COLM | CHIROPRACTIC

INTAKE FORMS

Contact Information

Name: _____ **Preferred Name:** _____

First *M.I.* *Last*

May we contact you via SMS (text)? ☐ Yes ☐ No

Address: _____ May we contact you via email? ☐ Yes ☐ No

City: _____ **State:** _____ **Zip:** _____ May we contact you about events? ☐ Yes ☐ No

D.O.B: ___/___/___ **Phone:** _____ **Email:** _____

Gender: ☐ Male ☐ Female ☐ Other **Status:** ☐ Single ☐ Married Other: _____

Referred by: _____ **Relationship:** _____

Emergency Contact

Name: _____ **Phone:** _____ **Relationship:** _____

Wellness Profile

Do you have a specific complaint that brings you in today?

☐ No I am interested in nervous system assessment to achieve optimal health and functioning.

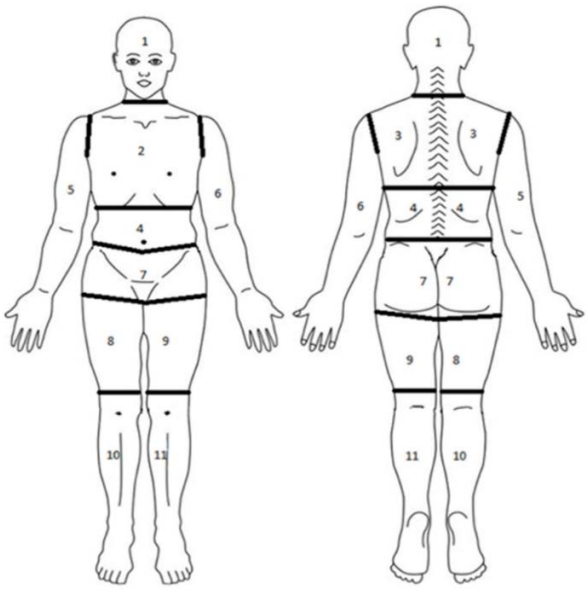
☐ Yes **My primary complaint is:** _____ **Secondary:** _____

Started: ___/___/___ **Result of:** ☐ Auto Accident ☐ Workplace ☐ Worsening chronic problem

☐ Other _____

How does it affect your daily life? _____

Circle where you are experiencing discomfort:



Severity

1 2 3 4 5 6 7 8 9 10

Please check where it applies to circled areas:

Quality:
- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff
- ☐ Sore
- ☐ Numbness
- ☐ Radiating (spreads)

Improves with:
- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medicine
- ☐ Massage
- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Other:

Frequency:
- ☐ Off and On
- ☐ Constant

Are you pregnant?
- ☐ Yes
- ☐ No

Worsens with:
- ☐ Sitting
- ☐ Standing
- ☐ Laying Down
- ☐ Overuse
- ☐ Lifting
- ☐ Stress
- ☐ Bending
- ☐ Other: _____

Last Cycle: ___/___/___

Due Date: ___/___/___

Office use----------

Today's Date: _____ *Folder Number:* _____ ☐ Scanned ☐ ROF Complete ☐ Payment Scheduled

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HISTORY OF HEALTH

Previous Chiropractic Care

Have you had previous Chiropractic care? ☐ Yes ☐ No

Who was your Chiropractor? _____ **When?** _____

Were X-Rays taken in the last 6 months? ☐ Yes ☐ No

If yes, ask for a medical release form.

Illness:

- ☐ Autoimmune Disorder
  - ☐ _____
  - ☐ Blood Clots
- ☐ Cancer
  - ☐ _____
- ☐ CVA/TIA
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Other:
  - ☐ _____
  - ☐ _____
  - ☐ _____

Surgeries:

- ☐ Cancer
- ☐ Orthopedic
  - ☐ Shoulder (R/L)
  - ☐ Elbow/Forearm (R/L)
  - ☐ Wrist/Hand (R/L)
  - ☐ Hip (R/L)
  - ☐ Knee (R/L)
  - ☐ Ankle/Foot (R/L)
- ☐ Spinal Surgery
  - ☐ Neck:
  - ☐ Back:
  - ☐ Other: _____

Injuries:

- ☐ Back
- ☐ Broken Bones
- ☐ Head
- ☐ Neck
- ☐ Concussions (#) _____
- ☐ Other: _____

Medical History Comments:

_____

_____

_____

Physical	*Emotional*	*Chemical*
Rate your:	*Rate current levels of stress:*	*Check the following:*
Satisfaction with appearance	Personal Stress	Were you vaccinated?
☐ Low ☐ Mid ☐ High	☐ Low ☐ Mid ☐ High	☐ Yes ☐ No
Frequency of Cardio Weekly	Relationship Stress	Any adverse reactions?
☐ 1-2 ☐ 3-4 ☐ 5-7	☐ Low ☐ Mid ☐ High	☐ Yes ☐ No
Frequency of Lifting Weekly	Financial Stress	Do you get flu shots?
☐ 1-2 ☐ 3-4 ☐ 5-7	☐ Low ☐ Mid ☐ High	☐ Yes ☐ No
Hours of sleep per night (avg)	Health Stress	Do you take antibiotics?
☐ <4 ☐ 5-6 ☐ 7+	☐ Low ☐ Mid ☐ High	☐ Yes ☐ No
Do you feel refreshed after?	Family Stress	Do you consume/use:
☐ Yes ☐ No	☐ Low ☐ Mid ☐ High	☐ Gluten
How do you sleep?	Career Stress	☐ Dairy
☐ Back ☐ Stomach ☐ Side	☐ Low ☐ Mid ☐ High	☐ Artificial Sweeteners
Hours spent commuting daily	School Stress	☐ Tobacco
☐ 0-2 ☐ 3-4 ☐ 5-7	☐ Low ☐ Mid ☐ High	☐ Alcohol
Hours at a computer daily	Overall Stress	☐ Caffeine
☐ 0-2 ☐ 3-4 ☐ 5-7	☐ Low ☐ Mid ☐ High	☐ Soda/Sugary Drinks

Consent

By signing below, I am acknowledging that I understand the following statements:

Adjustments will be performed manually or with an instrument and *may* produce a "popping" sound.

Supportive therapies or diagnostic procedures may be used including: electricity, traction, motion, or x-rays, as needed.

Temporary soreness or stiffness may occur; less frequently symptoms may become aggravated prior to relief.

New symptoms may result as previous symptoms are relieved, this is a normal part of the healing process.

In extremely rare cases, bruising, swelling, separations, fractures, nerve, or vascular injury may occur.

There is no guarantee of positive outcome. I will keep the chiropractor informed to better achieve the desired outcome.

To the best of my ability, I have given a full and complete medical history to Colm Chiropractic.

I consent to the performance of recommended diagnostic and therapeutic procedures, both now and in the future. These may be performed by the doctor or staff under the direct supervision of the chiropractor.

Patient Signature: _____ Date: _____

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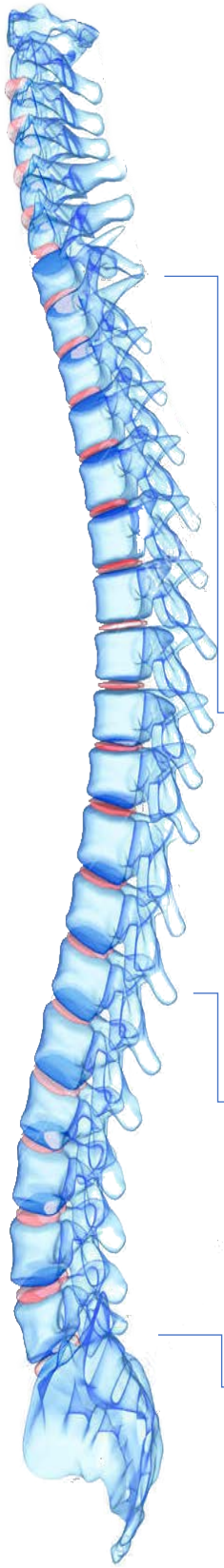
Review of Systems

Spinal Nerves



- **Cervical:** C1, C2, C3, C4, C5, C6, C7, C8
- **Thoracic:** T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12
- **Lumbar:** L1, L2, L3, L4, L5
- **Sacral:** S1, S2, S3, S4, S5

Organs and Glands

The organs and glands listed are linked to the corresponding sections of the spine and its spinal nerves.

Parotid Gland ◆ Scalp
Base of Skull ◆ Eyes
Lacrimal Gland ◆ Sinuses
Inner, Middle & Outer Ear
Nose ◆ Mouth
Intracranial Blood Vessels
Sympathetic Nervous System
Neck Muscles ◆ Diaphragm
Shoulders ◆ Elbows ◆ Arms
Wrists ◆ Hands & Fingers
Tonsils ◆ Vocal Cords
Esophagus ◆ Heart
Lungs ◆ Chest ◆ Thyroid

Arms ◆ Wrists
Esophagus ◆ Chest ◆ Heart
Lungs ◆ Trachea ◆ Larynx
Diaphragm ◆ Stomach
Gallbladder ◆ Liver
Pancreas ◆ Small Intestine
Spleen ◆ Kidneys ◆ Appendix
Adrenals ◆ Colon
Buttocks ◆ Uterus
Ovaries ◆ Testes

Large Intestine ◆ Colon
Thighs ◆ Buttocks ◆ Groin
Knees ◆ Legs ◆ Feet
Reproductive Organs

Buttocks ◆ Groin ◆ Legs
Ankles ◆ Feet ◆ Toes
Prostate Gland ◆ Bladder
Reproductive Organs

Associated Symptoms

Please indicate below any symptoms you are currently experiencing as well as any you have previously experienced.

current	previous		current	previous	
☐	☐	Sinus and Ear Infection	☐	☐	Anxiety
☐	☐	Runny Nose & Allergies	☐	☐	Seizures
☐	☐	Frequent Head Colds	☐	☐	ADD or ADHD
☐	☐	Sore Throat and Tonsils	☐	☐	Thyroid Dysfunction
☐	☐	Strep Throat	☐	☐	Metabolic Dysfunction
☐	☐	Chronic Cough & Croup	☐	☐	Insomnia
☐	☐	Difficulty Breathing	☐	☐	High/Low Blood Pressure
☐	☐	Poor Immunity	☐	☐	Enlarged Lymph Glands
☐	☐	Dizziness & Vertigo	☐	☐	Migraines & Headache
☐	☐	Tinnitus & Ear Fullness	☐	☐	TMJ Pain
☐	☐	Vision Problems	☐	☐	Stiff Neck
☐	☐	Watery or Dry Eyes	☐	☐	Arm Pain
☐	☐	Chronic Fatigue	☐	☐	Hand/Finger Numbness
☐	☐	Poor Concentration	☐	☐	Loss of Grip Strength
☐	☐	Depression	☐	☐	Frozen Shoulder
☐	☐	Asthma	☐	☐	Kidney Stones
☐	☐	Bronchitis & Pneumonia	☐	☐	Gall Bladder Attacks
☐	☐	Congestion	☐	☐	Skin Conditions & Rashes
☐	☐	Reflux & GERD	☐	☐	Menstrual Cramps/ PMS
☐	☐	Indigestion & Heartburn	☐	☐	Infertility
☐	☐	Stomach Pain	☐	☐	Menstrual Dysfunction
☐	☐	Ulcers	☐	☐	Rashes & Eczema
☐	☐	Gas & Bloating	☐	☐	Hyperactivity
☐	☐	Jaundice	☐	☐	Shoulder Pain
☐	☐	Liver Conditions	☐	☐	Midback Pain
☐	☐	Blood Sugar Dysregulation	☐	☐	Rib Pain
☐	☐	Irritable Bowel	☐	☐	Prostate Dysfunction
☐	☐	Colitis/Crohn's	☐	☐	Impotence
☐	☐	Gas Pains & Constipation	☐	☐	Ovarian Cysts/Endometriosis
☐	☐	Diarrhea	☐	☐	Fertility Problems
☐	☐	Hemorrhoids	☐	☐	Low Back Pain
☐	☐	Bladder Infection	☐	☐	Hip Pain
☐	☐	Incontinence	☐	☐	Thigh Pain
☐	☐	Painful/Excessive Urination	☐	☐	Numbness/Tingling in Legs
☐	☐	Varicose Veins	☐	☐	Sciatica
☐	☐	Leg Cramping	☐	☐	Pelvic Pain
☐	☐	Restless Legs	☐	☐	Knee Pain
☐	☐	Poor Circulation	☐	☐	Ankle Pain & Sprains
☐	☐	Cold Feet	☐	☐	Foot Pain & Weak Arches

Foundation Care Visits: _____ Frequency: _____ Weekly. Retainer Visits: _____ Frequency: _____ Weekly.

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HIPAA

Please read thoroughly and sign below

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ YES ☐ NO

May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO

May we discuss your medical condition with any member of your family? ☐ YES ☐ NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____