Adult Intake Form

Basic Information

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Work: _____

Date of Birth: _____ Sex: O Male O Female Marital Status? O M O W O D O S

Occupation: _____ Do you primarily: O Sit O Stand O Perform repetitive tasks O Heavy lifting

Email (please print clearly): _____

May we add you to our email list for office updates & schedule changes: O Yes O No

Emergency Contact: _____ Phone: _____

Children: O No O Yes / Ages: _____

How did you hear about our office?: _____

Is this a O Wellness visit, or is there a O Specific concern? _____

Do you have any concerns about seeing a chiropractor?: _____

Health History

Have you ever received chiropractic care? O Yes O No

When? _____ With who? _____

Did they take x-rays? O Yes O No If yes, were they taken in the past 12 months? _____

What was the primary reason for consulting that office?

O Relief care: symptom relief of pain and discomfort

O Corrective Care: correcting, relieving and stabilizing spinal joint and postural issues

O Wellness Care: maximizing the body's ability for optimal healing and functions

How was your experience?: _____

Please list any MAJOR or MINOR accidents, falls or injuries you can remember throughout your life:

_____

_____

_____

Current medications/drugs (prescription/non-prescription) and what for:

_____

_____

List all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

_____

Surgeries: _____

Family History of: O Cancer O Heart Disease O Diabetes O Stroke O Arthritis

Insurance Information

Insurance Cardholders name: _____ Cardholders DOB: _____

_____***My initials show:*** *I understand and agree that if I have health and/or accident insurance, those policies are an arrangement between the insurance carrier and myself. It is ultimately my responsibility to contact my insurance carrier and verify my benefits for chiropractic care (including but not limited to; my deductible, my copay or co-insurance, my allowed visits, etc.).*

_____***My initials show:*** *I understand that this health care provider will prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. I understand and agree that I am personally responsible for payment for services rendered to me. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. It is understood and agreed that the amount paid to the doctor for x-rays is for examination and interpretation only and the actual films remain the property of this office, being on file where they may be viewed.*

_____ ***My initials show:*** *I authorize this health care facility to release all information related to the care I receive, to my HMO, insurance company, third party payer, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes.*

Consent for Care

Chiropractic Care

_____***My initials show:*** *I understand Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic evaluates the spine for vertebral subluxation and uses specific adjustments to assist the body in correcting the subluxation in order to restore the body's natural healing ability. We do not diagnose or treat any disease. (We only offer to diagnose and adjust vertebral subluxations). If in the course of the chiropractic examination non-chiropractic or unusual findings are present, you will be advised to seek the services or another health care provider.*

_____***My initials show:*** *I authorize Drs. James and/or Elizabeth Phillip to examine and administer care to my child as they deem appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed.*

Notice of Privacy Practices

_____***My initials show:*** *I further acknowledge that Phillip Family Chiropractic's "Notice of Privacy Practices" is available and I have the right to review Phillip Family Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of heath care operations of Phillip Family Chiropractic. The Notice of HIPAA Privacy Practices for Phillip Family Chiropractic is also provided on request at the main administration desk of this practice and on the website at www.phillipfamilychiro.com. This Notice of Privacy Practices also describes my rights and Phillip Family Chiropractic's duties with respect to my protected health information. Phillip Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Phillip Family Chiropractic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.*

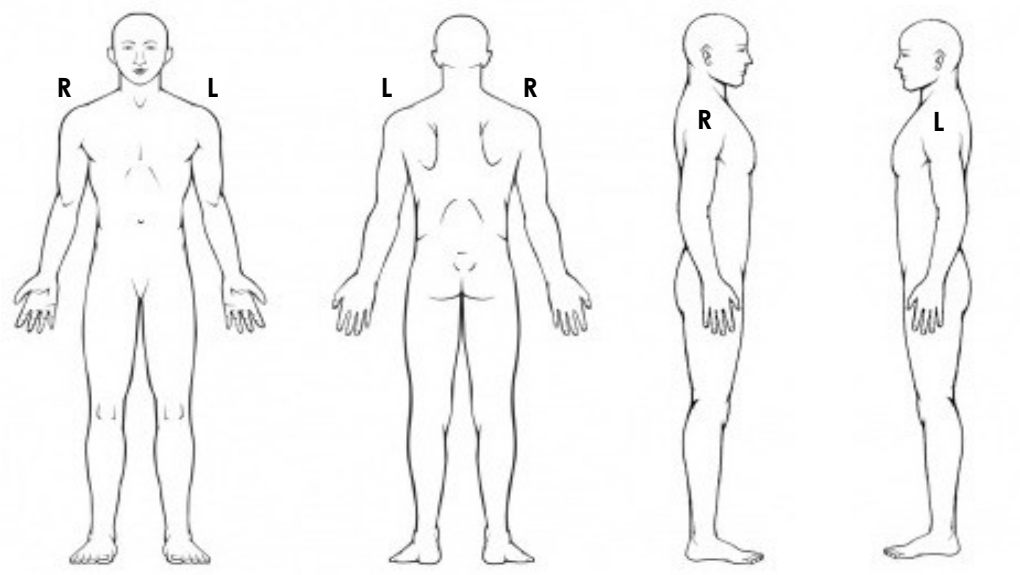
How long you decide to benefit from chiropractic care is *always up to you!*

Our goal is to provide a detailed assessment of your current health status and provide you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential is a healthy spine and nervous system free from interferences called subluxation. You have taken an important step for your health through chiropractic.

Patient/Parent-Guardian Signature: _____ **Date:** _____

Present Complaint/s

Please show us the area of your complaint/s by circling the area as accurately as possible.
Be sure to label complaint #1 & complaint #2



Complaint #1 _____

When did the problem/s start? _____

Is the pain: O Constant O Random O Off—and—on O Other: _____

Describe the pain (check all that apply): O Sharp O Dull O Ache O Pinch O Throbbing O Shooting
O Burning O Tightness/stiffness O Tingling O Numbness O Other: _____

Does the pain radiate/travel to other body parts? _____

Rate your Pain: **No Pain 1 2 3 4 5 6 7 8 9 10 Worse Pain**

Is there anything that makes your condition **better**? _____

Is there anything that makes your condition **worse**? _____

When is your condition worse? O Morning O Afternoon O Evening O During the night O No specific time

Is your condition interfering with: O Work O Sleep O Driving O Exercise O Other daily activities: _____

Have you seen anyone else for this condition? _____

Complaint # 2 _____

When did the problem/s start? _____

Is the pain: O Constant O Random O Off—and—on O Other: _____

Describe the pain (check all that apply): O Sharp O Dull O Ache O Pinch O Throbbing O Shooting
O Burning O Tightness/stiffness O Tingling O Numbness O Other: _____

Does the pain radiate/travel to other body parts? _____

Rate your Pain: **No Pain 1 2 3 4 5 6 7 8 9 10 Worse Pain**

Is there anything that makes your condition **better**? _____

Is there anything that makes your condition **worse**? _____

When is your condition worse? O Morning O Afternoon O Evening O During the night O No specific time

Is your condition interfering with: O Work O Sleep O Driving O Exercise O Other daily activities: _____

Have you seen anyone else for this condition? _____

Please fill out the rest of the paperwork to the best of your ability. Even if some questions may seem unrelated to your current condition, they all serve a purpose in helping us understand your health and give you the best care possible!

Other body systems

✓ **What other signals has your body been communicating? P = Past, C = Current**

P	C		P	C		P	C		P	C	
☐	☐	Dizziness	☐	☐	Elbow, Wrist, Hand Pain	☐	☐	IBS (Constipation or Diarrhea)	☐	☐	Disc Problems
☐	☐	Headaches	☐	☐	Arm &/or Hand Numbness	☐	☐	Digestive Disorders	☐	☐	Chronic Fatigue
☐	☐	Ear Infections	☐	☐	Shoulder Pain	☐	☐	Low back Pain	☐	☐	Lupus
☐	☐	TMJ	☐	☐	Mid Back Pain	☐	☐	Sciatica	☐	☐	Fibromyalgia
☐	☐	Neck Pain	☐	☐	Heart Disorders	☐	☐	Leg &/or Feet Numbness	☐	☐	ADD/ADHD
☐	☐	Migraines	☐	☐	Stomach Disorders	☐	☐	Hip Pain	☐	☐	GERD
☐	☐	Sinus Issues	☐	☐	Unexplained Nausea	☐	☐	Leg Pain	☐	☐	Anxiety
☐	☐	Thyroid Issues	☐	☐	Reflux	☐	☐	Knee Pain	☐	☐	Depression
☐	☐	Asthma	☐	☐	Kidney Disorders	☐	☐	Reproductive Disorders	☐	☐	Nervousness
☐	☐	Ulcers	☐	☐	Bladder Problems	☐	☐	Fertility Issues	☐	☐	Epilepsy
☐	☐	Chest Pains	☐	☐	Growing Pains	☐	☐	Menstrual Issues	☐	☐	_____

Stress + Adaptability

✓ **Please check areas of stress that apply to your life. P = Past, C = Current**

P	C	Physical Stress	P	C	Emotional Stress	P	C	Chemical Stress
☐	☐	Birth Trauma (as a baby)	☐	☐	Relationships	☐	☐	Environment
☐	☐	Slips & Falls	☐	☐	Work	☐	☐	Smoker/second hand
☐	☐	Repetitive movements	☐	☐	Children	☐	☐	Poor diet
☐	☐	Poor Posture	☐	☐	Money/bills	☐	☐	Caffeine—amount?
☐	☐	Caring for young children	☐	☐	Homework / school	☐	☐	Excessive sugar
☐	☐	Sedentary lifestyle	☐	☐	Housework	☐	☐	Processed foods
☐	☐	Extensive sitting	☐	☐	Fast paced life	☐	☐	Artificial sweeteners
☐	☐	Extensive driving	☐	☐	Hold in feelings	☐	☐	Conventional meat
☐	☐	Extensive phone/tablet use	☐	☐	Quick tempered	☐	☐	Antibiotics
☐	☐	Extensive Computer Work	☐	☐	Verbal abuse	☐	☐	Prescription drugs
☐	☐	Sitting on your wallet	☐	☐	Perfectionist	☐	☐	Over-the-counter drugs
☐	☐	Sleeping position (stomach)	☐	☐	Procrastinator	☐	☐	Recreational drugs
☐	☐	Heavy purse/backpack	☐	☐	Sickness/loss of a loved one	☐	☐	Energy drinks
☐	☐	Heavy lifting/bending	☐	☐	Self esteem	☐	☐	Fast food
☐	☐	Continuous sitting/standing	☐	☐	Other	☐	☐	Microwaveable food
☐	☐	Work Injuries	☐			☐	☐	Soda
☐	☐	Other				☐	☐	Other

*Chiropractic adjustments improve our body's ability to respond to and **adapt** to life stressors.*

Nutrition Profile

Do you follow a specific diet? O No O Yes

If so, which diet? O Paleo O Keto O Vegan O Vegetarian O Whole 30 O Carnivore

O Mediterranean O Weight Watchers O Other: _____

Do you eat animal products (Meat, dairy, eggs, bone broths, etc)? _____

What foods do you intentionally eat for nutrient density? _____

_____

What foods do you intentionally avoid in your diet? _____

_____

Types of Care in our office

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others support their body Your doctor will weigh your needs and desires when recommending your plan of care .

Which type of chiropractic care fits your healthcare needs best?

- ☐ **Patch Care:** Short term relief of pain & discomfort. Once we get you pain free, you can choose to halt further care until your pain comes back or continue onto restoration care.

  (I want the doctor to recommend a short term care plan to get rid of my pain).

- ☐ **Restoration Care:** After your pain or discomfort is mostly under control, there are typically still subluxations and imbalances in your spine and nervous system that need to be worked with to prevent your problem/s from re-occurring and help you become more adaptable to the stressors that come with everyday life.

  (I want the doctor to recommend an appropriate schedule to continue to address my subluxations and imbalances so that my body functions better as a whole.)

- ☐ **Wellness Care:** After your problems are corrected, you have the option to keep it that way through regular wellness adjustments.

  (After restoration care, I would like to discuss a wellness schedule that works for me!)

- ☐ **Self Controlled Care:** Although we know most would benefit from consistent care, we respect each individuals choices when it comes to healthcare.

  (I don't want the doctor to recommend care, I would like to come in on my own schedule when I feel the need to.)

Please rate your commitment to your care:

Not Committed - **1 2 3 4 5 6 7 8 9 10 -** *Very Committed*

What are your goals in receiving care here?

1. _____
2. _____
3. _____

On a scale of 1-10, where do you rate your health at now? *Sick* - **1 2 3 4 5 6 7 8 9 10 -** *Healthy*

On a scale of 1-10, where would you like your health to be? *Sick*- **1 2 3 4 5 6 7 8 9 10 -** *Healthy*

Family Health

At our clinic, we are not only interested in *your* health and wellness, but also the health and wellness of the important people in your life. Please mention any health conditions of concerns you may have about your:

Children: _____

Spouse: _____

Mother/Father: _____

Siblings: _____

Other: _____

Prenatal Form

Name: _____ Date: _____

Current Pregnancy & Birth

Weeks pregnant: _____ **Estimated due date:** _____

Reason for this visit: O In-Utero Constraint / Baby positioning (Breech, posterior, transverse)
O Backache of pregnancy O Groin / Pubic pain O Headache O Chronic Condition
O Prenatal Wellness O Other: _____

Number of Ultrasounds received this pregnancy: _____

Planned Birth Location: O HOME O HOSPITAL O BIRTH CENTER O OTHER: _____

Will your birth be attended by: O OB/GYN O Midwife Name: _____

Will you be using a doula? O Yes O No If so, who? _____

What are your hopes and expectations for the birth? O Natural Birth (no interventions if at all possible) O Epidural only if necessary O Definite epidural O VBAC O Planned C-section
O Unsure, will let doctors decide O Unsure, but would like more resources for natural birth

Please mark topics you would like to know more about: O Doula O Homebirth
O Birthing Class O Birth Plan O Circumcision O Breastfeeding O Postpartum Plan
O Chiropractic for Infants & Children O Postpartum Rehab O Other: _____

Will you be taking a birthing class? O Yes O No O Not Sure

Pregnancy & Birth History (if applicable)

Number of previous pregnancies: Vaginal _____ C-section _____ Miscarriage _____

If any of your previous births resulted in a C-section, what was the cause? _____

_____

Have any of your previous pregnancies involved malposition of the baby (i.e. sunny side, up, breech, posterior, etc...)? Please explain _____

_____

Please feel free to tell us any other info you think we may want to know about your previous pregnancies &/or births: _____

_____

Webster Agreement

O I acknowledge that the Webster Technique is a specific chiropractic analysis and diversified adjustment. The goal of the adjustment is to reduce the effects of sacral/pelvic subluxation and/or SI joint dysfunction. In doing so, neuro-biomechanical function in the pelvis is improved.

O I acknowledge that in a theoretical and clinical framework of the Webster technique in the care of pregnant women, sacral subluxation may contribute to difficult labor for the mother (i.e. dystocia). Difficult labor is caused by inadequate uterine function, pelvic contraction and baby mal-presentation. The correction of sacral subluxation may have a positive effect on the causes of difficult labor.

O I acknowledge that sacral misalignments may contribute to these primary causes of difficult labor via uterine nerve interference, pelvic misalignment and the tightening of specific pelvic muscles and ligaments. The resulting tense muscles and ligaments and their abnormal effect on the uterus may prevent the baby from comfortably assuming the best possibly position for birth.

O I understand that this sacral/pelvic analysis and adjustment may be used on all weight bearing spines: male, female, pregnant or non pregnant. I acknowledge that this is not a breech turning technique.

By signing this form I understand the purpose of the Webster Technique and I agree to have the doctor(s) of Phillip Chiropractic perform the technique on me at his/her discretion.

Printed Name: _____

Patient/Parent-Guardian Signature: _____ **Date:** _____