NEW PATIENT INTAKE FORM

Please fill out form and **bring to your first appointment** at Clark Chiropractic.

First Name________________MI ____ Last _______________________ Birth Date____/____/____ Age_____ Today's date____/____/____

Address ____ City __________________________ State_________Zip ____________

Home # (   )____________________Work # (   ) ____________________ Ext.______________Cellular # (   )_____________

____ Male ____ Female Soc. Sec. # _____-____-_______ E-mail Address ________________________ Employer _______________

\# of Children ______ Ages of Children ___________ Single Married Significant Other Widowed Separated Divorced

Your occupation __________________________Work duties __________________ ***WOMEN ONLY: Are you pregnant? No ____ Yes ____***

Name of Spouse (Parent if patient is under 18) _________________ Birth Date of Spouse (Parent if patient is under 18)_________________

Who may we thank for referring you to our office?________________________ Method of payment for First Visit: *Cash Check CC*

*****FOR PRESENT CONDITIONS MARK "P", PAST CONDITIONS MARK "X" (3 MONTHS OR LONGER) (Please 'Circle' if necessary to be more specific)**

___Numbness/Tingling/Pain in (Arms / hands/ fingers) R / L Both

___Numbness, Tingling or Pain in (Buttocks/Thighs/Legs/Feet/Toes) R / L Both

___Headaches/Migraines	___Hip Pain R / L	___Neck Stiffness/ Pain	___Back Stiffness/Pain
___Fractured Bones	___Arthritis	___Frequent Colds / Flu	___Diabetes
___Swollen Painful Joints	___Convulsions/Epilepsy	___Skin Problems	___Cancer
___Anemia	___Tremors	___Blurred Vision R / L	___Double Vision R / L
___Pain w/ Cough / Sneeze	___Chest Pain	___Lung Problems	___Loss of Taste
___Heart Problems	___Stroke	___Gall Bladder Problems	___Digestive Problems
___Prostate Problems	___Kidney Trouble	___Loss of Smell	___Loss of Balance
___Dizziness/Vertigo	___Buzzing/Ringing in ears	___Sinus Problems/Allergies	___Nervousness/Anxiety
___Fatigue	___Depression	___ Irritability/Mood Swings	___Tension/Stress
___Colon Trouble	___Sleeping Problems	___Cold Hands	___Stomach Upset
___Cold feet	___Bed Wetting	___Recurring Infection	___Diarrhea/Constip./Gas
___Foot Problems	___Shortness of Breath	___Hot Flashes	___Jaw/TMJ Problems
___Cold Sweats	___Light Sensitivity	___Problems Urinating	___Heartburn/Reflux
___High Blood pressure	___PMS	___Menopause	___Ulcers
___Other	___Cancer (Type)		___

Additional Explanation:

Have you ever been to a chiropractor before? Y / N   If NO why not?____

Current Health Condition

Chief Complaint (why you are here today):

____

____

When did this condition begin? ___________ Has it ever occurred before: Yes No

Was this due to an accident/Trauma? Yes No

If Yes, explain.(ex. fall, auto, sports,)

____

Symptoms: When this problem is at it's worst, can you explain in your words how exactly it feels?____

Severity Mild Moderate Severe

Does this pain travel or radiate? If so, Where?_______________________

____

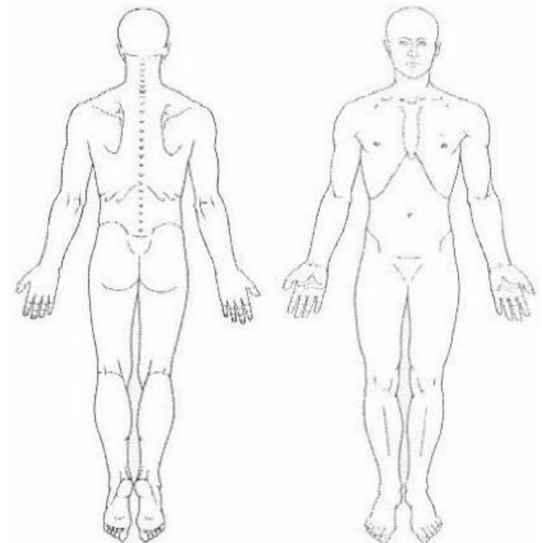
Quality: (circle all that apply)

Burning	Diffuse	Dull/Aching	Localized
Sharp	Shooting	Stabbing	Tingling
Radiating	Other ______________________		

Is there anything that makes this better? __________________________

Is there anything that makes this worse? ___________________________

Please mark on the diagram below the area of discomfort.



Goals: 1.)____

2.)____

3.)____

Please Mark the Diagram Accordingly Above:
R=Radiating B=Burning D=Dull A=Aching S=Sharp
N=Numbness T=Tingling

Clark CHIROPRACTIC

Timing:
- ❑ Worse AM ❑ Worse PM ❑ Worse W/ Activity ❑ Worse Sleeping
- ❑ Occasional (0-25%) ❑ Intermittent (25-50%) ❑ Frequent (50-75%) ❑ Constant (75-100%)

Rate the severity of your symptoms or condition (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Is the condition getting better, worse, or staying the same? __________________

Have you suffered with this or a similar problem in the past? ☐ No ☐ Yes If yes how many times? _______ When was the last episode? ____________

When was the first? _____________ How did the injury happen? ____

What solutions have you attempted to solve this problem? ____

What were the results: ☐ Favorable ☐ Unfavorable Please Explain: ____

Secondary Complaint: ____

Daily Activities: Effects of Current Condition on Performance

Activity				
Carrying Groceries	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Changing Positions	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sit to Stand	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Climbing Stairs	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Pet Care	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Driving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Extended Computer Use	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Household Chores	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Lifting Children	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Reading/Concentration	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Self Care – Bathing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Self Care – Dressing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Self Care – Shaving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sexual Activities	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sleep	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sitting Still	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Standing Still	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Yard Work	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Walking	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform

Please List any effects that this may have on any Recreational Activities:

____

Are there any other Complaints/Conditions/Past Accidents & Surgeries that the doctor should address? If so, list and describe**:**

____

____

____

Medications: What Medications are you currently taking and for what Conditions?

____

____

Is there anything else you think the doctor should know concerning your condition? Yes No

____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

____ Temporary Relief (Symptomatic) ____ Maximum Correction (Correct the problem & reduce chance of reoccurrence)

The questions below will allow us to better serve you.
What is most important to you when it comes to your relationship with your health care provider and your overall office experience?____
Would you say you are open and interested in new and cutting edge health care practices or more comfortable with conventional approaches? ____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

HIPPA

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.
I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I,______________________________________have read and fully understand the above statements.
(Print name)
I therefore begin my chiropractic examination and any other further care on this basis.

____ ________________________

(Signature) (Date)

FAMILY HEALTH HISTORY

This form is to assist the doctor by providing past family health history information

The reason for this form is to assist the doctor by providing past health history information for their review

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Difficulty Sleeping							
Disc Problems							
Ear Problems							
Emphysema							
Epilepsy/Seizures							
Fatigue							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neck Pain							
Numbness							
Pinched Nerve							
Scoliosis							
Sinus & Allergies							
Stomach Trouble							

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