



Welcome to our office!

It is well known that families who maintain strong, healthy, well-aligned spines have greatly improved health.

People whose spines are not healthy and kept in proper alignment are much more likely to develop serious health challenges later in life.



## **ADULT CHIROPRACTIC INTAKE FORM**

### **MY PURPOSE FOR TODAY'S APPOINTMENT IS:**

***(check all that apply to you)***

- I'm here for an evaluation. I'm a healthy person and I'm interested in maximizing my health and preventing future problems.
- I'm here for an evaluation because I'm having health challenges and am looking for a natural health solution.
- I'm here for an evaluation. I am curious to know if my spine is healthy and to see if I have any problems that I don't know about.
- I am here for an evaluation because I'm curious to learn more about Chiropractic Care
- I am here for an evaluation only
- Other

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### **IF THE DOCTOR FEELS THAT SHE CAN HELP YOU:**

***(Please check the one that best applies to you)***

- I am willing to follow the doctor's recommendations because I strongly value my health.
- I am willing to receive care if payment plans are available.
- I am willing to receive care but only if my insurance pays for all of it.
- I am not interested in receiving any future care.

# TERMS OF ACCEPTANCE FOR CHIROPRACTIC HEALTH CARE

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: to eliminate misalignments within the spinal column, which interfere with the expression of the body's natural wisdom.** It is important that each patient understand both the objective and the method that will be used to attain our goal. 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 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 natural 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 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 that you seek the services of a health care provider that 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. **OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's natural wisdom. Our only method of achieving this is through specific adjusting to correct vertebral subluxations.**

I, \_\_\_\_\_ have read and fully understand the above statements.  
(print name)

All questions regarding the doctor's objectives to my care in this office have been answered to my complete satisfaction.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Consent to Treatment of Minor Child

I hereby authorize Cadence Chiropractic to administer treatment as they so deem necessary to my daughter / son / other,  
(name) \_\_\_\_\_.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_

# NEW PATIENT HEALTH HISTORY

Today's Date: \_\_\_\_\_

File #: \_\_\_\_\_

## PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Marital Status:  Single  Married Do you have Insurance:  Yes  No Work Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Number of children and ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

## HISTORY of COMPLAINT

Please list your health concerns below:

Health Concern in order of severity	Rate Severity: 1 = mild 10 = unbearable	Have you had the condition before? When?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? \_\_\_\_\_

Chiropractor? Y / N Medical Doctor? Y / N Other: \_\_\_\_\_

Dr's Name? \_\_\_\_\_

How long ago? \_\_\_\_\_ What were the results:  Favorable  Unfavorable

→ please explain: \_\_\_\_\_

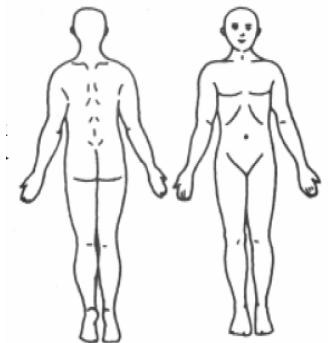
**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

**R** = Radiating **B** = Burning **D** = Dull **A** = Aching

**N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms? \_\_\_\_\_

What makes your symptoms feel worse? \_\_\_\_\_



## LIST RESTRICTED ACTIVITY:

## CURRENT ACTIVITY LEVEL

## USUAL ACTIVITY LEVEL

_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

Is your problem the result of ANY type of accident?  Yes,  No Explain: \_\_\_\_\_

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

**PAST HISTORY**

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer \_\_\_ Stroke  
\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular Issue \_\_\_ Other serious conditions: \_\_\_\_\_

**PLEASE identify ALL PAST and CURRENT conditions you have:**

Headache	Numb/Tingling in arms, hands, fingers	Fainting	Impotence/Sexual Dysfunction	High Blood Pressure
Neck Pain		Double Vision		Low Blood Pressure
Jaw Pain/TMJ	Numb/Tingling in legs, feet, toes	Blurred Vision	Digestive Problems	Asthma
Shoulder Pain		Ringing in Ears	Colon Trouble	Difficulty Breathing
Upper Back Pain	Convulsions/Epilepsy	Hearing Loss	Diarrhea/Constipation	Lung Problems
Mid Back Pain	Tremors	Depression	Menopausal Problems	Kidney Trouble
Low Back Pain	Chest Pain	Irritable	PMS	Gall Bladder Trouble
Hip Pain	Pain w/Cough/Sneeze	Mood Changes	Bed Wetting	Liver Trouble
Foot or Knee Problems	Pregnant (Now)	ADD/ADHD	Learning Disability	Hepatitis (A,B,C)
Elbow or Wrist Problems	Frequent Colds/Flu	Allergies	Eating Disorder	Other _____
Back Curvature	Sinus/Drainage Problem	Prostate Problems	Ulcers	_____
Scoliosis	Swollen/Painful Joints	Trouble Sleeping	Heartburn	_____
Skin Problems	Dizziness		Heart Problem	_____
	Loss of Balance			

**PLEASE List past surgical operations and the date they occurred:** \_\_\_\_\_

**PLEASE List ALL over the counter and prescription medications you are currently taking:** \_\_\_\_\_

When was your last automobile accident? \_\_\_\_\_

Have you ever been knocked unconscious? When? \_\_\_\_\_

**SOCIAL HISTORY**

**1. Smoking:**  cigars  pipe  cigarettes How often?  Daily  Weekends  Occasionally  Never

**2. Alcoholic Beverage:** consumption occurs  Daily  Weekends  Occasionally  Never

**3. Recreational Drug use:**  Daily  Weekends  Occasionally  Never

**4. Hobbies -Recreational Activities- Exercise Regime:** How often do you exercise? \_\_\_\_\_

I hereby authorize and request payment for services to be made directly to Cadence Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Cadence Chiropractic for any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_\_  
**Date Form Reviewed**

## INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Cadence Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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## NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that a more comprehensive version of this "Notice Of Privacy Practice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

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## MEDICAL INFORMATION RELEASE FORM (HIPAA Release Form)

### Release of Information:

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This "**Release**" will remain in effect until terminated by me in writing. This information may be released to:

- Spouse \_\_\_\_\_
- Child(ren) \_\_\_\_\_
- Other \_\_\_\_\_
- Information is not to be released to anyone.

### Messages:

Please call  my home  my work  my mobile number: \_\_\_\_\_

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call

The best time to reach me is (*day*) \_\_\_\_\_ between (*time*) \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

## **X-RAY AUTHORIZATION**

As your healthcare provider, we are legally responsible for your chiropractic records; we must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-ray in our files.

The fee for copying your X-Rays and Video Fluoroscopy study on a disc is \$10.00. This fee must be paid in advance.

Digital X-Rays on CD will be available within 72 hours of prepayment and on regular practice hour days.

**PLEASE NOTE:** X-Rays are utilized in this office to help locate and analyze vertebral subluxations. These X-Rays are not used to investigate for medical pathology. The doctors of Cadence Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you may seek proper medical advise.

By signing below you are agreeing to the above terms and conditions.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Your Age

**FEMALE PATIENTS ONLY:**

To the best of my knowledge, I believe I am not pregnant at the time X-Rays are taken at Cadence Chiropractic.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date