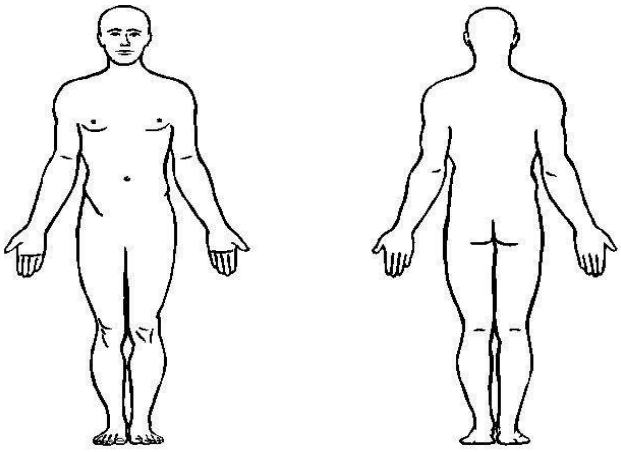
Patient Intake Form

Name: _____Birthdate:_____/_____/_____ Sex: ❑ Female ❑ Male
Height _____ft. ____ in. Weight _____lbs. Occupation: _____For how long? _____ yrs. _____ mos.
Address: _____
City: _____ State: _____ Zip Code: _____Phone:(_____)_____
E-mail (all info. is considered private): _____
Person to contact in case of emergency: _____Phone: (_____)_____
How did you hear about The Fix Chiropractic (online, walk-by, friends name)?_____
Have you had chiropractic care before? ❑ Yes ❑ No if Yes, how recently: _____/_____/_____

Reason for visit: ❑ Injury ❑ Pain ❑ Auto Accident ❑ Maintenance ❑ Other _____
Where are you having pain or discomfort today? _____
When did your complaint(s) first begin (date)? _____/_____/_____
Today, the condition: ❑ Same ❑ Better ❑ Worse
Have you had this complaint(s) before? ❑ Yes ❑ No if Yes, how recently? _____/_____/_____
Which activities are difficult to perform: ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down

Use the image to the right:
Rate pain/discomfort on
image with number(s): 1 - 10
(1 = minimal, 10 = severe pain)



Type of pain:
❑ Sharp ❑ Dull ❑ Throbbing
❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling

Is the pain:
❑ Constant ❑ Intermittent ❑ Occasional

Are you currently experiencing:
❑ Nausea ❑ Dizziness ❑ Difficulty speaking
❑ Difficulty breathing ❑ Double Vision

Health History: Check any conditions that apply

❑ Arthritis	❑ Fused/Fixated Joints	❑ Joint Replacement	❑ Hernia	❑ Osteoporosis
❑ Osteopenia	❑ Heart Disease	❑ Cancer	❑ AIDS/HIV	❑ Allergies
❑ Seizures	❑ Dizziness/Vertigo	❑ High Blood Pressure	❑ Diabetes	❑ Pacemaker
❑ Stroke	❑ Tobacco Use	❑ Currently Pregnant: # of wks.?_____		❑Other_____

Family Health History: Check any conditions that apply
❑ Cancer ❑ Diabetes ❑ High Blood Pressure ❑ Heart Disease ❑ Stroke ❑ Seizures

Have you had any **surgeries**, **accidents**, **broken bones** or **hospitalizations**? ❑ Yes ❑ No
Please describe what: _____ Date:_____/_____/_____
Please describe what: _____ Date:_____/_____/_____
Please describe what: _____ Date:_____/_____/_____

Current prescriptions or over-the-counter medications: _____

Patient Signature: _____Date: _____/_____/_____

Informed Consent for Chiropractic Care

• **The nature of the chiropractic adjustment**. The doctor will use his/her hands or a mechanical device upon your body in such a way as to improve joint alignment and mobility. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. Improving joint alignment and movement can reduce pain and other symptoms. Routine chiropractic treatment can result in improved joint function and a healthier more active lifestyle.

• **The material risks inherent in chiropractic adjustment;** As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications while rare include: short term aggravation of symptoms, rib fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, and costovertebral strains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious vascular complications. Furthermore, the apparent association is noted very infrequently. Some patients will feel some stiffness and soreness following the first few days of treatment.

• **The probability of those risks occurring;** Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination. The reported cases of vascular complications associated with neck movement including adjustments of the upper cervical spine are not directly supported by current medical and scientific evidence there is not established definite cause and effect relationship. Since even that risk should be avoided if possible, we employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury. The risks of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatment, medications, and surgical procedures given for the same treatments.

•**Alternatives to chiropractic treatment include:** Heat, ice, massage and rest. Medical care with prescription drugs, anti-inflammatory medications, muscle relaxants and pain-killers. Physical therapy, injections or surgery.

By signing this Informed Consent, I acknowledge that I have discussed, or will have had the opportunity to discuss with my Doctor of Chiropractic the nature and purpose of chiropractic treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks and alternatives to chiropractic care, I hereby give my consent to apply to all my present and future treatments received.

Financial responsibility and Medicare/Medicaid Patients

The patient(s) acknowledge that they are financially responsible to remit payment in full for all services provided to them. Furthermore, patients understand and agree that we will not submit any billing data or related claim(s) for, or on, behalf to any private, public or government insurance program.

Medicare/Medicaid covers chiropractic care, however we do not bill Medicare/Medicaid for your treatments. By Medicare/Medicaid standards, treatments here are considered Wellness/Maintenance visits. You are responsible for the payment not Medicare/Medicaid. This cannot be appealed at a later date through Medicare/Medicaid. By signing below means you have received and understand this notice.

HIPAA Acknowledgement

I acknowledge that the Notice of Privacy Practices is posted at The Fix Chiropractic and a copy is available for me by request.

Date _____ Date _____

_____ _____

Print Patient Name Witness

_____

Patient Signature or Legal Guardian Signature

Consent to Evaluate and Treat a Minor Child

I _____being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.