PRECISION
CHIROPRACTIC

Intake Form

PATIENT INFORMATION

First Name _____ MI ____ Last Name _____

Home Address _____ City/State/Zip _____

Home Phone _____ Mobile Phone _____

Email Address _____

Date of Birth _____ Shoe Size W M _____

Marital Status _____ # of Children _____ Height _____ Weight _____ Sex: M F

Emergency Contact Name and Phone Number _____

EMPLOYMENT INFORMATION

Full Time ____ Part Time ____ Student ____ Retired ____ Unemployed ____ Other ____

Employer Name _____ Occupation _____

Physical Work Duties _____
_____
_____

Have you ever been to a chiropractor? Yes No
If so, who? _____

Purpose of your visit:

Wellness ____ Pain ____ Injury ____ Neurological Care ____ Performance Training ____

CURRENT COMPLAINTS

Due to a car accident? Yes ___ No ___ If yes, please ask for additional intake paperwork.
Due to an accident at work? Yes ___ No ___ If yes, please notify front desk staff.

Complaint #1 _____

Please describe the **location**, **intensity, and quality** (dull, sharp, burning, etc)

_____

_____

_____

When did this start? _____ **How** did this start? _____
How frequent do you experience this? Always ___ Hourly ___ Daily ___ Occasionally ___
Does this condition affect your sleep? Yes ___ No ___ How? _____
Does this condition affect your appetite? Yes ___ No ___ How? _____
Is this condition worse at certain times of the day? Yes ___ No ___ When? _____
Do certain movements make the condition worse? Yes ___ No ___ Which? _____
Have you missed work due to this condition? Yes ___ No ___
Does this condition interfere with your daily activities? Yes ___ No ___
Have you experienced this condition at a prior time in your life? Yes ___ No ___
Have you seen another medical professional for these complaints? Yes ___ No ___
If yes, who? _____

Complaint #2 _____

Please describe the **location**, **intensity, and quality** (dull, sharp, burning, etc)

_____

_____

_____

When did this start? _____ **How** did this start? _____
How frequent do you experience this? Always ___ Hourly ___ Daily ___ Occasionally ___
Does this condition affect your sleep? Yes ___ No ___ How? _____
Does this condition affect your appetite? Yes ___ No ___ How? _____
Is this condition worse at certain times of the day? Yes ___ No ___ When? _____
Do certain movements make the condition worse? Yes ___ No ___ Which? _____
Have you missed work due to this condition? Yes ___ No ___
Does this condition interfere with your daily activities? Yes ___ No ___
Have you experienced this condition at a prior time in your life? Yes ___ No ___
Have you seen another medical professional for these complaints? Yes ___ No ___
If yes, who? _____

Complaint #3 _____

Please describe the **location, intensity, and quality** (dull, sharp, burning, etc)

_____

_____

_____

When did this start? _____ **How** did this start? _____
How frequent do you experience this? Always ___ Hourly ___ Daily ___ Occasionally ___
Does this condition affect your sleep? Yes ___ No ___ How? _____
Does this condition affect your appetite? Yes ___ No ___ How? _____
Is this condition worse at certain times of the day? Yes ___ No ___ When? _____
Do certain movements make the condition worse? Yes ___ No ___ Which? _____
Have you missed work due to this condition? Yes ___ No ___
Does this condition interfere with your daily activities? Yes ___ No ___
Have you experienced this condition at a prior time in your life? Yes ___ No ___
Have you seen another medical professional for these complaints? Yes ___ No ___
If yes, who? _____

Complaint #4 _____

Please describe the **location, intensity, and quality** (dull, sharp, burning, etc)

_____

_____

_____

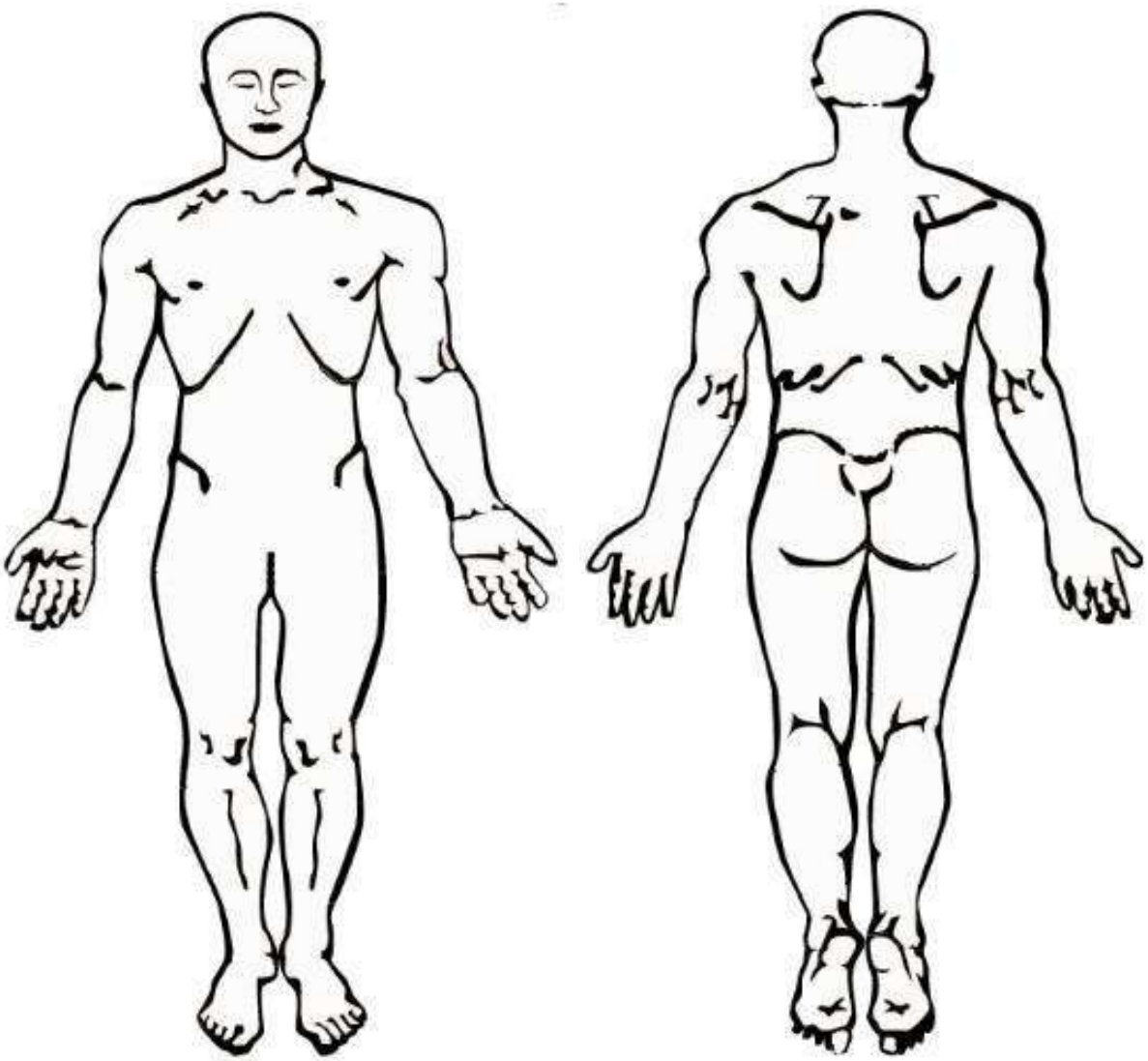
When did this start? _____ **How** did this start? _____
How frequent do you experience this? Always ___ Hourly ___ Daily ___ Occasionally ___
Does this condition affect your sleep? Yes ___ No ___ How? _____
Does this condition affect your appetite? Yes ___ No ___ How? _____
Is this condition worse at certain times of the day? Yes ___ No ___ When? _____
Do certain movements make the condition worse? Yes ___ No ___ Which? _____
Have you missed work due to this condition? Yes ___ No ___
Does this condition interfere with your daily activities? Yes ___ No ___
Have you experienced this condition at a prior time in your life? Yes ___ No ___
Have you seen another medical professional for these complaints? Yes ___ No ___
If yes, who? _____

*** If you have additional complaints, please ask the front desk staff to provide you with additional forms.

Please place <u>letters</u> at areas of pain or discomfort on the diagrams below.

Now, please rate each of on a scale of 1-10, with 10 being the worst:

A____ B____ C____ D____ E____ F____ G____ H____ I____ J____ K____ L____ M____



Are you a smoker? Yes ___ No ___ If yes, how many packs per day? _____

How much exercise (greater than 30 minutes) do you get per week? _____ times per week

What type of exercise? _____

PERSONAL HEALTH HISTORY

Date of Last Physical Exam _____ Name of Physician _____

Physician Phone _____ Physician City/State _____

Please list conditions you have been treated for in the last 10 years:

Please list all surgeries and operations:

Please list all current medications/dosages:

Please list all nutritional supplementation (please also include vitamins, minerals, and herbs):

What else should we know to provide the best health care to you?

Which **ONE** of the following do you **MOST** take into consideration when making decisions about your healthcare and the providers you choose?

_____ Cost _____ Time _____ Results _____ Integrity

By signing below I authorize Precision Chiropractic ATX and its staff to use the information provided herein to help make the best decisions for my care. I certify that the information provided is true and accurate to the best of my knowledge. I understand that Precision Chiropractic ATX will work with my insurance company to obtain the highest reimbursement for care, but all costs associated with care are ultimately the responsibility of the patient. All payments are due at the time of service unless otherwise agreed upon in writing by both Precision Chiropractic ATX and the patient.

_____ _____

Patient/Guardian Signature Date

How did you find Precision Chiropractic?

___ Referral from current patient Who? _____

___ Referral from healthcare provider Who? _____

___ Fitness professional Who? _____

___ Print advertising Where? _____

___ Google

___ Facebook

___ Yelp

___ Sign/Building

___ Doctor/Staff Presentation

___ Other _____

Medical Symptoms Questionnaire (MSQ)

Name: _____ Date: _____

Email Address: _____

Rate each of the following symptoms based upon your typical health profile for the **past 30 days**.

Point Scale
0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

Head	_____	Headaches
	_____	Faintness
	_____	Dizziness
	_____	Insomnia
		Total _____
Eyes	_____	Watery or Itchy Eyes
	_____	Swollen, Reddened or Sticky Eyelids
	_____	Bags or Dark Circles Under Eyes
	_____	Blurred or Tunnel Vision (does not include near or far-sighted)
		Total _____
Ears	_____	Itchy Ears
	_____	Earaches, Ear Infections
	_____	Drainage from Ear
	_____	Ringing in Ears, Hearing Loss
		Total _____
Nose	_____	Stuffy Nose
	_____	Sinus Problems
	_____	Hay Fever
	_____	Sneezing Attacks
	_____	Excessive Mucus Formation
		Total _____
Mouth/ Throat	_____	Chronic Coughing
	_____	Gagging, Frequent Need to Clear Throat
	_____	Sore Throat, Hoarseness, Loss of Voice
	_____	Swollen or Discolored Tongue, Gums, or Lips
	_____	Canker Sores
		Total _____
Skin	_____	Acne
	_____	Hives, Rashes, Dry Skin
	_____	Hair Loss
	_____	Flushing, Hot Flashes
	_____	Excessive Sweating
		Total _____
Heart	_____	Irregular or Skipped Heartbeat
	_____	Rapid or Pounding Heartbeat
	_____	Chest Pain
		Total _____

Lungs	_____	Chest Congestion
	_____	Asthma, Bronchitis
	_____	Shortness of Breath
	_____	Difficulty Breathing

Total _____

Digestion	_____	Nausea, Vomiting
	_____	Diarrhea
	_____	Constipation
	_____	Bloated Feeling
	_____	Belching, Passing Gas
	_____	Heartburn
	_____	Intestinal/Stomach Pain

Total _____

Joints/	_____	Pain or Aches in Joints
Muscles	_____	Arthritis
	_____	Stiffness or Limitation of Movement
	_____	Pain or Aches in Muscles
	_____	Feeling of Weakness or Tiredness

Total _____

Weight	_____	Binge Eating/Drinking
	_____	Craving Certain Foods
	_____	Excessive Weight
	_____	Compulsive Eating
	_____	Water Retention
	_____	Underweight

Total _____

Energy/	_____	Fatigue, Sluggishness
Activity	_____	Apathy, Lethargy
	_____	Hyperactivity
	_____	Restlessness

Total _____

Mind	_____	Poor Memory
	_____	Confusion, Poor Comprehension
	_____	Poor Concentration
	_____	Poor Physical Condition
	_____	Difficulty in Making Decisions
	_____	Stuttering or Stammering
	_____	Slurred Speech
	_____	Learning Disabilities

Total _____

Emotions	_____	Mood Swings
	_____	Anxiety, Fear, Nervousness
	_____	Anger, Irritability, Aggressiveness
	_____	Depression

Total _____

Other	_____	Frequent Illness
	_____	Frequent or Urgent Urination
	_____	Genital Itch or Discharge

Total _____

Grand Total _____

PRECISION
CHIROPRACTIC

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing. The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors.

Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE Precision Chiropractic ATX and Dr. Eberle TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ____ DAY OF _____, 20___

_____ **_____**
Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

Remarks:

PRECISION CHIROPRACTIC

IMAGING CONSENT

Patient Name: _____ DOB: _____

The exam that your doctor has ordered utilizes very small doses of ionizing radiation. Research is clear that the amount of radiation used in diagnostic imaging is safe, however we want to make sure you are aware of its use. If you have any questions about the effects of diagnostic imaging, please request those resources from your doctor.

Ionizing radiation can cause negative health effects to an unborn baby. The extent of health effects depends on the gestational age at the time of exposure and the amount of radiation that is delivered and exposed. Unborn babies are especially sensitive to ionizing radiation during weeks 2-15 of pregnancy. Consequences can include stunted growth, deformities, abnormal brain function, or cancer that could develop later in life. You should speak with your doctor if you believe you may be pregnant to discuss possible side effects and the risks/benefits of this procedure. If you think that you could be pregnant, please inform the doctor before the exam to discuss alternative diagnostic procedures.

Females (please initial if affirmative):

_____ To the best of my knowledge I am not pregnant and do not believe that there is any chance that I may be pregnant.

_____ I understand the risks and possible effects of ionizing radiation on an unborn baby.

By signing below, I consent to reasonable and necessary diagnostic imaging for the purposes of chiropractic analysis, identification of contraindications to care, and screening for pathological conditions.

Signature _____ Date _____