NEW PATIENT INTAKE

Name:_____ Today's Date:_____

Address:_____ City:_____ State:____ Zip:_____

Home Telephone: ( )_____ Work: ( ) _____ Cell: ( ) _____

Email Address: _____ Male____ Female____

Social Security: _____ Birth Date: _____ Age:____

Occupation: _____

Employer Name and Address: _____

Single_____ Married_____ Spouse's Name _____

Have you seen a Chiropractor before? Yes No If yes, when? _____

Whom may we thank for referring you to our office? _____

YOUR HEALTH SUMMARY

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

- ❑ Headaches
- ❑ Pins/Needles in in arms
- ❑ Dizziness
- ❑ Numbness in fingers
- ❑ Fatigue
- ❑ Sleeping problems
- ❑ Diarrhea
- ❑ Cold sweats
- ❑ Mood swings
- ❑ Pins/Needles in legs
- ❑ Loss of smell
- ❑ Buzzing in ears
- ❑ Numbness in toes
- ❑ Depression
- ❑ Neck stiffness
- ❑ Constipation
- ❑ Lights bother eyes
- ❑ Menstrual pain
- ❑ Fainting
- ❑ Back pain
- ❑ Ringing in ears
- ❑ Loss of taste
- ❑ Irritability
- ❑ Cold hands
- ❑ Fever
- ❑ Problem urinating
- ❑ Menstrual Irregularity
- ❑ Neck pain
- ❑ Loss of balance
- ❑ Nervousness
- ❑ Stomach upset
- ❑ Tensions
- ❑ Cold feet
- ❑ Hot flashes
- ❑ Heartburn
- ❑ Ulcers

List any medications you are taking: _____

_____

_____

_____

_____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability:

_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments and, all other procedures provided at Hood Chiropractic have been explained to me to my satisfaction. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ___/ ___/ ___ _____Witness Initials

Patient or Authorized person's signature Date

Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	**EFFECT**:			
Carrying/Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing/Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Exercise	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Primary Complaint: _____

1. What is your pain right now?
   No pain _____ Worst Possible Pain
   0 1 2 3 4 5 6 7 8 9 10

2. What is your average/typical pain?
   No pain _____ Worst Possible Pain
   0 1 2 3 4 5 6 7 8 9 10

3. What is your pain at its best? (how close to 0 does it get)
   No pain _____ Worst Possible Pain
   0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its worst? (how close to 10 does it get)
   No pain _____ Worst Possible Pain
   0 1 2 3 4 5 6 7 8 9 10

Patient Signature: _____ Date: _____