**



Patient Intake (cont'd)

When did your symptoms begin? _______________

Describe your symptoms and how they began:____

____

How often do you experience your symptoms each day? Constantly Frequently Occasionally Intermittently

Provide details here:____

Are your symptoms (please circle): Getting Better Not Changing Getting Worse

How bad are your symptoms at their: Best: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Worst: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

How do your symptoms affect your daily activities?

0	1	**2**	3	**4**	5	**6**	7	**8**	9	**10**
Not at all		Mild, easily forgotten		Moderate, interferes with activity		Limiting, prevents full activity		Intense, completely preoccupying		Severe, prevents activity

What activities make your symptoms worse? ____

What activities make your symptoms better? ____

Have you experienced this symptom(s) before? __ Y __ N When? _____________________________________

Who have you seen for your symptoms? No one Other Chiropractor Acupuncturist Massage Therapist Occupational Therapist Medical Doctor Physical Therapist

Date consulted: ________________________ Diagnosis: ____

Treatment received: ____

List all prescription and over-the-counter medications and nutritional/herbal supplements you are currently taking: _______________

____

Other Health Care Providers

Chiropractor:____Phone:_______________________

Acupuncturist:____Phone:_______________________

Massage therapist:____Phone:_______________________

Naturopath:____Phone:_______________________

Medical doctor:____Phone:_______________________

Family Medical History

Have any immediate family members been diagnosed with any of the following conditions?

Condition			
Rheumatoid arthritis	Yes	No	Who:________________________________
Lupus	Yes	No	Who:________________________________
Headaches:	Yes	No	Who:________________________________
Tumor/Cancer:	Yes	No	Who:________________________________
Cardiac disease:	Yes	No	Who:________________________________
Diabetes:	Yes	No	Who:________________________________
High blood pressure:	Yes	No	Who:________________________________
Multiple sclerosis:	Yes	No	Who:________________________________
Thyroid disorder:	Yes	No	Who:________________________________
Other: ____________________			Who:________________________________

Consent for Treatment

I, the undersigned, a patient at this office, hereby authorize **Prairie East Chiropractic & Wellness** to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.

Patient's Signature: ____ **Date:** _______________________ **Witness:** ______

Consent for Treatment of a Minor

I, the undersigned, hereby authorize **Prairie East Chiropractic & Wellness** to administer treatment as necessary to my (Son / Daughter),
Name: ____.
Patient's Signature: ____ **Date:** _______________________ **Witness:** ______

Patient Privacy Notice

Our office's requirements:

We:

(a) are required by law to maintain the privacy of your medical information and to provide you with a copy of our *Notice of Privacy* detailing our legal duties and privacy practices with respect to your medical information;

(b) are required to abide by the terms of the *Notice of Privacy*;

(c) reserve the right to change the terms of our *Notice of Privacy* and to make the *Notice of Privacy* provisions effective for all of your medical information we maintain;

(d) will:

i. distribute any revised *Notice of Privacy* to you prior to implementation; and

ii. give to you, and you must sign a receipt for, any revised notice;

(e) will not retaliate against you for filing a complaint.

Effective Date: *This notice is in effect as of March 1, 2011.*

___ I understand that I am entitled to a copy of **Prairie East Chiropractic & Wellness's** *Notice of Privacy*, but do not wish to receive a copy.

___ I understand that I am entitled to a copy of **Prairie East Chiropractic & Wellness's** *Notice of Privacy*, and do wish to receive a copy.

Print Name: ____

Sign Name: ____ **Date:** _______________________

By signing, you certify that you have received notice and that all of your questions have been answered to your satisfaction in language that you can understand.