Patient Information

Legal First Name: _____ **MI:** _____ **Last Name:** _____

Street: _____**Apt:** _____

City: _____ **State:** _____ **Zip:** _____

Social Security #:_____ **Marital Status: S M W D Spouse:**_____

DOB: _____ **Home Phone:** _____ **Work Phone:**_____

Cell Phone: _____ **Cell Carrier**_____

Please check your contact preference: _____Hm _____ Wk _____ Cell _____Email _____ Postal Mail

Email home: _____ **Email work:** _____

Emergency Contact:_____ **Phone Number:** _____

Whom may we thank for referring you to our office? _____

Your Occupation: _____ **Employer:** _____

Employer Address: _____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name: _____ **M.I.** _____ **Last Name:** _____

Policy Holder's Date of Birth: _____ **Policy Holder's SS#:** _____

Policy Holder's Employer: _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:
Policy Holder's Name:
First Name: _____ **M.I.** _____ **Last Name:** _____

Policy Holder's Date of Birth: _____ **Policy Holder's SS#:** _____

Policy Holder's Employer: _____

Electronic Health Requirements (we are required by law to ask you everything in next section)

Language: **English _____ Spanish _____ Indian _____ Japanese _____ Chinese _____ Korean _____**
French _____ German _____ Russian _____ Other _____

Race: **White _____ American Indian or Alaska Native _____ Native Hawaiian/Other Pacific Islander _____**
Asian _____ Black or African American _____ Hispanic or Latino _____ Decline to Answer ____
Other_____

Ethnicity: **Hispanic or Latino _____ Not Hispanic or Latino _____ Decline to Answer _____**

Patient History

Are you seeing anyone else for other problems or health conditions? □ Yes □ No

Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

_____

_____

_____

Past health history

Have you…	**Yes**	**No**	**If yes, include date & provider seen**
...been diagnosed with Diabetes?	□	□	_____
Type I____or Type II_____			
…been treated for hypertension?	□	□	_____
With or Without Heart Disease (Please circle one)			

Do you smoke? □Never □Former Smoker □Current/Every Day Smoker □Current Some Day Smoker

Medications

What medications are you currently taking? Include vitamins, herbs, minerals…

List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by

Please be as specific as possible

_____

_____

_____

_____

_____

Do you have allergies? □Food □Environmental □Medication

List Type of Allergy and Reaction

_____

_____

_____

Assignment & Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

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

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

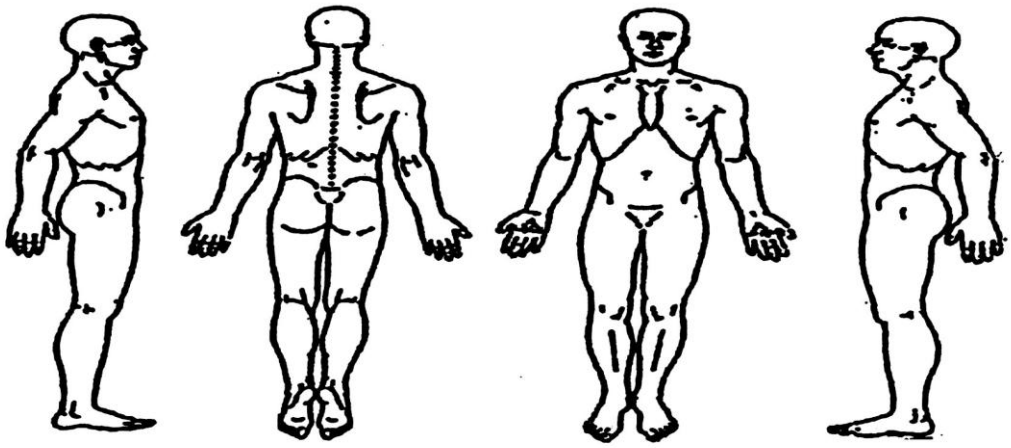
Patient's/Parent's/Guardian's Signature: _____ Date _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Neither

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

_____

15. What is your: Height_____ Weight _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members (Parents, Siblings, Children) with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	**For Females Only**		
□	□	Jaw Pain	□	□	Abdominal Pain		□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer		□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis		□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

20. List all surgical procedures you have had:
_____

21. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

22. What activities do you do outside of work?
_____

23. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

24. Have you had significant past trauma? □ No □ Yes

25. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

Informed Consent to Chiropractic Treatment

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are risks associated with such treatment. In particular you should note:

1) While rare; some patients may experience short term aggravation of symptoms including soreness, muscle tightness and ligamentous pain.
2) There are reported cases of stroke associated with common neck movements including rotation manipulation of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between the cervical spine manipulation and the occurrence of stroke. There are reported rates of occurrence showing 1 in 1 million will experience stroke. However, you are being informed of the possibility regardless of the extreme remote chance.
3) There are reported cases of strain/sprain injuries of ligament and muscle as well. Again, this is rare and the techniques employed by Dr. Nelson reduce that risk even more.

Chiropractic treatment, including manipulation, has been the subject of government reports and multi-disciplinary studies, and has been demonstrated to be a safe and effective care option for the treatment of back and neck pain, as well as headaches. Other conditions involving radiating pain, numbness, muscle spasm, loss of mobility and other symptoms have also shown improvement.

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor or referring physician, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature Patient Name (please print)

_____

Witness Signature

_____

Date