



Inspired Living Chiropractic
-A Family Wellness Center-

New Practice Member Intake Form

First Name: _____
Last Name: _____
Nickname: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Age: _____ Date of Birth: _____
Sex: () Male () Female
() Single () Married () Divorced () Separated () Widowed
Names and Ages of Children: _____

Social Security #: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
In case of an emergency, please contact:
Name: _____
Phone: _____
Relationship: _____

Type of work: _____
Insurance: () Work Comp () Auto () MA
Medicare () Private: _____
Whom may we thank for referring you to our
office? _____
How were you referred to our office?
() Yellow pages () Lecture () Drive by
() Coupon () Screening = Where? _____

() Mailing = which one? _____
() Other: _____

Your Health Profile

Please rate your overall health status:

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your health objectives? _____

Name/Address/Phone of the last doctor who put you on a health development program? _____

Were you able to stay on the program? Y N How long? _____

What were your results? _____

Are you healthier today than you were 5 years ago? Y N Not Sure

If so, what did you do to improve your health? _____

If not, why do you think your health declined? _____

Will you be healthier 5 years from now than you are today? Y N Not Sure

If so, what are you planning to do to improve your health and if not, what could you do to improve your health rather than have it continue to decline? _____

After making these changes in your life, how do you expect your health to be 5 years from now? _____

Have you had previous chiropractic care? Y N

If yes, what was the doctor's name? _____

What was the approximate date of your last visit? _____

What was the duration of your care? _____

Were you aware that:

- Doctors of Chiropractic work with the nervous system? ___Yes ___No
- The nervous system controls all bodily functions and systems? ___Yes ___No
- Chiropractic is the largest natural healing profession in this world? ___Yes ___No
- If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ___Yes ___No

What other wellness professionals are currently parts of your health care team? () Massage Therapist () Acupuncturist
() Naturopath () Homeopath () Other: _____

How many Medical Doctor's office visits did you and your family have last year? () None () Less than 5
() More than 5 () More than 10

Is your current condition the result of a recent: () auto accident? () work related injury

What was the date of injury? _____

If so, please inform the front desk staff immediately to obtain additional necessary paperwork.

Please describe below, in the following 2 sections, your primary, secondary and additional reasons, if any, for seeking care in our office:

Primary Complaint (List one only): _____

When did you first experience this problem? _____

How did this problem first begin? _____

How often do you experience this problem? () 1-2x/week () 3-4x/week () 5-6x/week () daily
() other: _____

Please grade the intensity of this problem (with 10 being worst):

At best 1 2 3 4 5 6 7 8 9 10

At worst 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)? _____

Please describe the location of the pain. _____

Does this problem cause pain to travel to any other area? Y N If yes, where? _____

Is this problem getting: () worse? () better? () staying the same?

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)? _____

Have you seen any other doctors for this problem? Y N If yes, who? _____

What treatment was given? _____

How effective was the care? _____

Secondary Complaint -- if any (List one only): _____

When did you first experience this problem? _____

How did this problem first begin? _____

How often do you experience this problem? () 1-2x/week () 3-4x/week () 5-6x/week () daily
() other: _____

Please grade the intensity of this problem (with 10 being worse):

At best 1 2 3 4 5 6 7 8 9 10

At worst 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc)? _____

Please describe the location of the pain: _____

Does this problem cause pain to travel to any other area? Y N If yes, where? _____

Is this problem getting: () worse? () better? () staying the same?

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)? _____

Have you seen any other doctors for this problem? Y N If yes, who? _____

What treatment was given? _____

How effective was the care? _____

Lifestyle / Social History

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

Do you smoke?	Y	N	If yes, how much?	_____
Do you drink alcohol?	Y	N	If yes, how much?	_____
Do you drink coffee?	Y	N	If yes, how much?	_____
Do you drink tea?	Y	N	If yes, how much?	_____
Do you drink water?	Y	N	If yes, how much?	_____

How regularly do you exercise? daily ___x/week occasionally never

What kind of exercise do you do? _____

How many hours of sleep do you get on average? _____

On a scale of 1-10 please rate your stress level (1=none and 10=extreme):

Occupational _____

Personal _____

Women Only

Pregnancies and outcomes:

Date of pregnancy	Outcome
_____	_____
_____	_____
_____	_____

When was your last period? _____

Are you pregnant? Yes No Not sure

Medical History

Please list the cause of death and age of any immediate family members (parents or siblings):

Relationship	Cause of Death	Age of death
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any of the following illnesses you have had:

- | | | |
|--|---|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Eczema |

Surgeries:

Date	Type	Reason for surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous injuries or trauma (please give type and date): _____

Medications (including over the counter drugs):

Medication & Dosage	Reason for taking
_____	_____
_____	_____
_____	_____

Nutritional Supplements you are currently taking: _____

Allergies: _____

Stress History

Please indicate whether you have **ever** experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health condition/concerns.

Childhood

Repeated/Prolonged Antibiotic Use	Y	N	Inhaler Use	Y	N
Car Accident	Y	N	Prescription Medications	Y	N
Childhood Illness	Y	N	Surgery	Y	N
Fall/Jump from a Height < 3 feet	Y	N	Vaccinations	Y	N
Fall/Jump from a Height > 3 feet	Y	N	Youth Sports	Y	N
Head Trauma	Y	N	Other Traumas (physical or emotional)_____		

Adulthood

Alcohol Consumption	Y	N	Inhaler Use	Y	N
Repeated/Prolonged Antibiotic Use	Y	N	Prescription Medications	Y	N
Car Accident	Y	N	Smoker	Y	N
Coffee Drinker	Y	N	Surgery	Y	N
Drug Use/Abuse	Y	N	Contact Sports	Y	N
Fall/Jump from a Height	Y	N	Extreme Sports	Y	N
Head Trauma	Y	N	Workplace Stress	Y	N
Home Environment Stress	Y	N	Other Traumas (physical or emotional)_____		

Please check any of the following you have had in the last six months:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress
- Hearing Difficulty

GENERAL

- Fatigue
- Allergies
- Headaches
- Fever

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating after Meals
- Heartburn
- Black/Bloody Stools
- Colitis

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

CARDIO-VASCULAR- RESPIRATORY

- Chest Pain
 - Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EYES, EARS, NOSE, THROAT

- Vision Problems
 - Dental Problems
- Sore Throat
- Ear Aches
- Stuffed Nose

MALE / FEMALE

- Menstrual Irregularity
- Menstrual Cramps
 - Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems:

Which best describes your reason for consulting our office?

- I have a specific concern and require help with this concern
- I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.
- I want to be healthier five years from now than I am today

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient, and the "Chiropractor" refers to Inspired Living Chiropractic: A Family Wellness Center.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing, or providing treatment for me, obtaining payment for my healthcare bills or to conduct healthcare operations of Chiropractor. I understand that analysis, diagnosis, or treatment of me by Chiropractor may be conditional 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 healthcare provider, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, of there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Practices prior signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is available at the front desk of Inspired Living Chiropractic: A Creating Wellness Center. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative's Authority

TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare 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 used 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 a diagnosis or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(Print Name)

Consent to evaluate and adjust a minor child

I, _____ being the parent of legal guardian of
_____ have read and fully understand the above terms of
acceptance and hereby grant permission for my child to receive chiropractic care.

All questions regarding the doctor's objectives pertaining to my/ my child's care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature

Date

Authorization to Release Medical Information

I authorize the release of medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature

Date

Agreement for Payment of Services:

I understand and agree that health and accident insurance policies are an arrangement 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 if any amount is authorized to be paid directly to this office, it will be credited to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT.** It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

Patient's Signature

Date

E-Practice Form

In our never-ending quest to serve our practice members better, we are constantly updating our database and requesting current information. By providing this information it will allow you to take advantage of and have access to our on-line scheduling, online class/lecture registration and receive up to the minute information about all the events occurring at Inspired Living Chiropractic: A Family Wellness Center (including schedule changes, current events, and newsletters). This data will never be released to anyone! Our efforts are to provide you with unparalleled service. We look forward to continuing our tradition of exceeding all your expectations.

Name: _____

E-Mail Address: _____