



BURTIS CHIROPRACTIC CENTER INTAKE FORM

TODAY'S DATE: _____

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: ____/____/____ Social Security #: ____-____-____

Gender: [male] or [female]

MARITAL STATUS: Single / Married / Divorced / Widowed / Other Maiden Name: _____

Spouse's Name: _____ Number of Children: _____

I give my consent to receive appointment reminders by Email and Text Message: YES [] NO []

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

Google Search [] Referral [] Who referred you? _____

Facebook/Instagram [] Advertisement []

Drove By [] Other [] Please specify: _____

EMPLOYMENT (or parent's employment for minors)

Regular Work Status: (circle one)

EMPLOYED / PART-TIME EMPLOYED / RETIRED / UNEMPLOYED / FULL-TIME STUDENT / PART-TIME STUDENT

Employer/School Name: _____

Employer City and State: _____

Occupation: _____ Employer Phone #: _____

PREVIOUS CHIROPRACTIC CARE EXPERIENCE

Have you had previous Chiropractic Care? [YES] or [NO]

If yes, reason for visit: _____

Doctor's name: _____ Date of last chiropractic visit: _____

CURRENT SYMPTOMS

Purpose of visit today: [] Wellness [] Complaint [] Injury [] Other

If an injury, where did the injury occur? [] Automobile [] Work [] 3rd Party Premise [] Other

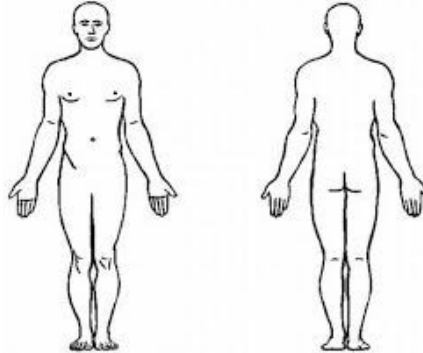
Date of Injury: _____

Details about reason for this visit: _____

Rate your pain on a scale of 1-10: (1 being the least pain and 10 is the maximum pain)

At its best: _____ At its worse: _____ Current level: _____

Please indicate the areas affected:



Describe how the injury, pain, or discomfort originated: _____

In detail, describe the pain/discomfort you are feeling and where: (left or right side, dull vs sharp pain, etc.)

Indicate the areas of your life it has impacted:

Work Daily Activities Sleep Appetite Other

Please describe: _____

What date did this concern begin on? _____

Frequency you are experiencing pain from this condition?

Always Hourly Daily Occasionally

Has this concern:

Gotten Worse Stayed Constant Come and Gone

Have you reduced or limited your work hours because of this condition? [YES] or [NO]

If yes, explain: _____

Have you missed any work due to this injury? [YES] or [NO]

If yes, dates of missed work: _____ TO _____

Is your pain/discomfort worse at certain times of the day? [YES] or [NO]

If yes, when: _____

Does the weather affect your pain/discomfort? [YES] or [NO]

If yes, explain: _____

List anything that aggravates your condition: _____

List anything that relieves or improves your condition: _____

Have you seen any other doctors for this concern? [YES] or [NO]

If yes, Doctor's name: _____

Where: _____

Type of Treatment? _____

X-rays/MRI taken? [YES] or [NO]

Results? [GOOD] [BAD] OR [INDIFFERENCE]

Have you ever had this same condition in the past? [YES] or [NO]

If yes, when: _____

List any other practitioners seen for this injury/condition: _____

If any, what other type of treatment have you received? _____

Were you satisfied with your treatment? [YES] or [NO]

Please list any health conditions that you have been treated for in the last year: (condition, cause, current/resolved)

(FEMALE ONLY) Are you pregnant, or have had any signs of pregnancy? [YES] or [NO]

(FEMALE ONLY) Are you planning on getting pregnant in the next 12 months? [YES] or [NO]

PERSONAL INCIDENT HISTORY

Broken any bones? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Had any major sprains or strains? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Been hospitalized? [YES] or [NO]

Briefly explain: _____

Had surgery? [YES] or [NO]

Briefly explain: _____

Been in an Auto Accident? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Been Struck Unconscious? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Been diagnosed with an eating disorder? [YES] or [NO]

Briefly explain: _____

Had a stroke? [YES] or [NO]

Briefly explain: _____

FAMILY HEALTH HISTORY

List diagnosed health conditions and untimely deaths of your blood-related family members:

(Condition and relationship to you) (ex: arthritis, cancer, diabetes, heart disease, high blood pressure)

CHILDREN ONLY:

Please list any health conditions treated for since birth: (condition, cause, current/resolved): _____

Please list any complications during pregnancy/delivery: _____

CHILD HEALTH PROBLEMS AND CONCERNS

Please check all that you have had or currently have.

- | | | | |
|-------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> constipation | <input type="checkbox"/> Growing Pain | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Headaches | _____ |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Sleep Problems | _____ |

SOCIAL HISTORY AND LIFE CHOICES

- | | | | | |
|--|--------------------------------|---------------------------------|---------------------------------------|--------------------------------|
| Alcohol: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Diet Food Products: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Energy Products & Over-the-Counter Stimulants: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Caffeine Drinks & Products: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Soft Drinks: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Water: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Fresh & Homemade Foods: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Preprocessed, Packaged, & Restaurant Food: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Exercise: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Tobacco: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |
| Drugs/Medications: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Never |

Please list medications: _____

HEALTH PROBLEMS AND CONCERNS

Please check all that you have had or currently have.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cramps | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Irregular Menstrual Cycle | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Sleep Problems/Insomnia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diagnosed emotional/
mental disorders | <input type="checkbox"/> Liver disease/cirrhosis | <input type="checkbox"/> Skin Sensitivity |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Spinal Curvatures |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Excessive Menstruation | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Swelling of Ankles |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Eye Pain or Difficulties | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gallbladder disease/
stones | <input type="checkbox"/> Migraines | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Gout | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease(STD) |
| <input type="checkbox"/> CHF (congestive heart disease) | <input type="checkbox"/> Headache | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Other:
_____ |
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Poor Posture | _____ |
| <input type="checkbox"/> COPD/emphysema | | <input type="checkbox"/> Prostate Trouble | _____ |
| <input type="checkbox"/> CVA (stroke/TIA) | | <input type="checkbox"/> Retinal Disease | |

AUTHORIZATION

I certify that I'm the patient or legal guardian listed below. I understand the information given on this intake form is true and accurate to the best of my knowledge. I consent to the collection and use of that information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for payment in full for all services unless other arrangements have been made with the business manager. If my account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for any expense incurred in collecting my account. If my bill becomes delinquent and you have to employ an outside agent to collect the bill, all collection expenses will become my responsibility. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand that if my account is inactive for 18 months any credit balance under the amount of \$20.00 will not be reimbursed.

I agree with this statement of authorization.

If signing for your child:

I hereby, authorize Dr. Scott Burtis to administer treatment as he so deems necessary, even in the absence of a legal guardian to my child. (In cases where another family member/friend might bring the patient into our office.)

Name of Patient (Please Print): _____

Patient's/Guardian's Signature: _____ Date: _____