New Patient Intake Form

Confidential Patient Information

Kirkman Chiropractic

It's Your Future, Be There Healthy!

110 North Kirkman Road
Orlando, FL 32811-1404

Fax to: 407-291-2538
Office: 407-291-1000
www.KirkmanChiro.com

Date: ____________________________

Patient's Full Name: ____________________________

Date of Birth: _____ /_____ /__________ Age: _______ Sex ❒ M ❒ F ❒ Transgender

Address: ____________________________

Apt./Unit # _____________ City/State/Zip: ____________________________

Employer: ________________________ Occupation: ____________________

Home Phone: ___________________________ Cell Phone: ____________________

Work Phone: ___________________________ Email: ____________________

Contact Preference: ❒ Home ❒ Cell ❒ Work Social Security #: ________ - _____ - _______

Marital Status: ❒ S ❒ M ❒ D ❒ W

Spouse's Name: ____________________________

Insurance Carrier: ____________________________ ID #: ____________________

Emergency Contact: ________________________________ Phone: ____________________

Is this visit a result of an accident? ❒ Yes ❒ No (if yes, date of accident) ____/____/__________

State where accident occurred ____________________________ Type: ❒ Auto ❒ Work Related

Have you reported your accident to your insurance company? ❒ Yes ❒ No

Are you currently represented by an Attorney? ❒ Yes ❒ No *(if yes please provide the name and phone number below)*

Attorney Name: ______________________________ Phone Number: ____________________

Responsible Party Information *(If other than Patient)*

Full Name: ____________________________

Date of Birth: _____ /_____ /__________ Social Security #: ________ - _____ - __________

Address: ____________________________

Apt./Unit # _____________ City/State/Zip: ____________________________

Please Tell Us About Yourself

What is your race/ethnicity? Please mark the one box that describes the race/ethnicity category with which you primarily identify:

❒ Asian or Pacific Islander: Persons having origins in any of the peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

❒ African American (not of Hispanic origin): Person having origins in any of the black ethnic groups.

❒ Hispanic: Persons having origins in any of the Mexican, Puerto Rican, Cuban, Central or South American or other Spanish Cultures, regardless of ethnicity.

❒ Native American or Alaskan Native: Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

❒ Caucasian (not of Hispanic origin): Persons having origins in any of the original peoples of Europe, North Africa or the Middle East.

What is your primary Language? ❒ English ❒ Spanish ❒ Other: ____________________

How were you referred to our office?

❒ Office Sign	❒ Physician Referral: Name: ____________________
❒ Yellowpages.com	❒ Patient Referral: Name: ____________________
❒ Insurance Website/Book	❒ Health Fair/ Location: ____________________
❒ Google	❒ Office Website (www.kirkmanchiro.com)
❒ Yahoo	❒ Bing

Staff Initial: __________

REV1118

** Please read and sign the informed consent and acknowledgement of Privacy Practices on the back of this form.*

Patient Name: ____ Date: __________________________

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. 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 for professional services rendered to me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at Kirkman Chiropractic to treat my condition as deemed appropriate. It is understood and agreed that the amount paid to the doctor for x-rays, is for examination only, and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Kirkman Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider to whom we feel can further assist you.

Possible Risks Associated with Chiropractic Care.

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns- Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor or a staff member at Kirkman Chiropractic.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies (Canadian Medical Association Journal, CMAJ, October 2, 2001) estimate that the incidence of this type of stroke is 1 in every 5.85 million upper cervical adjustments.

Other Problems- There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

____

Patient Signature: Date

____

Parent/Legal Guardian Signature: Date

CONSENT TO TREATMENT OF MINOR:

(I) (We), the undersigned, parent(s)/person having legal custody/legal guardianship of (Name of Minor) ____________________________________, a minor,

do hereby authorize (Name of Agent) ____ as agent(s) for the undersigned to consent to any x-ray, examination, and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment deem advisable.

This authorization shall remain effective until (month and day) _______________________________, (year) 20________, unless sooner revoked in writing delivered to the agent(s) noted above.

Signature (Parent/Legal Guardian/Person Having Legal Custody — Circle Relationship): ____

Signature (Parent): ____ **Date:** ________________________________

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Date ____________

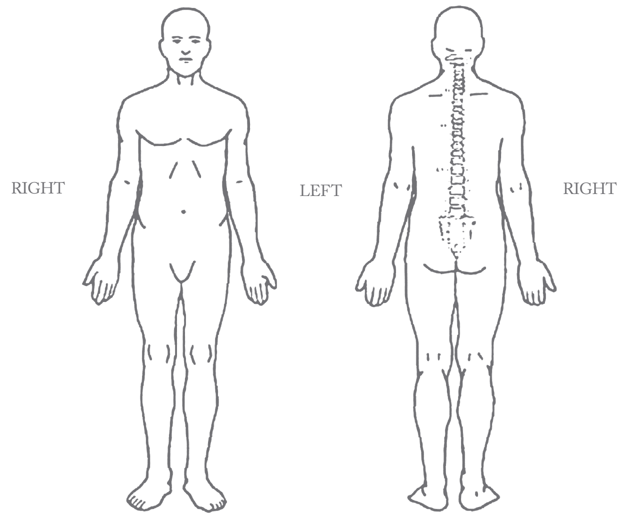
First Name: ____________ Last Name: ____________ Initial ______

Major Complaint Information

What is your major complaint(s)? ____________

When did this symptom(s) begin? ____________

USING THE SYMBOLS PROVIDED BELOW, MARK THE AREAS OF COMPLAINT FOLLOWED BY THE LEVEL OF SEVERITY, 1 THRU 10 (1=MINOR, 10=SEVERE).



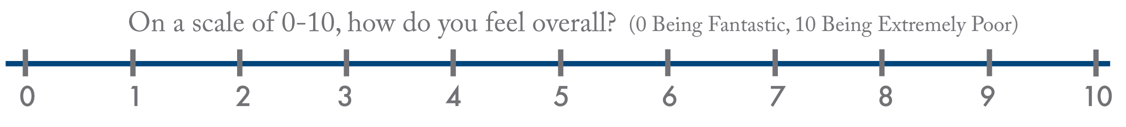
B Burning **S** Sharp/Stabbing
N Numbness/Tingling **A** Ache

Example: B7 or S3

If this is an injury, describe what happened:

____
____
____
____

On a scale of 0-10, how do you feel overall? (0 Being Fantastic, 10 Being Extremely Poor)



Have you experienced these symptoms before? ❍ Yes ❍ No When? ____________

These symptoms developed from? ❍ Auto Accident ❍ Work-Related ❍ Other: ____________

How is your condition changing? ❍ Getting better ❍ Getting worse ❍ Not changing

How often do you experience your symptoms?

❍ Constantly (76%-100% of the day) ❍ Frequently (51-75% of the day)

❍ Occasionally (25-50% of the day) ❍ Intermittently (0-25% of the day)

Describe the nature of your symptoms:

❍ Sharp ❍ Dull ❍ Numb ❍ Burning ❍ Shooting ❍ Tingling

❍ Radiating ❍ Tightness ❍ Stabbing ❍ Throbbing ❍ Other: ____________

How often do your symptoms affect your ability to perform daily activities such as working or driving?

(0=no effect, 10=no activities possible) ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7 ❍ 8 ❍ 9 ❍ 10

What activities aggravate your condition? ____________

What makes your pain better (ice, heat, massage, etc.)? ____________

Does it cause pain to cough, grunt, or sneeze? ❍ Yes ❍ No If so, where? ____________

Have you seen a doctor for this condition? ❍ Yes ❍ No Doctor's Name: ____________

Date Consulted: ____________ Diagnosis: ____________

Staff Initial: ____________

Patient Name: ____ Date: ____________________

Check those activities below during which you experience difficulty or pain:

___ Lying on back	___ Getting in/out of car	___ Sleeping	___ Stooping	___ Standing for periods over one hour
___ Lying on side with knees bent	___ Gripping	___ Pushing	___ Sitting	___ Sneezing
___ Turning over in bed	___ Climbing	___ Pulling	___ Bending forward	___ Coughing
___ Lying flat on stomach	___ Dressing self	___ Reaching	___ Bending backward	___ Other: ____________
	___ Sexual activity	___ Kneeling	___ Walking	

List any allergies:____

List all medications you are currently taking now, including over the counter medication:____________________________

Have you ever had any surgeries, hospitalizations, or accidents? Please list: ____________________________

Family History: (Father, Mother, Sibling, Grandparent, Child) Has a member of your family had any of these conditions?

❍ Heart disease ❍ Cancer ❍ High blood pressure ❍ Thyroid disease

❍ Stroke ❍ Arthritis ❍ Diabetes ❍ Other:______________________

Do you have, or ever had, any diseases or medical problems not listed? ❍ Yes ❍ No

If so, please specify:____

If female, are you pregnant? ❍ Yes ❍ No ❍ Not Sure If yes, what is your due date? ____________________

Have you been x-rayed in the last 6 months? ❍ Yes ❍ No When?______________________________

Have you ever been to a chiropractor before? ❍ Yes ❍ No

Name of Chiropractor: ________________________________Dates: ____________________

Do you have a family physician? ❍ Yes ❍ No

Name of physician:______________________________ Phone:______________________________

Address:______________________________ City, State, ZIP: ______________________________

Social History:

Do you smoke? ❍ Yes ❍ No If yes, how much? ______ per day/week/month (please circle) Were you ever a smoker? ❍ Yes ❍ No

Do you drink alcohol? ❍ Yes ❍ No If yes, how much? ______________________ per day/week/month (please circle)

Review of Systems:

Do you currently have any problems in any of the following areas?	No	Yes	Details
1. **CONSTITUTIONAL SYMPTOMS** (fever, weight loss, etc.)			
2. **EYES** (poor vision, pain, tearing, redness, light sensitivity, etc.)			
3. **EARS, NOSE, THROAT** (hearing problems, ear ache, cough, runny nose, etc.)			
4. **CARDIOVASCULAR** (high blood pressure, heart, racing pulse, palpitations, etc.)			
5. **RESPIRATORY** (asthma, shortness of breath, coughing, etc.)			
6. **GASTROINTESTINAL** (constipation, diarrhea, acid reflux, etc.)			
7. **GENITOURINARY** (kidney problems, bladder problems, etc.)			
8. **MUSCULOSKELETAL** (joint pain, arthritis, muscle pain, etc.)			
9. **INTEGUMENT** (acne, warts, skin growths, rash, etc.)			
10. **NEUROLOGICAL** (numbness, seizures, paralysis, etc.)			
11. **PSYCHIATRIC** (depression, anxiety, insomnia, etc.)			
12. **ENDOCRINE** (diabetes, hypothyroid, hyperthyroid, etc.)			
13. **HEMATOLOGICAL/LYMPHATIC** (blood clotting, anemia, lymph nodes swelling, etc.)			
14. **IMMUNOLOGIC** (multiple sclerosis, lupus, HIV, rheumatoid arthritis, etc.)			

Staff Initial: __________