Barnum Chiropractic & Wellness Patient Intake Form

Date: ___________________________________

Name ____ **Preferred Name** _________________________

Address ____

City _____________________________________ **State** __________________ **Zip Code** ___________________

Cell Phone (_____**)** _________**-**______________ **Email** ____

Date of Birth ________/__________/___________ **Social Security Number:** ______**-**_______**-**__________

Sex: ☐ Male ☐ Female **Marital Status:** ☐ S ☐ M ☐ W ☐ D

Employment: ☐ Unemployed ☐ Employed Full Time ☐ Employed Part Time ☐ Retired ☐ Student

Employer ______________________________________ **Occupation** _____________________________

Emergency Contact Name: ____

Relationship ______________________________________ **Phone (**_______**)** _________**-**_____________

List Current Medications:
If there are **no** current medications, check here: _____

1.______________________________________ **2.**___________________________________

3.______________________________________ **4.**___________________________________

5.______________________________________ **6.**___________________________________

7.______________________________________ **8.**___________________________________

Insurance Information:

Personal Health Insurance Carrier: ____

ID #:____ Group #: ____________________________________

Policy Holder's Name & DOB: _________________________________ _________________________________

Patient Name____**Date**_______________

Review of Systems – (Check box if you have/had any of the following, circle NO if none)

Cardiovascular	Past	Present	No	**Respiratory**	Past	Present	No	**Allergic/Immunologic**	Past	Present	No
Swelling of legs				Emphysema				Cortisone Use			
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism								HIV/AIDS			
Heart Disease				**Eyes**							
Heart Attack				Glaucoma				**Psychiatric**			
Chest Pain				Double Vision				Depression			
High Cholesterol				Blurred Vision				Anxiety			
Pacemaker								Stress			
Jaw Pain				**Endocrine**							
Irregular Heartbeat				Thyroid				**Gastrointestinal**			
Genitourinary				Diabetes				Ulcers			
Kidney Stones								Gall Bladder Problems			
Kidney Disease								Liver Problems			
Burning Urination				**Hematologic**							
Frequent Urination				Cancer				**Musculoskeletal**			
Blood in Urine				Hepatitis				Arthritis			
Neurologic				Blood Clots				Gout			
Vertigo								Joints Replaced			
Carpal Tunnel								Osteoporosis			
Parkinson's								Broken Bones			
Stroke											
Seizures											
Head Injury											
Brain Aneurysm											
Severe Headaches											
Pinched Nerves											

Family History:

Arthritis: ☐ __Parent ☐ __Sibling __Grandparent Other: ____________________________

Cancer: ☐ __Parent ☐ __Sibling __Grandparent

Diabetes: ☐ __Parent ☐ __Sibling __Grandparent

Heart Disease: ☐ __Parent ☐ __Sibling __Grandparent

Hypertension: ☐ __Parent ☐ __Sibling __Grandparent

Stroke: ☐ __Parent ☐ __Sibling __Grandparent

Thyroid: ☐ __Parent ☐ __Sibling __Grandparent

Surgeries: (Write date of surgery if any apply to you)

______Appendectomy ______Cardiovascular procedure ______Cervical spine ______Hysterectomy

______Joint Replacement ______Prostate ______Lumbar spine ______Gall Bladder

______Brain ______Shoulder ______Thoracic spine ______Knee

______Carpal Tunnel ______Gastrointestinal ______Urogenital ______Hernia

Other__________

Patient Name____**Date**________________

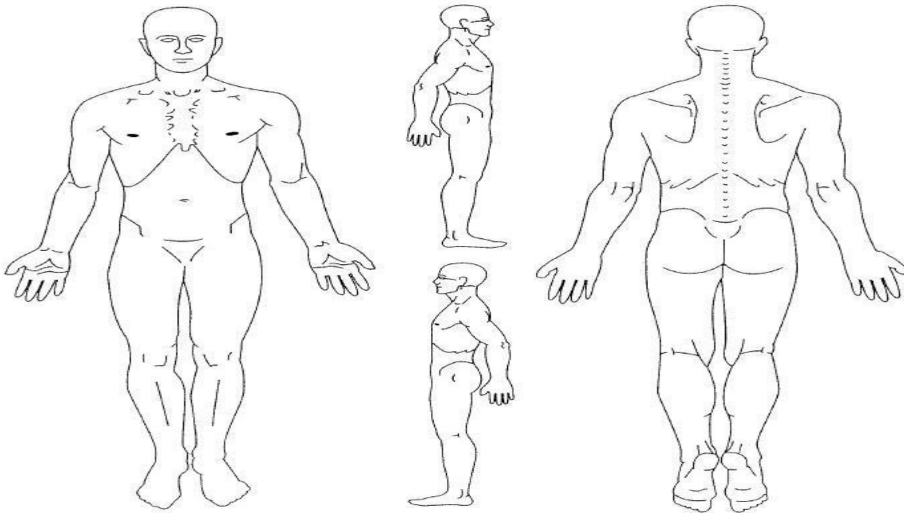
Are you pregnant? Yes_____ No ______

How did you hear about us? (Please list their name if someone referred you): __________________________

Have you had previous chiropractic care? If yes, when was the last visit and where?

____

By using the key below, mark on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

When did your symptoms begin? Month _______ Day ________ Year __________

<u>What is your pain RIGHT NOW?</u>

No pain ____ **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

<u>What is your TYPICAL or AVERAGE pain?</u>

No pain ____ **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

<u>What is your pain level AT ITS BEST? (How close to '0' does your pain get?)</u>

No pain ____**Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

<u>What is your pain level AT ITS WORST? (How close to '10' does your pain get?)</u>

No pain ____ **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

Patient Name ______________________________ **Date** ______________

Effects of Current Condition on Performance

Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Work Performance:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self-Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

___________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
___________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name ____________________________ Patient's Signature______________________________

INFORMED CONSENT FORM

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

• spinal manipulative therapy	•palpation	•vital signs
• range of motion testing	• orthopedic testing	• basic neurological
• muscle strength testing	• postural analysis	•testing
• ultrasound	•hot/cold therapy	•electrical Stim
• radiographic studies	•mechanical traction	

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: ___________________ **Patient's Name** _______________________________________

Signature ____________________________ **Signature of Parent/Guardian** __________________ **(if minor)**