GRICE Chiropractic

1305 Grandview Ave
Pittsburgh, PA 15211
Phone: 412-381-9977
Fax: 412-381-1215

NEW PATIENT INTAKE FORM

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

Preferred Name: _____ Date of Birth: ___/___/_____ Sex: ☐ Male ☐ Female ☐ Other

Address: _____

City: _____ State: _____ Zip Code: _____

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

Email: _____ Marital Status: ☐ Single ☐ Married ☐ Other _____

Employer Data

Employment Status: ☐ Employed ☐ Unemployed ☐ Full-time Student ☐ Part-time Student ☐ Other

Employer: _____

Occupation: _____

Emergency Contact

Contact Name: _____ Relation to Patient: _____

Contact Cell Phone: (_____) _____-_____

How did you hear about us? ☐ Search Engine (Google, Safari, etc.) ☐ Social Media (Facebook, Insta, etc.)

☐ Friend or Co-worker Name: _____ ☐ Other _____

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Medical History: (Check all that apply to you)

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Carpal Tunnel
- ☐ Depression/Anxiety/Stress
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Immune Disorder
- ☐ Seizures
- ☐ Stroke
- ☐ Skin Disorder
- ☐ Thyroid

Please list all current medication being taken: _____

_____

Are you Pregnant? ☐ Yes ☐ No

Surgeries: (Check all that apply to you)

- ☐ Appendectomy
- ☐ Brain
- ☐ Breast Augmentation
- ☐ Carpal Tunnel
- ☐ Cardiovascular Procedure
- ☐ Gallbladder
- ☐ Gastro-Intestinal
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Prostate
- ☐ Uro-Genital
- ☐ Cervical Spine
- ☐ Lumbar Spine
- ☐ Thoracic Spine
- ☐ Shoulder
- ☐ Knee
- ☐ Hip
- ☐ Joint Replacement
- ☐ 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: _____

Allergies: (Check all that apply to you)

- ☐ Animal
- ☐ Chemical _____
- ☐ Milk or Lactose
- ☐ Mold
- ☐ Seasonal
- ☐ Sulfates
- ☐ 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 hrs/night	☐ >8 hrs/night	☐ Never

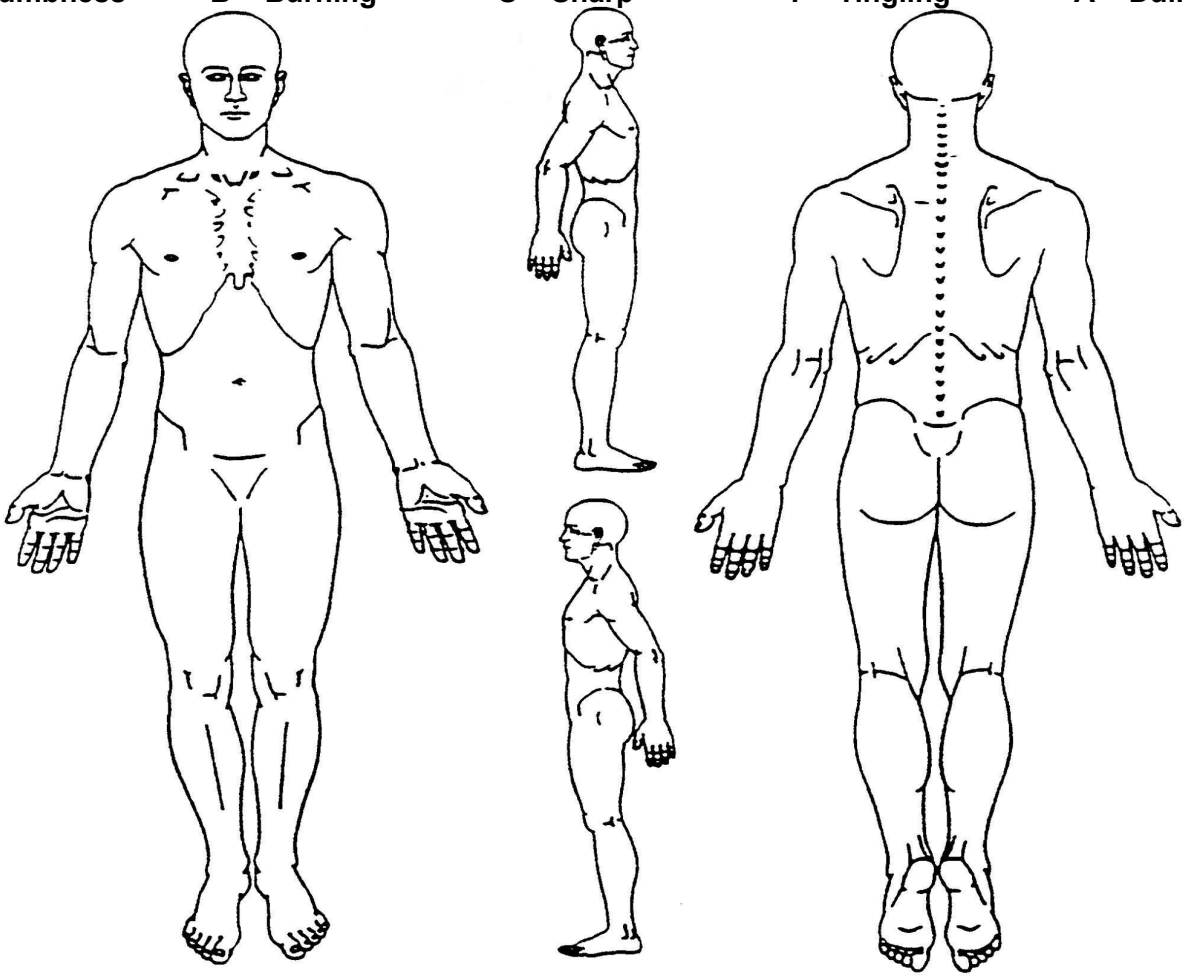
Occupational Activities: (Check all that apply to you)

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

Other _____

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

How are your symptoms changing? ☐ Getting better ☐ Getting Worse ☐ Not changing

Does anything improve your pain? ☐ Yes ☐ No

If Yes, please list: _____

When did your symptoms begin? _____

How did your symptoms begin? _____

_____

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

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_____

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, 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 a 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 contect, 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.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____