Adult Intake Form

First Name: _____ M.I.: ____ Last Name: _____
Preferred Name: _____ Social Security Number: _____
Preferred Language? English__ Spanish__ Other (please specify)_____
Address: _____
City/State/Zip: _____
Birth Date: _____ Age: _____ Sex: M F
Home Phone: ( ) _____ Cell Phone: ( ) _____
Work Phone: ( ) _____
Email: _____
Occupation: _____ Employer's Name: _____
Marital Status: S M D W Other Spouse's Name: _____
Who can we thank for referring? _____
In the event of an emergency, who can we contact?
Name: _____ Phone: ( ) _____ Relationship:
_____

Pediatric Intake

First Name: _____ M.I.: ____ Last Name: _____
Preferred Name: _____ Social Security Number:_____
Address:_____City/State/Zip:_____
Birth Date: _____ Age: _____ Sex: M F

Of Siblings: _____ Sibling's Names & Ages: _____

Parents' Name: _____

Best Contact Phone: ( ) _____ Alternate Phone: ( ) _____

Parent's Email: _____

Who can we thank for referring? _____

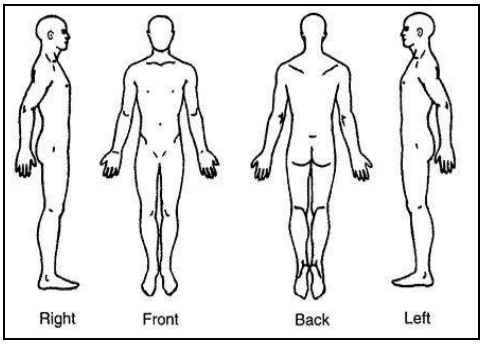
In the event of an emergency, who can we contact? Name: _____ Phone: ( )
_____Relationship: _____

Have you ever received chiropractic care? Yes No If Yes, when? _____

Note: This sheet MUST reflect every area you would like adjusted, even if it is not your main concern.

Location (Where does it hurt?) **CIRCLE** the area on the illustration.

Symptom 1:



Circle the type of pain you are experiencing:

Sharp Shooting Dull Stabbing Aching Burning

Intensity: ○- ○- ○- ○- ○- ○- ○- ○- ○- ○

1 2 3 4 5 6 7 8 9 10

Duration: When did it start? _____

(EX: 1 week ago, 1 month ago)

How did it start? _____

_____

(EX: Gardening, Bending Over, Cleaning)

How often: ◯ Constant (75-100% present)

◯ Frequent (50-75% present)

◯ Occasional (25-50% present)

Radiation: Affect other areas? Where does it radiate, shoot or travel?

_____

Aggravating or relieving factors: What makes **better** or **worse**; time of day, movement?

_____

Prior interventions: (what have you tried to this symptom?)

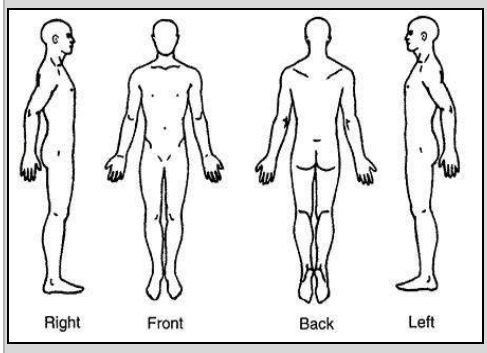
◯ Prescription medication ◯ Surgery

◯ Over the counter drugs ◯ Acupuncture

◯ Homeopathic remedies ◯ Chiropractic

◯ Physical Therapy ◯ Massage ◯ Ice/Heat

Symptom 2:



Circle the type of pain you are experiencing:

Sharp Shooting Dull Stabbing Aching Burning

Intensity: ○- ○- ○- ○- ○- ○- ○- ○- ○- ○

1 2 3 4 5 6 7 8 9 10

Duration: When did it start? _____

(EX: 1 week ago, 1 month ago)

How did it start? _____

_____

(EX: Gardening, Bending Over, Cleaning)

How often: ◯ Constant (75-100% present)

◯ Frequent (50-75% present)

◯ Occasional (25-50% present)

Radiation: Affect other areas? Where does it radiate, shoot or travel?

_____

Aggravating or relieving factors: What makes it **better** or **worse**; time of day, movement?

_____

Prior interventions: (what have you tried to relieve this symptom?)

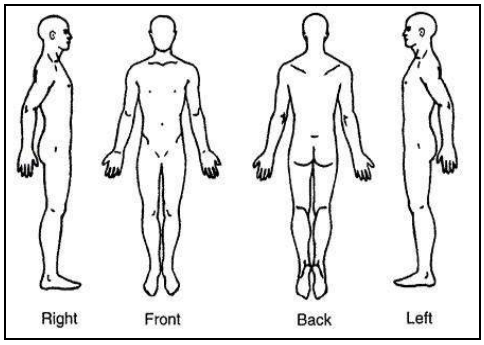
◯ Prescription medication ◯ Surgery

◯ Over the counter drugs ◯ Acupuncture

◯ Homeopathic remedies ◯ Chiropractic

◯ Physical Therapy ◯ Massage ◯ Ice/Heat

Symptom 3:



Circle the type of pain you are experiencing:

Sharp Shooting Dull Stabbing Aching Burning

Intensity: ○- ○- ○- ○- ○- ○- ○- ○- ○- ○

1 2 3 4 5 6 7 8 9 10

Duration: When did it start? _____

(EX: 1 week ago, 1 month ago)

How did it start? _____

_____

(EX: Gardening, Bending Over, Cleaning)

How often: ◯ Constant (75-100% present)

◯ Frequent (50-75% present)

◯ Occasional (25-50% present)

Radiation: Affect other areas? Where does it radiate, shoot or travel?

_____

Aggravating or relieving factors: What makes it **better** or **worse**; time of day, movement?

_____

Prior interventions: (what have you tried to relieve this symptom?)

◯ Prescription medication ◯ Surgery

◯ Over the counter drugs ◯ Acupuncture

◯ Homeopathic remedies ◯ Chiropractic

◯ Physical Therapy ◯ Massage ◯ Ice/Heat

 PRINT NAME: _____ DOB: _____ ACCOUNT #: _____

What else should the doctor know about your current condition/symptoms?

_____

Do you suffer from any condition other than that for which you are now consulting us? ❑ Yes No

If yes, please describe: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis ❑Anemia ❑Heart Disease ❑Arthritis ❑Pneumonia ❑Measles
❑Goiter ❑Epilepsy ❑Rheumatic Fever ❑Mumps ❑Influenza ❑Mental Disorder
❑Polio ❑Chicken Pox ❑Pleurisy ❑Lumbago ❑Tuberculosis ❑Diabetes
❑Alcoholism ❑Eczema ❑Whooping Cough ❑Cancer ❑Venereal Disease ❑HIV Positive

List any other past conditions you may have had:

_____

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Hypertension	Stroke	Thyroid	Heart Disease	Other	
Mother	❑	❑	❑	❑	❑	❑	❑	❑	Living/Deceased
Father	❑	❑	❑	❑	❑	❑	❑	❑	Living/Deceased
Sibling(s)	❑	❑	❑	❑	❑	❑	❑	❑	Living/Deceased

WORK HISTORY

❑Administration ❑Business Owner ❑Clerical/Secretary ❑Executive/Legal
❑Heavy Equip. Operator ❑Light Manual Labor ❑Construction ❑Computer User
❑Food Service Industry ❑Medium Manual Labor ❑Daycare/Childcare ❑Home Services
❑Manufacturing ❑Heavy Manual Labor ❑Health ❑Housekeeper
❑Other: _____

What type of activities does your work involve?

❑Sitting ❑Standing ❑Bending ❑Turning ❑Twisting ❑Lifting ❑Pulling/Pushing ❑Other: _____

SOCIAL HISTORY

Caffeine use:	❑never	❑occasional	❑often	Drink alcohol:	❑never	❑occasional	❑often
Chew tobacco:	❑never	❑occasional	❑often	Cigarettes:	❑never	❑occasional	❑often
Exercise:	❑never	❑occasional	❑often	Wear Seat Belts:	❑never	❑occasional	❑often

MEDICATIONS

List any supplements/vitamins you are taking: _____

 PRINT NAME: _____ DOB: _____ ACCOUNT #: _____

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No
If Yes, please indicate the following:

Medication: _____ Medication: _____
Route: Oral Route: Oral
Intravenous Intravenous
Other: _____ Other: _____
Frequency: _____ Frequency: _____
Began Use: _____ Began Use: _____
Discontinued Use: _____ Discontinued Use: _____

Medication: _____ Medication: _____
Route: Oral Route: Oral
Intravenous Intravenous
Other: _____ Other: _____
Frequency: _____ Frequency: _____
Began Use: _____ Began Use: _____
Discontinued Use: _____ **Discontinued Use: _____**

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE	**DATE**	**DATE**
_____Back Operation	_____ Hernia	_____ Gall Bladder
_____Female Organs	_____ Thyroid	_____ Stomach

Other _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom?

For what ailments were these X-rays taken? _____

DATE OF LAST PHYSICAL EXAMINATION: _____ Do you have a pacemaker? ❑Yes ❑No

Are you currently pregnant? ❑Yes ❑No How many weeks?_____ Due Date?_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with the quality of professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov
We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree your inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to them in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

"No Show" and "Cancellation" Policy & Procedure and Agreement

At Impact Family Chiropractic, our goal is to provide quality Chiropractic care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of care.

- **No Show Fee (Patients who fail to attend a scheduled appointment time): $50.00**
- **Cancellation Fee (Patients who fail to reschedule or cancel their appointments with 24-hour notice): $35.00**
- **These fees are not covered by insurance and is therefore the sole responsibility of the patient.**

How to Cancel or Reschedule your Appointment: Call the office at 919-977-5744. If you do not speak to our staff directly, please leave a message with your Name, Number, Appointment time, the time you called, and we will get back to you as soon as possible. A message must be left.

My signature below acknowledges my agreement to the terms set forth and the HIPAA information and office cancellation policy.

_____	_____	_____
Patient or Guardian Name	Patient or Guardian Signature	Date

 PRINT NAME: _____ DOB: _____ ACCOUNT #: _____

INFORMED CONSENT TO CHIROPRACTIC SERVICES

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
Please Initial Each Line, Consenting to Care. No care will be rendered if this is not signed. Thank you.

___ Spinal manipulative therapy	___ Palpation	___ Vital signs
___ Range of motion testing	___ Orthopedic testing	___ Basic neurological testing
___ Muscle strength testing	___ Postural analysis	
___ Ultrasound	___ Hot/Cold therapy	___ Electrical Stim
___ Radiographic studies	___ Mechanical traction	___ Graston
___ Other (please explain)	___ Manual therapy	___ Medical Massage

The material risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment due to the adjustment, other therapies, or medical massage. We 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 our attention, it is your responsibility to inform us.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. Any other complications are also generally described as rare.

The availability and nature of other treatment options Other treatment options for your condition may include; but are not limited to: Self-administered, over-the-counter analgesics and rest; Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers ; Hospitalization ; and Surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options, and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW: I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment, medical massage, and related treatment. I have discussed it with *Dr. Danielle Vann* and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name: _____ Signature: _____ Date: _____

Doctor's Name: Danielle R. Vann D.C. Signature: _____

 PRINT NAME: _____ DOB: _____ ACCOUNT #: _____

REVIEW OF SYSTEMS

Please check Yes, No, or Deny All to ***ALL*** questions .

Constitutional

Yes	No	Deny All ☐
☐	☐	Excessive daytime sleepiness
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Low Energy
☐	☐	Trouble getting to sleep
☐	☐	Trouble staying asleep
☐	☐	Weight gain
☐	☐	Weight loss

Eyes

Yes	No	Deny All ☐
☐	☐	Blurred Vision
☐	☐	Double Vision
☐	☐	Loss of vision

Ears, Nose, Mouth, and Throat

Yes	No	Deny All ☐
☐	☐	Loss of sense of smell
☐	☐	Hearing loss
☐	☐	Ringing in your ears

Bladder and Sexual Function (Genitourinary)

Yes	No	Deny All ☐
☐	☐	Discomfort and burning
☐	☐	Loss of Bladder control
☐	☐	Loss of desire for sex
☐	☐	Menopause (for women)
☐	☐	Trouble with erection (for men)
☐	☐	Urgency to urinate

Skin

Yes	No	Deny All ☐
☐	☐	Change in hair or nails
☐	☐	Change in skin color
☐	☐	Itching
☐	☐	Rash

Neurological

Yes	No	Deny All ☐
☐	☐	Confusion
☐	☐	Falling down
☐	☐	Headaches
☐	☐	Incoordination
☐	☐	Involuntary Movements or Jerking
☐	☐	Lightheaded or Dizzy
☐	☐	Loss of Consciousness/Fainting/Passing out
☐	☐	Numbness
☐	☐	Seizure or Convulsion
☐	☐	Spinning or vertigo
☐	☐	Tingling
☐	☐	Tremor
☐	☐	Trouble speaking
☐	☐	Trouble Walking
☐	☐	Weakness
☐	☐	Trouble swallowing

Cardiovascular and Respiratory

Yes	No	Deny All ☐
☐	☐	Chest Pain
☐	☐	Palpations
☐	☐	Shortness of breath

Gastrointestinal

Yes	No	Deny All ☐
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Nausea
☐	☐	Vomiting

Musculoskeletal

Yes	No	Deny All ☐
☐	☐	Back pain
☐	☐	Joint pain or swelling
☐	☐	Muscle pain or cramps
☐	☐	Neck pain

Endocrine

Yes	No	Deny All ☐
☐	☐	Heat or cold intolerance
☐	☐	Increased thirst
☐	☐	Loss of hair

Memory, Thinking, Mood, Psychiatric

Yes	No	Deny All ☐
☐	☐	Anxiety
☐	☐	Depressed mood
☐	☐	Hallucinations (seeing or hearing things)
☐	☐	Memory loss

Hematologic (blood) and lymphatic

Yes	No	Deny All ☐
☐	☐	Anemia
☐	☐	Easy bruising or bleeding
☐	☐	Slow to heal after cuts

Allergic and Immune

Yes	No	Deny All ☐
☐	☐	Allergic reaction to medicine or x-ray dye

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care in accordance with this state's statutes. I understand that it is my responsibility to bring to the attention of the providing physician ANY new information regarding my health and well-being or any changes in health status that would be pertinent to my case management.

_____

Patient's Name

_____

Patient's or Guardian's Signature

_____

Date

 PRINT NAME: _____ **DOB:** _____ **ACCOUNT #:** _____