# CHIROPRACTIC INTAKE & HISTORY

## PATIENT INFORMATION

Patient Name _____ (LAST NAME)

_____ (FIRST NAME) (MIDDLE INITIAL)

Address _____

City _____ State _____

Home Phone _____

Cell Phone _____

Email _____

Sex ❑ M ❑ F Age _____ Birthday _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

**IN CASE OF EMERGENCY, CONTACT**

Name _____

Relationship _____

Contact Number _____

**Who may we thank for referring you?** _____

## HOW CAN WE HELP YOU?

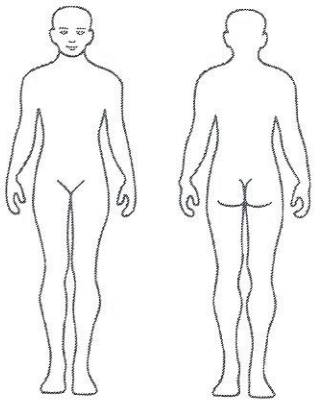
What brings you in today? _____

_____

If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle) 0 (NO SYMPTOMS) 1 2 3 4 5 6 7 8 9 10 (INTENSE SYMPTOMS)

Please circle areas to the right where you have pain or other symptoms:



**What does it feel like? (check where appropriate)**

❑ Numbness ❑ Sharp

❑ Tingling ❑ Shooting

❑ Stiffness ❑ Burning

❑ Dull ❑ Throbbing

❑ Aching ❑ Stabbing

❑ Cramping ❑ Swelling

❑ Nagging ❑ Other _____

## IMPACT OF YOUR SYMPTOMS

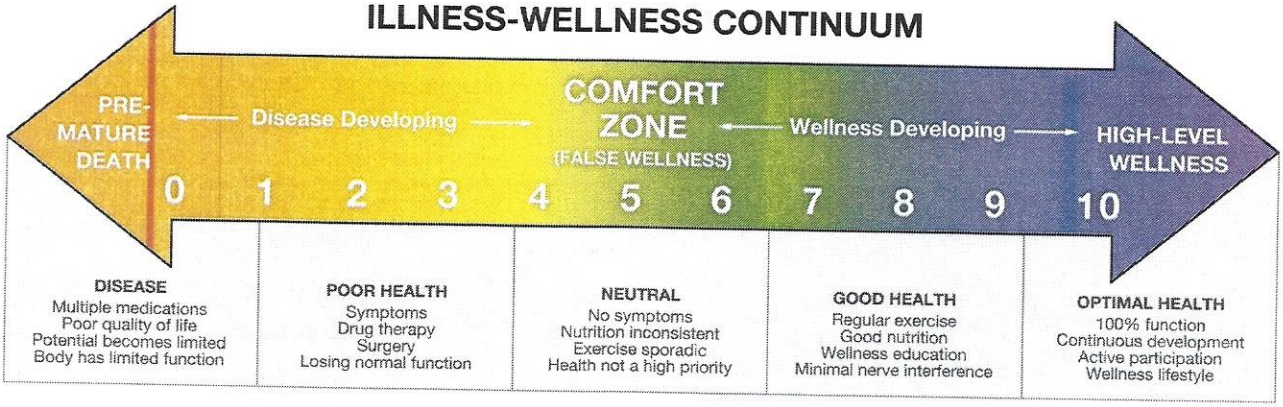
How is this symptom / condition interfering with your life? (check where appropriate)

| | No Effect | Mild Effect | Moderate Effect | Severe Effect | | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|---|---|---|---|---|
| Work | ❑ | ❑ | ❑ | ❑ | Energy | ❑ | ❑ | ❑ | ❑ |
| Exercise | ❑ | ❑ | ❑ | ❑ | Attitude | ❑ | ❑ | ❑ | ❑ |
| Recreation | ❑ | ❑ | ❑ | ❑ | Patience | ❑ | ❑ | ❑ | ❑ |
| Relationships | ❑ | ❑ | ❑ | ❑ | Productivity | ❑ | ❑ | ❑ | ❑ |
| Sleep | ❑ | ❑ | ❑ | ❑ | Creativity | ❑ | ❑ | ❑ | ❑ |
| Self-Care | ❑ | ❑ | ❑ | ❑ | Other _____ | ❑ | ❑ | ❑ | ❑ |

How committed are you to correcting this issue? 0 (NOT COMMITTED) 1 2 3 4 5 6 7 8 9 10 (VERY COMMITTED)

## PATIENT WELLNESS ASSESSMENT

### ILLNESS-WELLNESS CONTINUUM




| DISEASE | POOR HEALTH | NEUTRAL | GOOD HEALTH | OPTIMAL HEALTH |
|---|---|---|---|---|
| Multiple medications<br>Poor quality of life<br>Potential becomes limited<br>Body has limited function | Symptoms<br>Drug therapy<br>Surgery<br>Losing normal function | No symptoms<br>Nutrition inconsistent<br>Exercise sporadic<br>Health not a high priority | Regular exercise<br>Good nutrition<br>Wellness education<br>Minimal nerve interference | 100% function<br>Continuous development<br>Active participation<br>Wellness lifestyle |

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

## CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ❑ No ❑ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

## HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma/Allergies
- ❑ Back Pain
- ❑ Cardiovascular Issues
- ❑ Cancer
- ❑ Circulation Issues
- ❑ Childhood Illness
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ❑ Elbow/Wrist/Hand Issues
- ❑ Endocrine Issues (Thyroid)
- ❑ Foot/Ankle Issues
- ❑ Gout
- ❑ Headaches / Migraines
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hip Issues
- ❑ Immune Issues
- ❑ Lymphatic Issues
- ❑ Multiple Sclerosis
- ❑ Neck Pain
- ❑ Reproductive Issues
- ❑ Ringing in Ears
- ❑ Scoliosis
- ❑ Shoulder Issues
- ❑ Stroke
- ❑ TMJ Issues
- ❑ Urinary Issues
- ❑ Osteoporosis
- ❑ Other _____

## ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

_____

_____

_____

MEDICATIONS (list)

_____

_____

_____

SUPPLEMENTS (list)

_____

_____

_____

Restore Life
CHIROPRACTIC

I hereby authorize payment to be made directly to Restore Life Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Restore Life Chiropractic for any and all services I receive at this office.

_____ _____

**Patient or Authorized Person's Signature** **Date Completed**

_____ _____

**Doctor's Signature** **Date Reviewed**

Patient Name _____ Patient No. _____

Restore Life
CHIROPRACTIC

# X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your Chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files.

**THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.**

Please Note: X-rays are utilized in this office to help locate and analyze Vertebral Subluxations. These x-rays are not used to investigate for medical pathology. The doctor of Restore Life Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

**BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.**

_____ _____

PRINT YOUR NAME HERE DATE

_____

SIGNATURE

---

**FEMALE PATIENTS ONLY: To the best of my knowledge, I believe I am not pregnant at the time X-rays are taken.**

_____ _____

SIGNATURE DATE

Patient Name _____ Patient No. _____

Restore Life
CHIROPRACTIC

## Informed Consent

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases complications such as sprain/strain injuries, irritation of a disc condition, and although extremely rare; minor fractures, and possible stroke (which occurs at a rate between one instance per one million, to one per two million) have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Restore Life Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____ *Witness Initials*_____

Patient or Authorized Person's Signature Date

*IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW*

## WRITTEN CONSENT FOR A CHILD

**NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD** _____

**I AUTHORIZE DR. NICHOLAS MOORE AND ANY AND ALL RESTORE LIFE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.**

**AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY RESTORE LIFE CHIROPRACTIC.**

_____

DATE

_____
GUARDIAN SIGNATURE

_____
WITNESS SIGNATURE

_____
GUARDIAN'S RELATIONSHIP TO MINOR / CHILD

## Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.

Patient Name _____ Patient No. _____

Restore Life
CHIROPRACTIC

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

***Patient Initials*** _____

Patient Name _____

Patient No. _____

Restore Life
CHIROPRACTIC

# MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE)

**Name:** _____ **Date of Birth:** _____

***Release of Information***

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____ [ ]
Child(ren)_____
[ ] Other_____ [ ]
Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

***Messages***

Please call [ ] my home [ ] my work [ ] my cell Number:_____ If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

Signed: _____ Date: _____

Witness:_____ Date: _____

## Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions

_____ _____ _____
**(Signature)** **(Date)** **(Witness)**

Patient Name _____ Patient No. _____