



# CLIENT INTAKE FORM

What is your **PRIMARY COMPLAINT** that brings you into our office? \_\_\_\_\_

Date when symptoms first appeared \_\_\_\_\_ What area of the body? \_\_\_\_\_

How did it begin? \_\_\_\_\_

Type of pain?  Sharp  Dull  Ache  Burn  Throb  Other

Do you know the cause?  Yes  No If so, what? \_\_\_\_\_

Do you have numbness or tingling?  Yes  No If so, where? \_\_\_\_\_

Does the pain radiate into:  Arm  Hand  Leg  Foot  Other \_\_\_\_\_  Does not radiate

How often do you experience these symptoms?  Constant 100%  Frequent 75%  Intermittent 50%  
 Occasional 25%  Rare 10%

Have you ever experience the same or similar symptoms at any other time?  Yes  No If so, when? \_\_\_\_\_

What makes symptoms worse? \_\_\_\_\_

Are you taking any medication to currently relieve the symptoms of this problem? Including OTC.  Yes  No

If yes, what?  Nerve Pills  Pain Pills  Muscle Relaxer  Blood Pressure  Other \_\_\_\_\_

Is there anything else that relieves your symptoms? \_\_\_\_\_

Do any family members suffer from the same complaint?  Yes  No If so, who? \_\_\_\_\_

Have you been to another doctor for this problem?  Yes  No If so, who/where? \_\_\_\_\_

Are your current symptoms accident related (auto, work or other)?  Yes  No If yes, please describe: \_\_\_\_\_

When did this accident occur?  Past year  Past 5 years  Over 5 years

Please list all surgeries, the type and when it occurred:  
\_\_\_\_\_  
\_\_\_\_\_

Please list other injuries, accidents, falls, etc. that you have experienced other than your primary complaint:  
\_\_\_\_\_  
\_\_\_\_\_



# HEALTH HISTORY

Please indicate any health conditions you have or are currently experiencing

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fractured bones (please describe)_____   | <input type="checkbox"/> Eating Disorders      | <input type="checkbox"/> Foot Trouble (circle one) R L Both       |
| <input type="checkbox"/> Auto Accident(s)   | <input type="checkbox"/> Under Stress          | <input type="checkbox"/> Diabetes - Type 1 or Type 2 (circle one) |
| <input type="checkbox"/> 0-1 yrs ago _____  | <input type="checkbox"/> Depression            | <input type="checkbox"/> Lower Back Pain/Stiffness                |
| <input type="checkbox"/> 1-5 yrs ago _____  | <input type="checkbox"/> Irritability          | <input type="checkbox"/> Convulsions, Epilepsy                    |
| <input type="checkbox"/> 5+ yrs ago _____   | <input type="checkbox"/> Trouble Concentrating | <input type="checkbox"/> Pain with Cough or Sneeze                |
| <input type="checkbox"/> Other accidents, falls. Describe: _____  | <input type="checkbox"/> ADD / ADHD            | <input type="checkbox"/> Gall Bladder Problems                    |
| _____   | <input type="checkbox"/> Learning Disability   | <input type="checkbox"/> Digestive Problems                       |
| <input type="checkbox"/> Headaches:   | <input type="checkbox"/> Skin Problems         | <input type="checkbox"/> Impotence                                |
| <input type="checkbox"/> Tension <input type="checkbox"/> Migraine <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Mood Changes          | <input type="checkbox"/> Kidney Trouble                           |
| <input type="checkbox"/> Blurred or Double Vision   | <input type="checkbox"/> Anemia                | <input type="checkbox"/> Menstrual Problems                       |
| <input type="checkbox"/> Ringing in ears  | <input type="checkbox"/> Bedwetting            | <input type="checkbox"/> Pregnant (currently)                     |
| <input type="checkbox"/> Hearing Loss (circle one) R L Both   | <input type="checkbox"/> Ear Infections        | <input type="checkbox"/> Fertility Problems                       |
| <input type="checkbox"/> Jaw Pain or Clicking (circle one) R L Both   | <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> HIV, AIDS                                |
| <input type="checkbox"/> Neck Pain or Stiffness (circle one) R L Both   | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Cancer                                   |
| <input type="checkbox"/> Shoulder Pain (circle one) R L Both  | <input type="checkbox"/> Heart Problems        | <input type="checkbox"/> Arthritis                                |
| <input type="checkbox"/> Upper Back Pain/Stiffness  | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Allergy, Sinus                           |
| <input type="checkbox"/> Numbness/Tingling/Pain (circle one) R L Both   | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Hip Pain (circle one) R L Both           |
| <input type="checkbox"/> Arms <input type="checkbox"/> Hands <input type="checkbox"/> Fingers                               | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Ulcers                                   |
| <input type="checkbox"/> Numbness/Tingling/Pain (circle one) R L Both   | <input type="checkbox"/> Varicose Veins        | <input type="checkbox"/> Hemorrhoids                              |
| <input type="checkbox"/> Buttocks <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Toes | <input type="checkbox"/> Liver Problems        | <input type="checkbox"/> Prostate Problems                        |
| <input type="checkbox"/> Difficulty in Excessive Standing, Sitting, Riding  | <input type="checkbox"/> Trouble Sleeping      | <input type="checkbox"/> Others, please specify                   |
| <input type="checkbox"/> Bending, Twisting, Lifting (circle one)  | <input type="checkbox"/> Frequent Colds, Flu   | _____   |

**Family History** - Please list significant diseases/conditions experienced by immediate family members:

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## Health Habits:

Do you smoke or have you ever smoked in the past?  Yes  No If yes, please describe \_\_\_\_\_

Do you consume alcohol?  Yes  No Do you consume caffeine?  Yes  No

Do you have a high stress level?  Yes  No If yes, please list reasons: \_\_\_\_\_

Do you exercise?  Yes  No If yes, how many times per week and what type? \_\_\_\_\_



# GENERAL INFORMATION

Please print clearly. Information in confidential.

Date: \_\_\_\_\_

Patient First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone (Work): \_\_\_\_\_

Phone (Cell): \_\_\_\_\_ Email: \_\_\_\_\_

Are You:  Married  Single  Widowed  Divorced Spouses Name: \_\_\_\_\_

Spouses Phone: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Emergency Contact Info: \_\_\_\_\_

How did you hear about us?:  Online Search  Referral  Event  Social Media  Other

Have you had previous Chiropractic care?  Yes  No Chiropractor's Name: \_\_\_\_\_

Were you given any type of treatment plan, home care stretching/strengthening program to assist your recovery?

Yes  No If yes, please describe: \_\_\_\_\_

Did you follow it?  Yes  No If not, why? \_\_\_\_\_

Why are you changing Chiropractors? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_ Phone: \_\_\_\_\_

May we update your medical doctor regarding your treatment in our office?  Yes  No

Date of last physical/exam? \_\_\_\_\_

Please list all vitamins/medications that you currently take (including over the counter):

\_\_\_\_\_

Dosage of each medication:

\_\_\_\_\_

Females: Are you pregnant:  Yes  No

Can we email you periodically about practice updates?  Yes  No

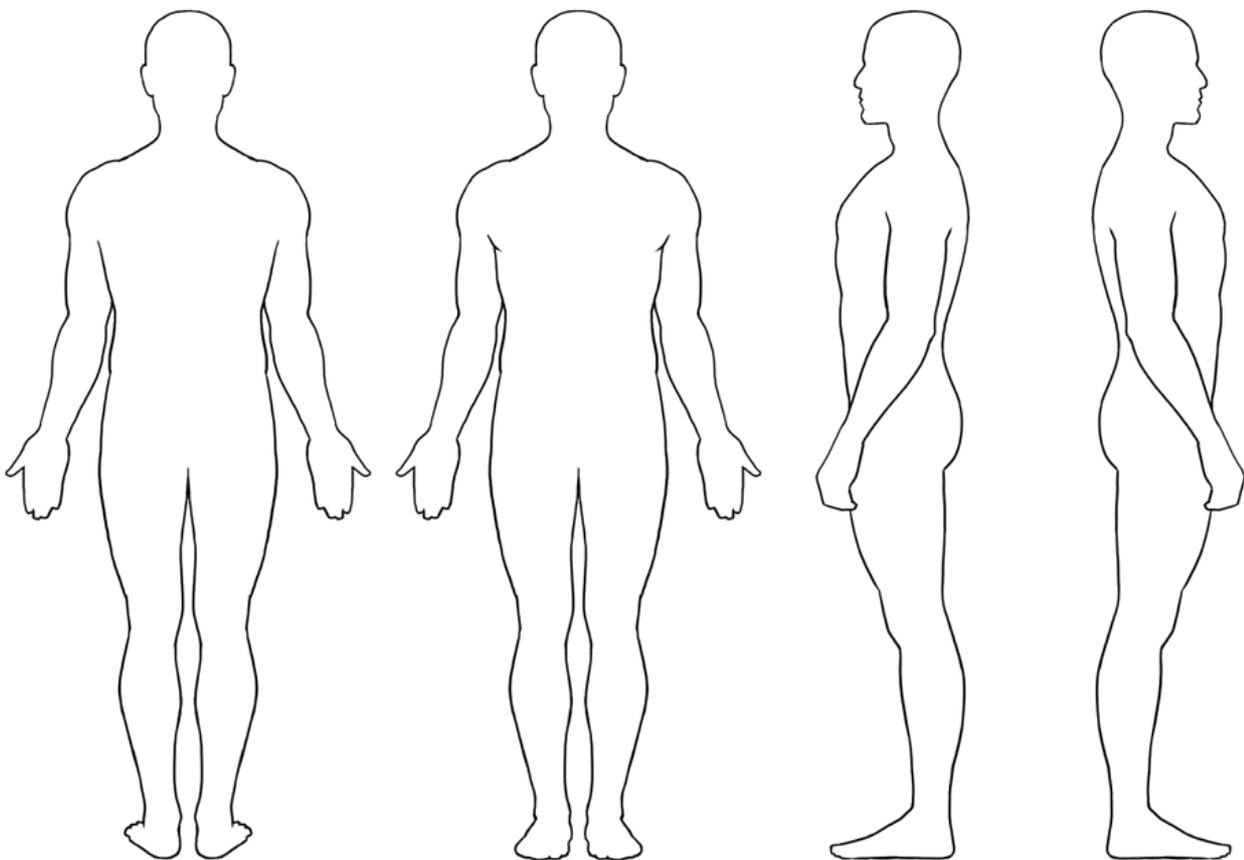


# GENERAL INFORMATION

Please circle all areas of complaint on the diagrams below and label them with the following indicators of pain:

**A** = ache, **D** = dull, **T** = tingling, **N** = numbness, **B** = burning

**S** = sharp or stabbing, **X** = other (please specify)



Please also label the number that best represents the intensity of your symptoms in each area of pain on a scale of 0-10 (0 being no symptoms, 10 being extreme)

No pain **0 1 2 3 4 5 6 7 8 9 10** Extreme Pain



# PRIVACY PRACTICES

I have received or reviewed the privacy practice notice for HHFC, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Authorized to speak with regarding care

\_\_\_\_\_  
Relationship/Phone # of individual(s)

\_\_\_\_\_ OK to leave detailed messages on primary #

\_\_\_\_\_ Do NOT leave detailed messages on primary #



## FINANCIAL POLICIES AND TERMS OF ACCEPTANCE OF CARE

It is important for each patient to understand both the objectives and methods of chiropractic care to prevent any confusion or problems in the future. Please take time to review the information below.

**Adjustment:** An adjustment is the specific application of forces and physiotherapy to facilitate the reduction or correction of spinal misalignment (subluxation).

**Vertebral Subluxation:** a misalignment of one or more of the 24 vertebrae in the spinal column which causes the alteration of both muscle and nerve function. This will interfere with the transmission of nerve impulses which can cause the lessening of the body's ability to function properly.

Our office does not diagnose or treat any diseases or conditions other than Vertebral Subluxation. However, if during the course of an examination we find a non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we recommend you seek out the services of your primary care provider. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding the treatment prescribed by others.

All visit charges are payable when services are rendered. Healing Hands Family Chiropractic requires a courtesy call of giving at least 24 hours notice in the event you cannot keep your scheduled appointment. If we do not receive notification of a cancellation of your scheduled appointment within the 24 hour notice, your appointment will be considered a NO SHOW. We reserve the right to charge the full amount of the missed appointment. It is also our policy that appointments remain punctual; you will be given 10 minute after the start of your scheduled appointment before you are considered a NO SHOW. Healing Hands Family Chiropractic also reserves the right to reschedule any appointments where the patient shows up after the 10 minute start of their appointment and you will be charged the full amount of the missed appointment.

We also offer multiple ways to pay including cash, check or credit card. Please be aware that if you choose to pay by credit or debit card, there will be an additional 3% convenience fee for all transactions.

I (please print) \_\_\_\_\_ have read and fully understand the above Policies and Terms of Acceptance, and hereby grant permission to receive chiropractic services.

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_



# INFORMED CONSENT FORM

The primary treatment used by the doctors at Healing Hands Family Chiropractic is spinal manipulative therapy.

The nature of the Chiropractic Adjustment: The doctors at Healing Hands Family Chiropractic may use a mechanical instrument on your body to move your joints; they may also use their hands or other mechanical devices to work on the joints and soft tissue of your body or other modes of physiotherapy and supportive therapies. During treatment you may hear a clicking associated with the use of the mechanical instrument and may feel a sense of movement in your joints, or a release of your soft tissue.

The material risk inherent in a Chiropractic adjustment: Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment. As with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications are considered rare but patients may experience fractures, disc injuries, dislocations, muscle strain, ligament sprain, cervical myelopathy, and/or Horner's Syndrome and stroke. Some people have documented feelings of stiffness or soreness in the days following treatment.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed and there is no promise of cure. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts known then, is in my best interest. The doctors at Healing Hands Family Chiropractic will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to their attention, it is your responsibility to inform them.

I also understand and am informed that there may be other treatment options available for my condition besides chiropractic procedures. These treatment options can include, but are not limited to, self-administered, over-the counter analgesics, rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms.

I also understand and I have been informed that if seeking pregnancy care that the doctors at Healing Hands Family Chiropractic will NOT “turn” the fetus in utero or will be practicing any other types of obstetrical or gynecological care. I understand and I have been informed that I am seeking care and treatment of musculoskeletal conditions associated with pregnancy only.

If you do not fully understand the above or have questions about anything mentioned in this document, please do NOT sign it until these matters have been resolved with further discussion.

I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Healing Hands Family Chiropractic.

I (please print) \_\_\_\_\_ have read and fully understand and agree to both the *informed consent to treat & authorization of care*.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_