Riverside Chiropractic Health Center

New Patient Intake Form

Today's Date: _____

PATIENT INFORMATION:

Full Legal Name: _____ Preferred Name:_____

Birth Date: _____/_____/_____ Age: _____ Gender _____ Marital Status _____

Address: _____ City: _____State: _____ Zip Code: _____

Email: _____ Home Number: _____ Mobile Number: _____

Height:_____Weight: _____ Hobbies: _____

Employer + Address: _____ Occupation: _____

How did you hear about our office? :_____

Primary Care Physician Name and Phone Number:_____

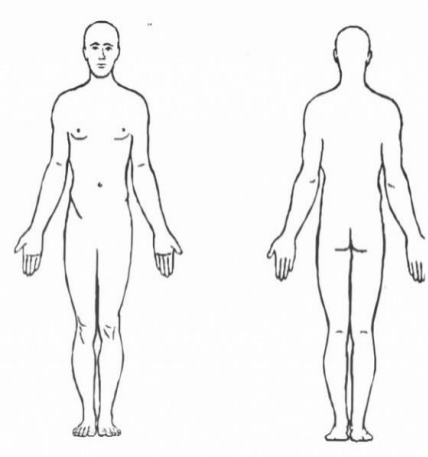
EMERGENCY CONTACT:

Name: _____Phone Number: _____Relationship to Patient: _____

PATIENT CONDITON:

Reason(s) for visit: _____

Please indicate on the diagram below where your discomfort is. With the key please tell us the type and severity of your pain. You can make these notes next to the area(s) indicated on the diagram



Type of Pain:
A= Achy S= Sharp N=Numb C=Cramps T=Tight

Pain Scale:
1= Mild 5= Moderate 10= Severe

When & how did your symptoms appear? _____

_____

How often do you have this pain/sensation?

☐ 0/25% of the day ☐ 26/50% of the day ☐ 51/75% of the day ☐ 76/100% of the day

HEALTH HISTORY:

What treatment have you already received for your condition? ☐ Chiropractic ☐ Physical Therapy

☐ Massage ☐ Stretching ☐ Acupuncture ☐ Surgery ☐ None ☐ Other _____

☐ Medications ☐Epidural or steroid Injection (if so how many and when):_____

List all health care professionals seen for this/these issue(s) including type of doctor: (ex. Primary doctor, Orthopedic, Podiatrist, Emergency Room, Chiropractors, Walk In, Physical Therapy, etc.)

_____

_____

_____

Please list estimated dates of the following: Spinal Exam _____ Spinal X-Ray: _____ MRI:_____

List all strains/ sprains/ broken bones, how they happened and estimated dates:

_____

_____

List all surgeries and/or hopspitalizations, reasons and estimated dates:

_____

_____

Female Patients: Are you pregnant? Yes☐ No☐ If yes, due date: _____

Please list Medications (What & Why):

_____

_____

Work Activity:

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy Labor

Habits:

☐ Smoking Packs/ Day _____

☐ Alcohol Drinks/ Week _____

☐ Caffeine Cups/Day _____

☐ High stress Reason_____

Do you exercise on a regular basis? ☐ Yes ☐ No

If yes what kind of excerise do you do and how often?

_____

What are your goals for your care with us? Be as specific as you can.

_____

Patient Signature_____ Date_____

Doctor Signature_____ Date_____

Activities of Daily Living

Outcome Assessment Tool

Name:_____ Date:_____

Areas of Pain and/or Dysfunction (Please list):_____

*(If you have more than one area of pain and/ or dysfunction **ABBREVIATE** for each number on the scale of 0-10. Ex. N=Neck H=Hip LB=Low Back, etc. **ABOVE THE NUMBER**. If you have any questions please ask us.)*

	0	2	4	6	8	10
1. Pain Intensity	NO PAIN	INTERMITTENT PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN	WORST POSSIBLE PAIN
2. Sleeping	PERFECT SLEEP	INTERMITTENTLY DISTURBED	MILDLY DISTURBED	MODERATELY DISTURBED	GREATLY DISTURBED	TOTALLY DISTURBED
3. Personal Care (washing, dressing, etc)	NO PAIN NO RESTRICTIONS	INTERMITTENT PAIN SOME RESTRICTION	MILD PAIN NEED TO GO SLOW	MODERATE PAIN NEED HELP	STRONG PAIN NEED HELP	SEVERE PAIN NEED 100% HELP
4. Travel (driving, etc)	NO PAIN ON LONG TRIPS	INTERMITTENT PAIN ON LONGTRIPS	MILD PAIN ON LONG TRIPS	MODERATE PAIN ON LONG TRIPS	MODERATE PAIN ON SHORT TRIPS	SEVERE PAIN ON SHORT TRIPS
5. Work	CAN DO USUAL WORK + EXTRA	CAN DO USUAL WORK, NO EXTRA	CAN DO 75% OF USUAL WORK	CAN DO 50% OF USUAL WORK	CAN DO 25% OF USUAL WORK	CANNOT WORK
6. Recreation	CAN DO ALL ACTIVITIES	CAN DO MOST ALL ACTIVITIES	CAN DO MOST ACTIVITIES	CAN DO SOME ACTIVITIES	CAN DO A FEW ACTIVITES	CANNOT DO ANY ACTIVITES
7. Frequency of pain	NEVER ANY PAIN	OCCASIONAL PAIN 10% OF DAY	OCCASIONAL PAIN 25% OF DAY	INTERMITTENT PAIN 50% OF DAY	FREQUENT PAIN 75% OF DAY	CONSTANT PAIN 100% OF DAY
8. Lifting	NO PAIN WITH HEAVY WEIGHT	INTERMITTENT PAIN WITH HEAVY WEIGHT	↑ PAIN WITH HEAVY WEIGHT	↑PAIN WITH MODERATE WEIGHT	↑PAIN WITH LIGHT WEIGHT	↑PAIN WITH ANY WEIGHT
9. Walking	NO PAIN ANY DISTANCE	↑PAIN AFTER LONG DISTANCE	↑ PAIN AFTER 1 MILE	↑ PAIN AFTER ½ MILE	↑PAIN AFTER ½ HOUR	↑PAIN WITH ALL WALKING
10.Standing	NO PAIN AFTER SEVERAL HOURS	↑PAIN AFTER SEVERAL HOURS	↑PAIN AFTER 2 HOURS	↑PAIN AFTER 1 HOUR	↑ PAIN AFTER ½ HOUR	↑PAIN WITH ANY STANDING
11. Other : _____ Please fill in if There is another ADL That is not listed	NO PAIN AFTER SEVERAL HOURS	↑ PAIN AFTER 3 OR MORE HOURS	↑PAIN AFTER 2 HOURS	↑PAIN AFTER 1 HOUR	↑PAIN AFTER ½ HOUR	↑ PAIN WITH ANY_____

Patient Signature: _____ Dr. Initials: _____ Date: _____

Informed Consent to Chiropractic Care

WHAT INFORMED CONSENT IS

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.

POSSIBLE TREATMENT MODALITIES

Chiropractic care centrally involves what is known as a chiropractic adjustment. There will most likely 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. The adjunctive procedures depend upon your specific circumstance and may include but are not limited to: ultrasound, hot/cold packs, electrical stimulation, laser, traction, exercises and other physical modalities.

RISKS & BENEFITS

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**.

ALTERNATIVES

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, surgery, **or no care at all**. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

PATIENT ACKNOWLEDGMENT & WITNESS

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:_____

Doctor Signature:_____ Date:_____

Riverside
CHIROPRACTIC
HEALTH CENTER

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Maximizing Results:

- It is recommended to be as relaxed as possible during your adjustments for best results.
- Try to wear loose fitting clothing and minimal jewelry when possible
- Please remove shoes, belts and everything out of your pockets before getting on the adjustment table
- Please refrain from wearing any colognes or perfumes because Dr. Katie is allergic

Thank you for your cooperation! Your best results are our top priority!

No Show/Cancellation Policy:

Our appointments run every 15 minutes, therefore please be on time. Please allow yourself enough time to check in prior to your appointment time. Patients who do not show up or fail to give 12 hours cancellation notice for their appointment will be charged a $30 fee.

Patient Name: _____

Patient Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____