



Priestley Family Chiropractic

Specializing in Pediatric Development and Adult Health

CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
Last Name
First Name Middle Initial
Address _____
City _____ State _____
Zip Code _____ Work Number _____
Cell Phone _____
Email _____
Sex M F Age _____ Date of Birth _____
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 _____
Whom may we thank for referring you? _____

INSURANCE INFORMATION

We will be happy to verify your insurance benefits and find out if you have any chiropractic coverage. However, we do collect payment in full for services rendered on the 1st visit.

Do you have insurance you would like to submit? _____

Yes No

I hereby authorize the doctor to release all information regarding my records if needed. Initials _____

I understand that I am financially responsible for all charges.

Initials _____

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

1

2

3

4

5

6

7

8

9

10

NO
SYMPTOMS

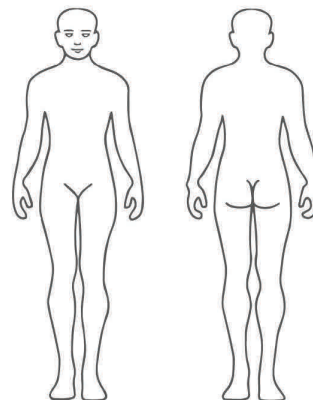
INTENSE
SYMPTOMS

Have you been to a chiropractor before? Yes No

Put an "X" on the picture where you have pain, numbness or tingling.

What does it feel like? (check where appropriate)

- | | |
|------------------------------------|--------------------------------------|
| ☐ Numbness | ☐ Sharp |
| ☐ Tingling | ☐ Shooting |
| ☐ Stiffness | ☐ Burning |
| ☐ Dull | ☐ Throbbing |
| ☐ Aching | ☐ Stabbing |
| ☐ Cramping | ☐ Swelling |
| ☐ Nagging | ☐ Other _____ |



Type of Chiropractic Care

What kind of care are you looking for?

Pain Relief _____ Corrective _____ Wellness _____

Are you aware that...

Chiropractic is the largest natural healing profession in the world?

Yes _____ No _____

The nervous system controls all bodily functions and systems?

Yes _____ No _____

Doctor's of Chiropractic work with the nervous system?

Yes _____ No _____

IMPACT OF YOUR SYMPTOMS

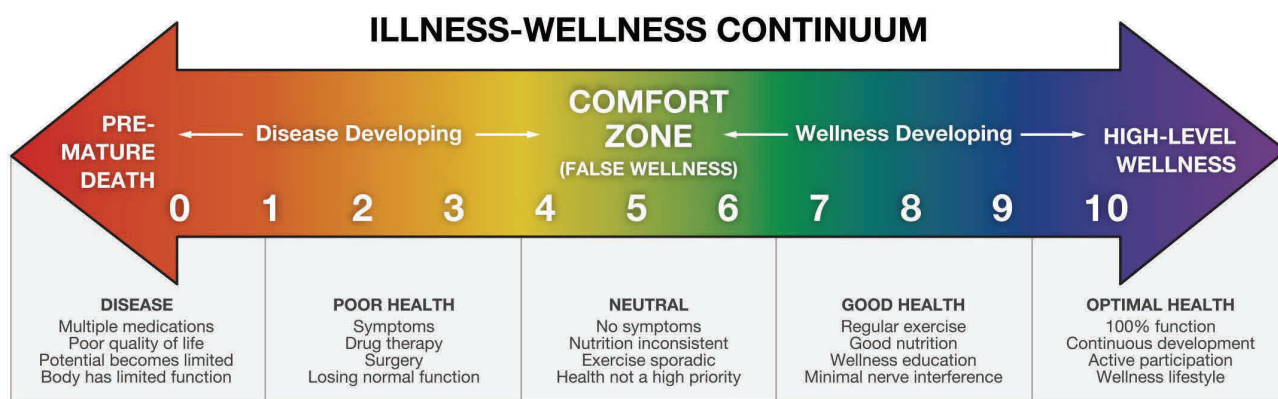
How is this symptom / condition interfering with your life? (check where appropriate)

	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 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
 NOT COMMITTED VERY COMMITTED

PATIENT WELLNESS ASSESSMENT



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

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

MEDICATIONS (list)

SUPPLEMENTS (list)

I hereby authorize the doctor, and/or his associates to examine me, and to perform any necessary diagnostic procedures, including x-ray to fully evaluate my condition for the presence of vertebral subluxation.

Patient Signature _____ **Date** _____
(If patient is under 18, Signature of Legal Guardian)

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Topics covered are Uses and Disclosure, Your Rights, Our Duties, Complaints & Contact Information.

A complete copy of this document is available upon request.

Patient Signature _____ **Date** _____
(If patient is under 18, Signature of Legal Guardian)

- I give permission to use my photo in the office as witness and celebration of my wellness.
- I give permission for my name to be recorded as a means for me to be called to my adjustment.
- I give permission to use my name in the office if I refer a new member to the practice.
- I understand that if I am chosen as Patient of the Week, I give permission for certain information about my case to be disclosed in the office.
- If I choose to give a testimonial of my experiences while under care, I give permission for certain information about my case to be disclosed for office purposes.

Patient Signature _____ **Date** _____
(If patient is under 18, Signature of Legal Guardian)

Electronic Health Records

In compliance with requirements for the government EHR incentive program

Preferred method of communication for patient reminders (Circle One): Email / Phone / Mail

Preferred Language: _____

Smoking Status (Select One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____ **Smoking end Date (Optional):** _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____ / _____

CMS requires providers to report both race and ethnicity

Race (Select one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Select one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

☐ **I choose to decline receipt of my clinical summary after every visit** (These summaries are often blank because of the nature and frequency of chiropractic care.)

Patient Signature _____ **Date** _____
(If patient is under 18, Signature of Legal Guardian)

Informed Consent to Chiropractic Care

Patient: Please discuss any questions or concerns with the doctor and/ or associates.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the below named minor in which I am legally responsible for) by the doctor, his staff, and/or his associates.

The Nature Of The Chiropractic Adjustment

The doctor will use his/her hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “pop” your knuckles. You may feel a sense of movement.

The Material Risks Inherent In The Chiropractic Adjustment

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The Probability Of Those Risks Occurring

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and outside the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, the doctor will look for risk factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as “rare”.

Ancillary Treatment

In addition to chiropractic adjustments, you may be given home instructions to use the following treatments, with the associated risks:

- Heat ~ risk of 1st and 2nd degree burns, hemorrhage
- Cryotherapy (cold packs) ~ risk of skin reactions
- Trigger Point Therapy ~ risk of bruising, release of emboli
- Massage ~ risk of deep vein thrombosis

The Availability And Nature Of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered over-the-counter analgesics and rest
- Medical care with prescription drugs
- Hospitalization
- Surgery

The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include:

Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort, his/her pain tolerance, and self discipline is not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable effects and patient dependence. The risk of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The Risks And Dangers Attendant To Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I understand if I have any questions I am able to ask the doctors and their associates. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor’s interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

Printed Name of Patient

Date

Signature of Patient