Confidential Patient Intake – Stalheim Chiropractic S.C. Today's Date: ______/________/__________

Patient Information:

For office use…Remind: ☐ Text/carrier__________ ☐ Email, time ___________; Summary: ☐ Print ☐ Email ☐ None

How did you hear about our office? ☐ Location ☐ Yellow Page s ☐ Insurance Plan ☐ Location ☐ Family/Friend (who?) ____________________

Last:_______________________ **First:**_______________ **Middle:** ____________ **"Goes by":**_______________

Address: ____**Apt #** _______

City: ____ **State:** ______________ **Zip:** ______________________

Home Phone: (_______) _______-__________ **Work Phone:** (______) _______-___________ **ext.** _________

Cell Phone: (_______) _______-____________ **Email Address:** ________________________________

Birth Date: _____ /_____/______ **Age:**______ **Sex:** Male / Female **Social Security #:** _______-______-________

Your Employer____**Occupation:**______________________________

Ethnicity: ☐ White ☐ Black ☐ Asian ☐ Native American ☐ Other **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouses Name: __________________ **Spouses Employer** ___________________ **Job Title** _______________

Names/ages of children at home: ____

Emergency Contact:____**Phone:**______________________

Current Health Condition:

1. The reason I am seeking care today is: ____

2. And this condition is the result of: ☐ An accident or injury --- ☐ Work ☐ Auto ☐ Home ☐ Other Date___________

☐ A long-term problem ☐ Unknown Cause

☐ An interest in: ☐ Wellness ☐ Other ____________________

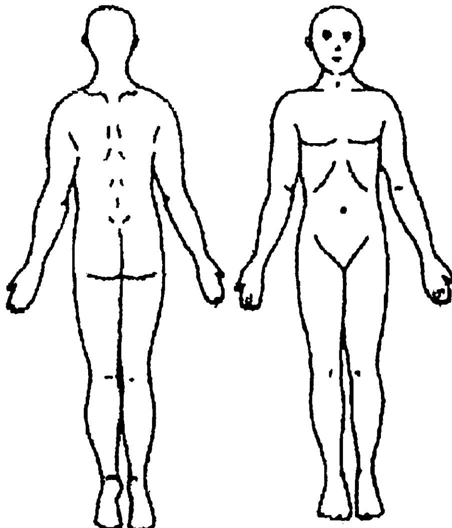
3. Onset (when did you first notice the condition)? ________________ **Any Previous episodes?** ☐ **yes** ☐ **no**

4. Intensity (how bad are your current symptoms?) **0--☐--☐--☐--☐--☐--☐--☐--☐--☐--10**
[mark minimum and maximum level in boxes] **Absent** **Uncomfortable** **Severe**

5. Duration and Timing (what % of a day do you feel the symptoms?) 0--10--20--30--40--50--60--70--80--90--100

6. What does it feel like? ☐ **Ache** ☐ **Burn** ☐ **Numb** ☐ **Stiff** ☐ **Sharp** ☐ **Dull** ☐ **Tingling** ☐ **Throbbing** ☐ **Cramping**

7. Location: mark on the body diagram with "x" for location of symptoms.



8. Radiation (to what areas does the pain shoot or travel)

____

9. Aggravating or relieving factors:

What makes it worse? _________________________________

What makes it better? _________________________________

10. Prior Interventions (what have you tried so far to help?)

☐ **Prescriptions** ☐ **Ice** ☐ **Chiropractic**
☐ **OTC medications** ☐ **Heat** ☐ **Massage**
☐ **Physical therapy** ☐ **Medical**_______________________

11. How does your current condition limit your daily activities? Please mark one box for each activity

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Working	☐	☐	☐	☐
Dressing	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Shopping	☐	☐	☐	☐
Family care	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Driving	☐	☐	☐	☐
House Work	☐	☐	☐	☐
Lying down	☐	☐	☐	☐
Lifting	☐	☐	☐	☐

12. Have you received prior chiropractic care? ☐ Yes ☐ No When?_________ Doctor? ____________________

13. Any other important things your doctor should know? ____

14. FEMALES ONLY: Is there any chance you are pregnant at this time? ☐ Yes ☐ No ________ please initial here

15. *Review of Systems*: Please check the following if you currently have

Musculoskeletal
- ☐ Osteoporosis
- ☐ Knee injury
- ☐ Arthritis
- ☐ Shoulder problem
- ☐ TMJ problems
- ☐ Hip disorder
- ☐ Poor posture

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Headache
- ☐ Dizziness
- ☐ Tingling
- ☐ Numbness

Skin
- ☐ Skin cancer
- ☐ Psoriasis
- ☐ Eczema
- ☐ Acne
- ☐ Hair Loss
- ☐ Rash

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol
- ☐ Poor circulation
- ☐ Angina
- ☐ Excessive bruising
- ☐ Heart trouble
- ☐ History of Stroke

Respiratory
- ☐ Asthma
- ☐ Apnea
- ☐ Emphysema
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Pneumonia
- ☐ Allergies

Digestive
- ☐ Anorexia/bulimia
- ☐ Ulcer
- ☐ Food allergies
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing

Endocrine
- ☐ Thyroid issues
- ☐ Immune disorder
- ☐ Hypoglycemia
- ☐ Frequent infections
- ☐ Low energy

Sensory
- ☐ Blurred vision
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Ear Infections
- ☐ Loss of smell
- ☐ Loss of taste

Genitourinary
- ☐ Kidney stones
- ☐ Infertility
- ☐ Bedwetting

Males Only
- ☐ Prostate issues
- ☐ Erectile dysfunction

Females Only
- ☐ Irregular menstruation
- ☐ Currently Pregnant
- ☐ PMS symptoms
- ☐ Birth control

General
- ☐ Fainting
- ☐ Low energy
- ☐ Poor appetite
- ☐ Fatigue
- ☐ Sudden weight change
- ☐ Weakness

Psychological
- ☐ Bi-polar
- ☐ ADD/ADHD
- ☐ Parkinson's
- ☐ Other

Other
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

16. ***Illnesses***: check the illness you have now or have had in the past

Had	Have	
☐	☐	AIDS
☐	☐	Alcoholism
☐	☐	Allergies
☐	☐	Cancer
☐	☐	Chicken Pox
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Glaucoma
☐	☐	Heart Disease
☐	☐	Hepatitis
☐	☐	HIV positive
☐	☐	Measles
☐	☐	Multiple Sclerosis
☐	☐	Mumps
☐	☐	Polio
☐	☐	STD
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Ulcer
☐	Other:____________________	

17. ***Injuries***: Have you ever had... If yes, include date

- ☐ Broken bone____________________
- ☐ Spine or nerve disorder____________________
- ☐ Been knocked unconscious____________________
- ☐ Been involved in a car accident____________________
- ☐ Been injured in a work accident____________________
- ☐ Worn a cast or brace____________________
- ☐ Other Injury:____________________

____

18. ***Surgeries***: check or list all

- ☐ Appendectomy ____________________
- ☐ Bypass Surgery____________________
- ☐ Cosmetic Surgery ____________________
- ☐ Joint Surgery ____________________

____

- ☐ Eye Surgery____________________
- ☐ Hysterectomy____________________
- ☐ Pacemaker____________________
- ☐ Back or Neck ____________________
- ☐ Tonsillectomy____________________
- ☐ Other:____________________

____

____

19. ***Social History***

a. Tobacco Use	☐ None	☐ Daily	☐ Weekly	Amount? ____________	Type? ____________
b. Alcohol Use	☐ None	☐ Daily	☐ Weekly	Amount? ____________	Type? ____________
c. OTC Medication Use	☐ None	☐ Daily	☐ Weekly	Amount? ____________	Type? ____________
d. Water Intake	☐ None	☐ Daily	☐ Weekly	Amount? ____________	Type? ____________
e. Caffeine Intake	☐ None	☐ Daily	☐ Weekly	Amount? ____________	Type? ____________
f. Recreational Drugs	☐ None	☐ Daily	☐ Weekly	Amount? ____________	Type? ____________
g. Exercise	☐ None	☐ Daily	☐ Weekly	Amount? ____________	Type? ____________

h. Sleep Average hours/night __________ Position: ☐ Back ☐ Stomach ☐ Side

i. What is the most significant stress in your life now? ____________________

j. What are other health goals you would like to achieve? ____________________

20. ***Family History***:

Father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:____________
Mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:____________
Brother(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:____________
Sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:____________

Other known family traits or trends you feel are significant: ____________________

21. ***Nutrition***:

How many meals do you eat per day? ______ How many times do you snack per day? _______

Do you take any nutritional supplements? (list) ____________________

22. *Medications*: **please list all prescription medications that you currently take**

	Medication	Dosage		Medication	Dosage
1			6		
2			7		
3			8		
4			9		
5			10		

22a. Do you have any known medication allergy? ☐ Yes ☐ No If yes, list: ______________________________

____

STALHEIM CHIROPRACTIC INFORMED CONSENT DOCUMENT:

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:
The primary treatment used in this office as Doctors of Chiropractic is the chiropractic adjustment. We will be using that procedure and any other adjunctive measures deemed safe and necessary to care for you.
Analysis / Examination / Treatment:
As part of the analysis, examination, and treatment, you are consenting to the following procedures: chiropractic adjustments, palpation, vital signs, range of motion testing, surface EMG testing, spinal thermography, muscle strength testing, orthopedic testing, neurological examination, posture analysis, radiographic studies, soft-tissue therapy, and other necessary procedures
The material risks inherent in chiropractic adjustments.
As with any healthcare procedure, there are certain potential complications which may arise during chiropractic adjustments and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform us.
The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidence of stroke is exceedingly rare and is estimated to occur between one in one million and one in five million cervical spine adjustments. These other complications are also generally described as rare.
The availability of other treatment options:
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain medication
- Hospitalization or surgery

If you choose to use one of the above noted options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your medical care physician.

I have read the above explanation of the chiropractic adjustment and related treatment. I have the right to discuss this with my doctor and have questions answered. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended.

Signature ______________________________ **Date** ______________

I, as the patient or guardian, also agree I am responsible for all bills incurred at this office and payment of the full balance of incurred charges is ultimately my responsibility regardless of insurance arrangements. X-ray films (if taken) will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

I acknowledge that ☐ I have received or ☐ have reviewed, been offered a copy and declined to receive Stalheim Chiropractic SC's Notice of Privacy Practices for protected health information.

Patient Printed Name:______________________ **Or Parent/Guardian Name:** ______________________

Patient or Guardian Signature: ______________________________ **Date:** ______________

☐ initial ____ **I authorize sharing my information with the following person(s)** ______________________