**Intake Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Sex: (M) (F) Marital Status: (S) (M) (W) (D)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zipcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bus #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and assign directly to Paragon Chiropractic all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Initials)

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

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred to this Office By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had Chiropractic care before? Yes/No Name of Dr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had the same or similar issue? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your Condition: ( ) Job Related ( ) Auto Accident ( ) Home Injury ( ) Not Sure

Do you or have you suffered from any major illnesses? Yes/No

Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any operations, broken bones or other issues not mentioned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When are you available for care? (Please Circle.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Mondayam / pm | Tuesdayam / pm | Wednesdayam / pm | Thursdayam / pm | Fridayam / pm | Saturdayam / pm |

In the event that insurance payments are mailed directly to me, I am responsible to pay Paragon Chiropractic upon receipt of the check(s). Payment arrangements for these services after the insurance has paid are not acceptable. I will provide Paragon Chiropractic with a copy of the explanation of benefits that comes with the check. I have read, understand and agree to the above written responsibility on my party as a Paragon Chiropractic patient.

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

**Informed Consent**

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.

Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

*Common* 1, 2

* Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours.

*Rare* 3. 4

* Fractures or joint injuries in isolated cases with underlying physical defects, deformities, or pathologies
* Physiotherapy burns due to some therapies
* Disc herniations
* Caude Equina Syndrome (2) (1 case per 100 million adjustments)
* Compromise of the vertebrobasilar artery (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor.

**Please indicate to your doctor if you have headache or neck pain that is the worst you have ever felt (3)**

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved modality and function, and reduced muscle spasm. I also understands that my condition may worsen and referral may be necessary if a course of chiropractic care does not improve my condition.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procures.

* Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks
* Surgical risk may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery (5).
* Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition (6).

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chance of recovery.

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine*. Oct 1 2007;32(21):2375-2378; discussion 2379
2. Rubinstein SM, Leboeuf-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, can Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther*. Jul-Aug 2007;30(6):408-418.
3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine*. Feb 15 2008;33(4 suppl):S176-183.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine*. Feb 15 2008;33(4Suppl):S170-175.
5. Carragee EJ, Hurwitz EL, cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine*. Feb 15 2008;33(4 Suppl):S153-169.
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorder. *Spine*. Feb 15 2008;33(4 Sippl): S75-82.

**Please answer the following questions to help us determine possible risk factors:**

**QUESTIONS YES DOCTOR’S COMMENTS**

**GENERAL**

Have you ever had an adverse (i.e. bad) reaction to or following \_\_\_\_

chiropractic care?

**BONE WEAKNESS**

Have you been Diagnosed with osteoporosis? \_\_\_\_

Do you take corticosteroids (e.g. prednisone)? \_\_\_\_

Have you been diagnosed with compression fracture(s) of the spine? \_\_\_\_

Have you ever been diagnosed with cancer? \_\_\_\_

Do you have any metal implants? \_\_\_\_

**VASCULAR WEAKNESS**

Do you take aspirin or other pain medication on a regular basis? \_\_\_\_

If yes, about how much do you take daily? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take warfarin (Coumadin), heparin, or other similar “blood thinners”? \_\_\_\_

Have you ever been diagnosed with any of the following disorders/diseases?

* Rheumatoid arthritis \_\_\_\_
* Reiter’s syndrome, ankylosing spondylitis, or psoriatic arthritis \_\_\_\_
* Giant cell arthritis (temporal arteritis) \_\_\_\_
* Osteogenesit imperfect \_\_\_\_
* Ligamentous hypermobility such as with Marfan’s disease, \_\_\_\_

Ehlers-Danlos syndrome

* Medical cystic necrosis (cystic mucoid degeneration) \_\_\_\_
* Bechet’s disease \_\_\_\_
* Fibromuscular dysplasia \_\_\_\_

Have you ever become dizzy or lost consciousness when turning your head? \_\_\_\_

**SPINAL COMPROMISE OR INSTABILITY**

Have you ever had spinal surgery? \_\_\_\_

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with spinal stenosis? \_\_\_\_

Have you been diagnosed with spondyliolithesis? \_\_\_\_

Have you had any of the following problems? \_\_\_\_

* Sudden weakness in arms and/or legs? \_\_\_\_
* Numbness in genital area? \_\_\_\_
* Recent inability to urinate or lack of control when urinating? \_\_\_\_

**I have read the previous information regarding risks of chiropractic care and my doctor has verbally explained my risk (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given and explanation of the treatment, the frequency of care, and the alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
[or Parent/Guardian]

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

**IMPORTANT**: Please check (X) on all present symptoms.

**Medical History Intake IntakeForm**

**HEAD:**

* **Headache**
	+ sinus (allergy)
	+ entire head
	+ back of head
	+ forehead
	+ temples
	+ migraine
* Head feels heavy
* Loss of memory
* Light-Headedness
* Fainting
* Light bothers eyes
* Blurred vision
* Double vision
* Loss of vision
* Loss of taste
* Loss of balance
* Dizziness
* Loss of hearing
* Pain in ears
* Ringing in ears
* Buzzing in ears

**NECK:**

* Pain in neck
* Neck pain with movement
	+ Forward
	+ Backward
	+ Turn to left
	+ Turn to right
	+ Bend to left
	+ Bend to right
* Pinched nerve in neck
* Neck feels out of place
* Muscle spasms in neck
* Grinding sounds in neck
* Popping sounds in neck
* Arthritis in neck

**ARMS AND HANDS:**

* Pain in upper arms
* Pain in elbow
* Movement aggravated
* Tennis elbow
* Pain in forearm
* Pain in hands
* Pain in fingers
* Sensation of pins & needles in arms
* Sensation of pins & needles in fingers
* Numbness in arms (R-L)
* Fingers go to sleep
* Hands cold
* Swollen joints in fingers
* Sore joints in fingers
* Arthritis in fingers
* Loss of grip strength

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

**SHOULDER:**

* Pain in shoulder joint (R-L)
* Pain across shoulders
* Bursitis (R-L)
* Arthritis (R-L)
* Can’t raise arm
	+ Above shoulder level
	+ Over head
* Tension in shoulders
* Pinched nerve in shoulders (R-L)
* Muscle spasms in shoulders

**MID BACK:**

* Mid back pain

Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Pain between shoulder blades
* Sharp stabbing
* Dull ache
* Pain from front to back
* Muscle spasms
* Pain in kidney area

**CHEST:**

* Chest pain
* Shortness of breath
* Pain around ribs
* Breast pain
* Dimples or orange peel breast
* Irregular heartbeat

**ABDOMEN:**

* Nervous stomach
* Foods can’t eat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Nausea
* Gas
* Constipation
* Diarrhea
* Hemorrhoids

**LOW BACK:**

* Low back pain
* Upper lumbar
* Lower lumbar
* Sacroiliac
* Low back pain is worse when
	+ Working
	+ Lifting
	+ Stooping
	+ Standing
	+ Sitting
	+ Bending
	+ Coughing
	+ Lying down (sleeping)
	+ Walking
* Pain Relieved when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Slipped Disk
* Low back feels out of place
* Muscle spasms
* Arthritis

**HIP, LEGS, AND FEET:**

* Pain in buttocks
* Pain in hip joint
* Pain down leg (R-L)
* Pain down both legs
* Knee pain
	+ Inside
	+ Outside
* Leg cramps
* Cramps in feet
* Pins and needles in legs
* Numbness of legs
* Numbness of toes
* Feet feel cold
* Swollen ankles
* Swollen feet

**WOMEN ONLY:**

* Menstrual pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (where)
* Cramping
* Irregularity
* Cycle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (days)
* Birth control \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (type)
* Hysterectomy
* Genital cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Discharge
* Menopause
* Tumors
* Abortions
* Are you/do you think you are pregnant?

**MEN ONLY:**

* Urinary frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Difficulty starting
* Night urination
* Prostate pain/swelling

**GENERAL:**

* Nervousness
* Irritable
* Depressed
* Fatigue
* Generally feel run-down
* Normal sleep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hrs/night)
* Loss of sleep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hrs/night)
* Loss of weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Lbs.)
* Gain weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Lbs.)
* Coffee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cups/day)
* Tea \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cups/day)
* Cigarettes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (pack/day)
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Diabetes
* Hypoglycemia

**REMARKS:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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