GRICE Chiropractic

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NEW PATIENT INTAKE FORM

Title: ☐Mr. ☐Mrs. ☐Ms. ☐Miss. ☐Dr. ☐Other_____

First Name:_____ Middle Initial:___ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Leave Messages On: ☐Home ☐Cell ☐Work ☐Don't leave messages

Home Phone: (___) ___ - _____ Work Phone: (___) ___ - _____

Cell Phone: (___) ___ - _____ Email: _____

Date of Birth: ___/___/_____ Sex: ☐Male ☐Female

Social Security Number:____-____-_____ Marital Status: ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Unemployed ☐FT Student ☐PT Student ☐Other_____

Employer Data

Employer: _____

Your Occupation: _____

Spouse Data

First Name:_____ Middle Initial:___ Last Name:_____

Home Phone: (___) ___ - _____ Work Phone: (___) ___ - _____

Spouse Date of Birth: ___/___/_____

Emergency Contact

Contact Name:_____ Relationship to Patient:_____

Contact Home Phone: (___) ___ - _____ Contact Cell Phone: (___) ___ - _____

Doctor's Signature:_____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Fibromyalgia	☐ Asthma	☐ Osteoporosis	☐ Other_____

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular Procedure	☐ Cervical Spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar Spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic Spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-Intestinal	☐ Uro-Genital	☐ Hernia
☐ Breast Augmentation	☐ Other_____		

Allergies: (Check all that apply to you)

☐ Mold	☐ Seasonal	☐ Milk or Lactose	☐ Animal
☐ Chemical_____	☐ Sulfites	☐ Wheat/Glutens	☐ Other_____

Social History: (Check all that apply to you)

Caffeine Use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Drink Water:	☐ <64 oz/day	☐ >64 oz/day	☐ never
Cigarettes:	☐ <1 pack/day	☐ >1 pack/day	☐ never
Sleep:	☐ <8 hours/night	☐ >8 hours/night	☐ never

Other:_____

Family History: (Check all that apply to you)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease:	☐ Parent	☐ Sibling
Hypertension:	☐ Parent	☐ Sibling
Stroke:	☐ Parent	☐ Sibling
Thyroid:	☐ Parent	☐ Sibling

Other:_____

Occupational Activities: (Check all that apply to you)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment Operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐ Food Service Industry	☐ Medium Manual Labor	☐ Manufacturing	☐ Home Services
☐ Heavy Manual Labor	☐ Light Manual Labor	☐ Executive/Legal	☐ Housekeeper

☐ Other_____

Doctor's Signature:_____

Patient Name:_____ Date:_____

Review of Systems: (Check box if you have had trouble with any of the following)

CARDIOVASCULAR	PAST	PRESENT	NO
Poor Circulation			
Hypertension			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

GENITOURINARY	PAST	PRESENT	NO
Kidney Disease			
Burning Urination			
Frequent Urination			
Blood in Urine			
Kidney Stones			
Lower Side Pain			

NEUROLOGIC	PAST	PRESENT	NO
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's			
Carpal Tunnel			
Vertigo			

CONSTITUTIONAL	PAST	PRESENT	NO
Weight Loss/Gain			
Low Energy Level			
Difficulty Sleeping			

RESPIRATORY	PAST	PRESENT	NO
Asthma			
Tuberculosis			
Short Breath			
Emphysema			
Cold/Flu			
Cough			
Wheezing			

EYES	PAST	PRESENT	NO
Glaucoma			
Double Vision			
Blurred Vision			

PSYCHIATRIC	PAST	PRESENT	NO
Depression			
Anxiety			
Stress			

ENDOCRINE	PAST	PRESENT	NO
Thyroid			
Diabetes			
Hair Loss			
Menopausal			
PMS			

HEMATOLOGIC	PAST	PRESENT	NO
Hepatitis			
Blood Clots			
Cancer			
Bruising			
Bleeding			
Fever, Chills			
Sweating			
Varicose Vein			

ALLERGIC/IMMUNOLOGIC	PAST	PRESENT	NO
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

EAR, NOSE AND THROAT	PAST	PRESENT	NO
Difficulty Swallowing			
Dizziness			
Hearing Loss			
Sore Throat			
Nosebleeds			
Bleeding Gums			
Sinus Infections			

GASTROINTESTINAL	PAST	PRESENT	NO
Gall Bladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

MUSCULOSKELETAL	PAST	PRESENT	NO
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			
Neck Pain			
Low Back Pain			
Upper Back Pain			

Please list all current medication being taken:_____

_____

How are your symptoms changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

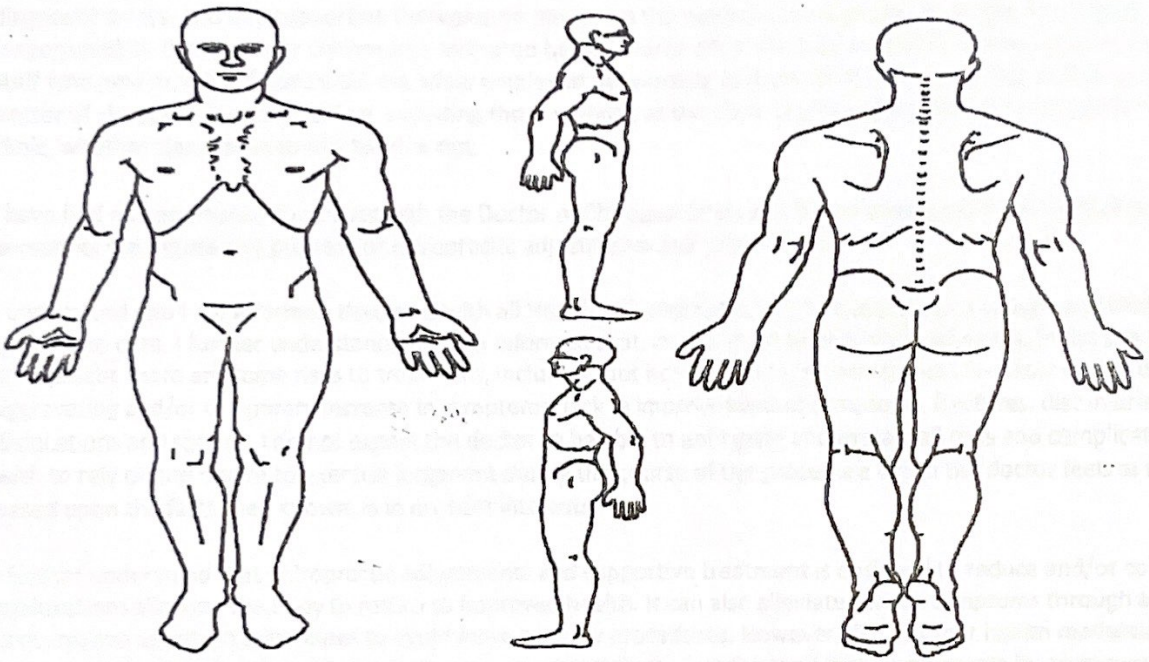
Are you Pregnant? ☐ Yes ☐ No

Doctor's Signature:_____

Patient Name:_____ Date:_____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N = Numbness **B = Burning** **S = Sharp** **T = Tingling** **A = Dull Ache**



Average pain intensity:

Last 24 Hours:	no pain	0	1	2	3	4	5	6	7	8	9	10 worst pain
Past Week:	no pain	0	1	2	3	4	5	6	7	8	9	10 worst pain

Does anything improve your pain? ☐ Yes ☐ No

If Yes, please list: _____

When did your symptoms begin? _____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐ Work Related Accident ☐ Other _____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp ☐ Ache ☐ Numb ☐ Shooting
☐ Burning ☐ Tingling ☐ Throbbing ☐ Other _____

Doctor's Signature: _____

Patient Name: _____ Date: _____

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, to whom I am legally responsible) by the doctor or chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other offices or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short period of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. 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 upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payments for treatments are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to self-administered, over the counter analgesics and rest, medical care with prescription drugs such as anti-inflammatory, 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 secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this content to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Signature:_____ Date:_____