ARMSTRONG CHIROPRACTIC CLINIC, LLC

Patient Intake

Date:_____

First Name_____ **Last Name**_____ **Sex:** ☐ Male ☐ Female

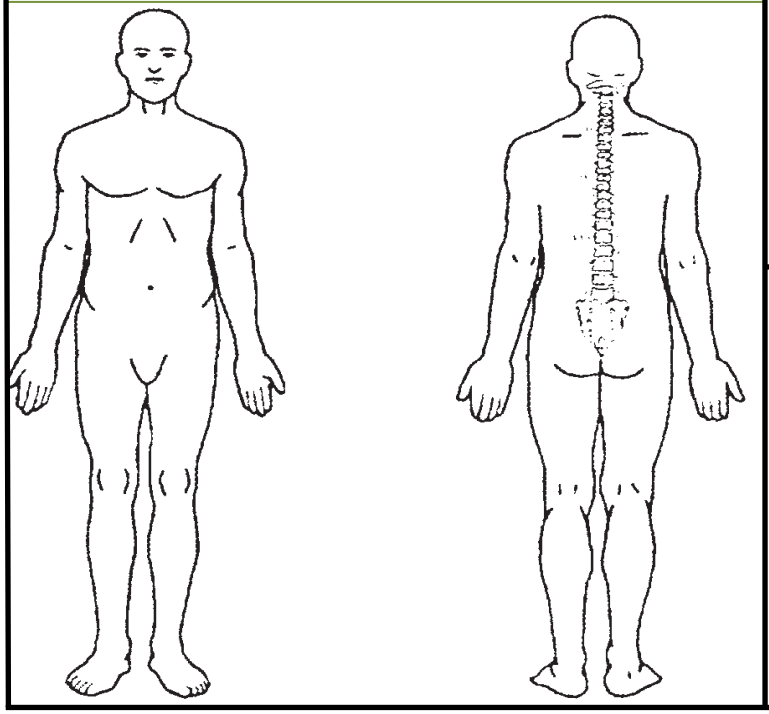
Major Complaint Information

What is your major complaint _____

When did this symptom(s) begin? _____

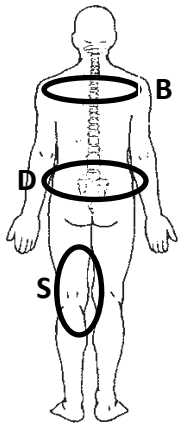
If this is an injury describe what happened_____

Using the symbols provided in the Pain Index box, mark the areas on the illustrations below where you are experiencing pain.



Pain Index

D Dull Nagging Ache
B Burning
S Sharp / Stabbing
N Numbness / Tingling



For example:
The image to the left illustrates a burning pain in the neck, a dull ache in the lower back, and a sharp pain in the left thigh.

Severity

On a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain imaginable, please answer the following questions:

Sitting here today, right now, what is the intensity of your pain on a scale of 0-10? (Please circle)

0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? ☐ Yes ☐ No

When? _____

What aggravates this condition? _____

What decreases the symptoms/pain? _____

Have you seen another doctor for this condition? ☐ Yes ☐ No Doctors Name: _____

Date Consulted: _____ Diagnosis: _____

In what position do you sleep? ☐ Back ☐ Side ☐ Stomach

Does heat/cold affect the pain? ☐ Yes ☐ No If so, how? _____

Does it cause pain to cough, grunt or sneeze? ☐ Yes ☐ No If so, where? _____

Check those activities below during which you experience difficulty or pain:

☐ Lying on back ☐ Walking ☐ Stooping ☐ Standing for long periods ☐Bending forward/backward

☐ Lying on side ☐ Dressing self ☐ Sitting ☐ Lying flat on stomach

☐ Turning over in bed ☐ Sexual Activity ☐ Kneeling ☐ Getting in/out of car ☐ Other_____

FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

Lower Back Pain

Does pain radiate into the leg? ☐ Yes ☐ No Where: _____

Have you ever had impaired bowel/urinary function? ☐ Yes ☐ No Explain: _____

Do you have numbness or tingling into the legs? ☐ Yes ☐ No Explain:_____

Neck Pain

If you have a neck injury does it affect: (Check all that apply) ☐ Hearing ☐ Vision ☐ Balance

Do you feel pressure or pain behind your eyes? ☐ Yes ☐ No

Does pain radiate into the arm? ☐ Yes ☐ No Where? _____

Do you have difficulty turning your head? ☐ Yes ☐ No What direction? ☐ Left ☐ Right ☐ Up ☐ Down

Headaches

Do you get headaches? ☐ Yes ☐ No Frequency? _____Family history of headaches? ☐ Yes ☐ No

Do you experience the following with your headaches:

Pain or cracking in your jaw? ☐ Yes ☐ No Nausea, Vomiting, Visual Disturbances? ☐ Yes ☐ No

When was your last eye exam by a doctor? ☐ 1-6 months ☐ 6-12 months ☐ 1-2 years ☐ over 2 years

If female are you pregnant? □ Yes □ No □ Not sure Date of last menstrual period? _____

List of all medications you are taking, including over the counter medication: _____

_____

Are you allergic to any medications? □ Yes □ No □ Not sure Please list: _____

_____

Have you ever had any surgeries/hospitalizations? □ Yes □ No Please List:

Type of surgery/hospitalization : Date: Type of surgery/hospitalization: Date:

_____ _____ _____ _____

_____ _____ _____ _____

Have you had x-rays or had an MRI or CT scan in the last 12-18 months? □ Yes □ No When? _____

Have you ever been seen by a Chiropractor? □ Yes □ No Please list:

Name of Chiropractor Dates: Name of Chiropractor: Dates:

_____ _____ _____ _____

Do you have a family physician? □ Yes □ No Name of Physician:_____

Phone:_____

Address: _____

Have you ever had: □ Motor Vehicle Accident □ Sports Injury □ Slip and Fall Injury

If yes, please explain _____

Additional Complaints

□ Loss of Concentration	□ Neck Stiffness	□ Shortness of Breath	□ Cold Hands/Feet
□ Eyes Sensitive to Light	□ Neck Motion Restricted	□ Irritability	□ Nervousness
□ Memory Loss	□ Anxiety	□ Jaw Pain	□ Constipation
□ Depression	□ Hypertension	□ Insomnia	□ Chest Pain
□ Dizziness	□ Right/Left Shoulder Pain	□ Palpitation	□ Diarrhea
□ Ringing in Ears	□ Right/Left Arm Pain	□ Fatigue	□ Convulsions
□ Loss of Balance	□ Excess Perspiration	□ Vision Problems	□ Diabetes
□ Loss of Smell	□ Right/Left Leg Pain	□ Digestive Trouble	□ Anemia
□ Loss of Taste	□ Low Back Pain/Stiffness	□ Nausea	□ Heart Disease
□ Sinus Trouble	□ Vomiting	□ Arthritis	□ HIV (Aids)

□ Allergies (Please List): _____

□ Other (Please List): _____

□ Please Specify Location:

□ Numbness _____ □ Swelling _____ □ Cuts_____ □ Bruises _____

Emergency Contact

Name:_____ Relation: _____

Home Phone: ( ) _____ Work/Cell Phone: _____

Address:_____

Personal Information

Address:_____

Home Phone: ( ) _____ Work/Cell Phone:_____

Email Address: _____

Social Security Number: _____ Birthdate: _____ Age:_____

Occupation:_____ Employer's Name:_____

Marital Status: □ S □ M □ D □ W Spouse's Name:_____

How did you hear about Armstrong Chiropractic Clinic?_____

Areas of Interest

Please mark any of the following that you are interested in or would like more information on:

____ Nutritional Supplements	____ Neck/Body Pillows	____ Ear infection/Colic/ADD
____ Detoxification	____ Acupuncture	____ Massage
____ Headaches	____ Weight Loss Information	____ Women's Health
____ Children's Health	____ Wellness Care	____ Other (s) _____

Authorization and Assignment

I authorize Armstrong Chiropractic Clinic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Armstrong Chiropractic Clinic authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Date _____ Patient's Signature _____

Informed Consent

I hereby authorize physicians and staff at Armstrong Chiropractic Clinic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Armstrong Chiropractic Clinic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating
care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment inthis office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any question concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date _____ Patient's Signature_____

Insurance/Payment Information

Do you have health insurance? □ Yes □ No If yes, please complete the following:

1. Primary Insurance company name:_____

   Address: _____

   Insured's Name: _____ ID #:_____ Group #: _____

2. Secondary Insurance company name: _____

   Address: _____

   Insured's Name: _____ ID #: _____ Group #: _____