WELL INTAKE FORM

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____ **TODAYS DATE** _____

PATIENT DEMOGRAPHICS

Patient Name: _____
DOB: _____ Age: _____ ☐ M ☐ F
Address: _____
City: _____ State: _____ Zip: _____
SSN: _____
Email: _____
Phone Number: _____
Occupation: _____

Marital Status:
Name of Spouse: _____
Occupation: _____
Phone Number: _____
Children? ☐ Y ☐ N If so, how many? _____
Emergency Contact: _____
Relationship? _____
Phone Number: _____

INSURANCE INFORMATION

Do you have Medicare? ☐ Y ☐ N Primary Company: _____ Policy #: _____
Do you have health insurance? ☐ Y ☐ N Primary Company: _____ Policy #: _____

HISTORY OF COMPLAINT

1. Please identify the condition(s) that brought you to our office:

1ST _____ 2ND _____ 3RD _____

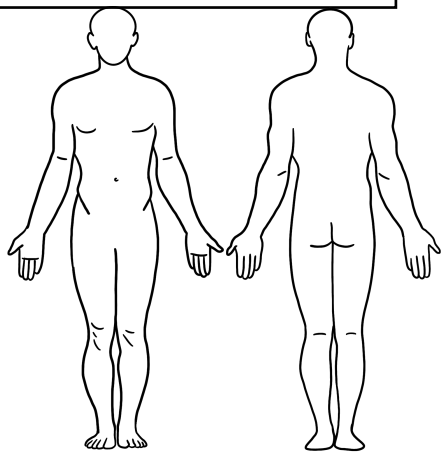
2. On a scale of 0-10 (0 = no pain & 10 = worst pain), rate your above complaints by checking the number **THAT APPLIES:**

1ST ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
2ND ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
3RD ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

3. When did the complaint(s) begin? _____ When is the complaint(s) worse? ☐ AM ☐ Mid-Day ☐ PM
4. How did the "injury" (complaint) happen? _____
5. Frequency? ☐ It is constant ☐ On and off during the day ☐ Comes and goes throughout the week
6. What relieves your symptoms? _____ When makes it feel worse? _____

DESCRIBE YOUR SYMPTOMS

LIST RESTRICTED ACTIVITY: *(Examples: standing)* _____
CURRENT ACTIVITY LEVEL: *(Example: 10 minutes without pain)* _____
USUAL ACTIVITY LEVEL: *(Example: 2+ hours without pain)* _____



PLEASE MARK the areas on the diagram to the right, with the following LETTERS:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

PAST HISTORY

1. Have you suffered with this or a similar problem in the past? ☐ Y ☐ N If yes, how many times? _____
   When was the last episode? _____ How did the injury happen? _____
2. Other forms of treatment tried? ☐ Y ☐ N Type? _____ Who Provided Treatment? _____
   How long ago? _____ Results Were: ☐ Favorable ☐ Unfavorable Explain: _____
3. Have you ever seen a chiropractor? ☐ Y ☐ N If yes, what were the results? ☐ Bad ☐ Good ☐ Great
4. Please identify ALL PAST and current conditions you feel may be contributing to your present complain:

	HOW LONG AGO?	TYPE OF CARE RECEIVED?	BY WHOM?
INJURIES/SURGERIES			
ADULT/CHILD DISEASES			

SOCIAL HISTORY

1. Smoking: ☐ Cigars ☐ Pipe ☐ Cigarettes How Often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverages (Consumption): How Often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug Use: How Often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. How does your present complaint affect your recreational activities/exercise regime/hobbies? _____
   _____

ACTIVITIES OF DAILY LIVING

1 = No Effect **3** = Painful (activities limited)
2 = Painful (can do) **4** = Unable to Perform

BENDING	☐	1	☐	2	☐	3	☐	4
CARRYING	☐	1	☐	2	☐	3	☐	4
CLIMBING	☐	1	☐	2	☐	3	☐	4
COMPUTER WORK	☐	1	☐	2	☐	3	☐	4
CONCENTRATING	☐	1	☐	2	☐	3	☐	4
DANCING	☐	1	☐	2	☐	3	☐	4
DOING CHORES	☐	1	☐	2	☐	3	☐	4
DRESSING	☐	1	☐	2	☐	3	☐	4
DRIVING	☐	1	☐	2	☐	3	☐	4
GARDENING	☐	1	☐	2	☐	3	☐	4
LIFTING	☐	1	☐	2	☐	3	☐	4
PLAYING SPORTS	☐	1	☐	2	☐	3	☐	4
PUSHING	☐	1	☐	2	☐	3	☐	4
READING	☐	1	☐	2	☐	3	☐	4
RECREATIONAL ACTIVITIES	☐	1	☐	2	☐	3	☐	4
ROLLING OVER	☐	1	☐	2	☐	3	☐	4
RUNNING	☐	1	☐	2	☐	3	☐	4
SEXUAL ACTIVITY	☐	1	☐	2	☐	3	☐	4
SHOVELING	☐	1	☐	2	☐	3	☐	4
SITTING	☐	1	☐	2	☐	3	☐	4
SITTING TO STANDING	☐	1	☐	2	☐	3	☐	4
SLEEPING	☐	1	☐	2	☐	3	☐	4
STANDING	☐	1	☐	2	☐	3	☐	4
WALKING	☐	1	☐	2	☐	3	☐	4
WATCHING TV	☐	1	☐	2	☐	3	☐	4
WORKING	☐	1	☐	2	☐	3	☐	4

SYMPTOMS

Please check all that apply in the **past 12 months:**

- ☐ ADD/ADHD
- ☐ ALLERGIES
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BED WETTING
- ☐ BLOOD PRESSURE (HIGH OR LOW)
- ☐ BLURRED VISION
- ☐ BROKEN BONES/FRACTURES
- ☐ CANCER
- ☐ COLON TROUBLE/DIGESTIVE ISSUES
- ☐ DEPRESSION
- ☐ DIARRHEA/CONSTIPATION
- ☐ DIFFICULTY BREATHING
- ☐ DIZZINESS/LOSS OF BALANCE
- ☐ DOUBLE VISION
- ☐ EATING DISORDER
- ☐ EPILEPSY/CONVULSIONS
- ☐ FAINTING
- ☐ FOOT OR KNEE PROBLEMS
- ☐ FREQUENT COLDS/FLU
- ☐ GALL BLADDER TROUBLE
- ☐ HEADACHES
- ☐ HEARING LOSS
- ☐ HEARTBURN
- ☐ HEART PROBLEMS
- ☐ HEPATITIS (A,B,C)
- ☐ HORMONE IMBALANCE
- ☐ IMPOTENCE/SEXUAL DYSFUNCTION
- ☐ IRRITABLE
- ☐ JAW PAIN/TMJ
- ☐ KIDNEY TROUBLE
- ☐ LEARNING DISABILITY
- ☐ LIVER TROUBLE
- ☐ LUNG PROBLEMS
- ☐ MENOPAUSAL PROBLEMS
- ☐ MOOD CHANGES
- ☐ NUMB/TINGLING ARMS, HANDS, FINGERS
- ☐ NUMB/TINGLING LEGS, FEET, TOES
- ☐ OSTEOPOROSIS
- ☐ PAIN IN CHEST
- ☐ PAIN IN HIP
- ☐ PAIN IN LOW BACK
- ☐ PAIN MID BACK
- ☐ PAIN NECK
- ☐ PAIN SHOULDER
- ☐ PAIN UPPER BACK
- ☐ PAINFUL/SWOLLEN JOINTS
- ☐ PREGNANT (NOW)
- ☐ PROSTATE PROBLEMS
- ☐ RINGING IN EARS
- ☐ SCOLIOSIS
- ☐ SINUS/DRAINAGE PROBLEM
- ☐ SKIN PROBLEMS
- ☐ SWOLLEN/PAINFUL JOINTS
- ☐ TREMORS
- ☐ TROUBLE SLEEPING
- ☐ TUMORS
- ☐ ULCERS

PHYSICAL STRESS

1. Have you ever been in a car accident? ☐ Y ☐ N If so, when? _____

   a. What speed was the collision? ☐ 0 - 10 ☐ 10 - 20 ☐ 20 - 30 ☐ 30 - 40 ☐ 40 - 50 ☐ 50+

   b. Type of impact? ☐ Front Impact ☐ Side Impact ☐ Rear Impact ☐ Roll-Over

   c. Was treatment received? ☐ Y ☐ N If yes, explain: _____

2. Have you ever been injured at work? ☐ Y ☐ N If yes, explain: _____

   a. Was treatment received? ☐ Y ☐ N

   b. Does your job require you to remain in long-term stressful postures? *(repeated lifting, long-term seating/computer use)* ☐ Y ☐ N

3. Have you ever had any spinal traumas in the past? ☐ Y ☐ N If yes, explain: _____

   a. Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field (explain): _____

   b. Trauma as a child: fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident, sports injury (explain): _____

   c. Work around the house *(lifting, bending, woke up with stiff neck, "back went out")* (explain): _____

VITALS PROFILE

1. What is your height? _____ 2. What is your current weight? _____ 3. Blood Pressure? ____/____

MEDICATIONS AND ALLERGIES PROFILE

1. In regards to medication, check all that apply.

☐ ACID REFLUX	☐ ANXIETY	☐ CHOLESTEROL	☐ HORMONE THERAPY (HRT)	☐ THYROID
☐ ADD/ADHD	☐ ASPIRIN	☐ CROHNS/COLITIS	☐ IBUPROFEN	☐ TYLENOL
☐ ALLERGY	☐ BIRTH CONTROL	☐ CPAP MACHINE	☐ MUSCLE RELAXER	☐ _____
☐ ANTIBIOTICS	☐ BLOOD PRESSURE	☐ DIABETES	☐ PAIN KILLER	☐ _____
☐ ANTIDEPRESSANTS	☐ BLOOD THINNER	☐ HEADACHE	☐ SLEEP	☐ _____

2. Please list any supplements or medications you take regularly: _____

3. Please list any allergies/sensitivities: _____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW?

INFORMED CONSENT

Notice of Privacy Practice

I have been offered a copy of the office Patient Privacy Notice, I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient or Guardian's Signature Date

_____

Patient or Guardian's Printed Name

Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment Objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Well Health & Chiropractic Dickson have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____

Patient or Guardian's Signature Date

_____

Patient or Guardian's Printed Name

X-Ray and Image Studies Consent

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to me and/or an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination if the doctor has deemed necessary in my case.

_____ _____

Patient or Guardian's Signature Date

_____

Patient or Guardian's Printed Name

Payment Responsibility and Coordination of Insurance Benefits

I understand that I am ultimately responsible for the charges assessed by Well Health & Chiropractic Dickson for my or my minor's treatment.

I understand that insurance policies are an arrangement between an insurance company and either myself, or someone else, depending on the situation, but not Well Health & Chiropractic Dickson. I understand that from time to time, if requested, Well Health & Chiropractic Dickson is able to prepare necessary reports and/or forms to assist me in receiving payment from an insurance company. I understand that these reports and/or forms are based on the independent opinion, knowledge and expertise of Well Health & Chiropractic Dickson staff and that opinion may or may not assist in the recovery of a payment on my case.

Should Well Health & Chiropractic Dickson decide to accept direct payment, by either an assignment of benefit or lien, from another entity such as an insurance company or attorney, those proceeds will be paid directly to Well Health & Chiropractic Dickson and credited to my account upon receipt. However, I understand and agree that all the services rendered to me, or the minor in my care, are charged to me and that I am personally responsible for payment.

_____ _____

Patient or Guardian's Signature Date

_____

Patient or Guardian's Printed Name

Female Patients Only

Please read carefully, and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on (Date): _____

☐ I am not pregnant to the best of my knowledge.

☐ I understand that x-rays may pose certain risk to the development of an unborn child, and I consent to have x-rays taken.

_____ _____

Patient or Guardian's Signature Date

_____

Patient or Guardian's Printed Name