New Patient Intake Form

Today's Date:_____

Name:_____

Birth Date:_____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Phone:_____

Occupation:_____ Employer:_____ City:_____

Marital Status: S M D W Spouse's Name:_____

Number of Children:_____ **Women**- Are you currently pregnant? Y N If yes, how far along?_____

Have you been to a Chiropractor before? Y N Reason:_____ Date:_____

Whom may we thank for referring you to our office? ☐Website ☐Lunch-n-Learn/Screening ☐Health Expo

☐Person:_____ ☐Other:_____

YOUR HEALTH SUMMARY

Check all that currently apply:

☐Headaches	☐Numbness in Fingers	☐Heart Attack	☐High Cholesterol
☐Neck Pain	☐Numbness in Toes	☐Seizures	☐Fever/Chills/Sweats
☐Neck Stiffness	☐Weight Loss	☐Stroke	☐Heartburn/Reflux
☐Arthritis	☐Weight Gain	☐Thyroid Disorder	☐Sleeping Problems
☐Pins/Needles-Arms	☐Bowel Problems	☐Diabetes	☐Fatigue
☐Pins/Needles-Legs	☐Upset Stomach	☐Ringing in Ears	☐Anxiety Disorders
☐Back Pain	☐Diarrhea	☐Dizziness	☐Cancer
☐Cold Hands	☐Irregular Heartbeat	☐Irritability	☐Problems Urinating
☐Cold Feet	☐High Blood Pressure	☐Loss of Balance	☐Nervousness
☐Osteoporosis	☐Stress/Tension	☐Asthma	☐Menstrual Pain

Are you currently taking Prescription Medications? Y N

For what conditions?_____

_____

List of current Vitamins/Supplements taken regularly:_____

_____

Functional Rating Index

For use only if experiencing pain

In order to properly assess your condition, we must first understand how much your problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely currently describes your condition.

1) Pain Intensity

No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Pain

2) Sleeping

Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

3) Personal Care (washing, dressing, etc.)

No Pain/No Restrictions	Mild Pain/No Restrictions	Moderate Pain/ Need to go slowly	Moderate Pain/ Need Some Assistance	Severe Pain/ Need 100% Assistance

4) Travel (driving, etc.)

No Pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5) Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 50% of usual work	Cannot work

6) Recreation

No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Pain

7) Frequency of Pain

No pain	Occasional pain; 25% of day	Intermittent pain; 50% of day	Frequent pain; 75% of day	Constant pain; 100% of day

8) Lifting

No pain w/ heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9) Walking

No pain after several hours	Increased pain after several hours	Increased pain after one hour	Increased pain after 1/2 hour	Increased pain with any walking

10) Standing

No pain after several hours	Increased pain w/ several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

WELLNESS

Did you know that our doctor, Dr. Colby Nelson, is also a **Certified Wellness Doctor**?
In fact, there are only a handful of doctors in the entire Midwest that have earned this certification!

Please mark any areas below where you would like Dr. Colby to help you improve your overall health & wellness.

☐Improved Diet ☐Stress Reduction ☐Vitamins/Supplements

☐Exercise ☐Weight Loss ☐ Stronger Immune System

☐More Energy ☐Mood/Happiness ☐Other:_____

Patient Acknowledgement and Receipt of

Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Patient's Printed Name:_____ Date:_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Patient's Signature:_____

If patient is a minor or under a guardianship order as defined by State law:

Signature of Parent/Guardian:_____

Informed Consent

I will use my hand or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "popping" sound as part of the process.

There are certain complications that may occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, sprains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains, separation and/ or fracture. Rare complications include, but are not limited to stroke. The most common complication or complaint following a spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence, I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining your for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

Printed Name:_____

Signature:_____ Date:_____

Signature of Parent or Guardian (if minor):_____

Insurance Information

Policy Holder Information

Name on card:_____

Date of birth:_____ Relationship to patient:_____

Address (if different than patient):_____

Please check any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident

Medical Savings Account & Flex Plans Other:_____

Insurance Policy Information

Primary Insurance Company name:_____

Insurance Plan: HMO PPO Other:_____

Insurance Company phone #:_____

Policy/Member #:_____

Group #:_____

*Please let us know if you also have a secondary insurance you would like to file.

Authorization and Financial Responsibility

I authorize the release of any medical or other information necessary to process my claims. I assign directly to Active Family Chiropractic & Wellness all insurance benefits, if any, otherwise payable to me for services rendered.

I certify that the above information is correct. I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

_____ _____

Signature of Patient (or person acting on patient's behalf) **Date**