

CHIROPRACTIC CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a client of Wager Family Chiropractic. Information collected about new clients is confidential and will be treated accordingly.

PATIENT DETAILS

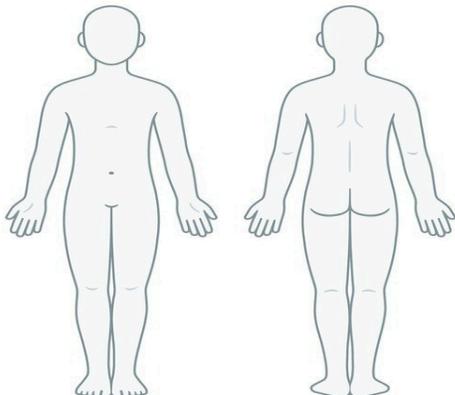
Patient Name: _____ Date of Birth: _____
 Street Address: _____
 City: _____ State: _____ ZIP Code: _____
 Mobile Phone: _____ E-mail: _____
 Occupation (if any): _____ Employer: _____
 Primary Physician: _____ How did you hear about u_s _____
Emergency Contact Information
 Emergency Contact: _____ Phone: _____
 Relationship to Patient: _____

INSURANCE POLICIES

Primary Insurance Company: _____
 Group #: _____ ID#: _____
 Policyholder Name: _____ Date of Birth: _____
 Relationship to Patient: _____
 Secondary Insurance Company: _____
 Group #: _____ ID#: _____
 Policyholder Name: _____ Date of Birth: _____
 Relationship to Patient: _____

Symptoms

Circle or list the areas on your body where you experience discomfort:



Describe your symptoms in order of severity, beginning with the worst symptom:

How long ago did your symptoms begin? _____

What caused your symptoms? Motor Vehicle Accident Work Accident Other If other? _____

How often do your symptoms occur?

- Constantly (76%-100% of the day)
 Frequently (51%-75% of the day)
 Occasionally (26%-50% of the day)
 Never (0%-25% of the day)

What makes your symptoms better: _____

What makes your symptoms worse: _____

PATIENT HEALTH INFORMATION

Indicate the medical conditions that you have had:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Skin Disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psychiatric Illness	<input type="checkbox"/> Stroke
			<input type="checkbox"/> Other: _____

Indicate the surgeries that you have had:

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Prostate
<input type="checkbox"/> Brain	<input type="checkbox"/> Hernia	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Cardiovascular Procedure	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Thoracic
<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Spine
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Knee	<input type="checkbox"/> Urogenital
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Lumbar Spine	Other: _____

Do you drink alcohol? Yes No

• If yes, how many drinks per week? _____

Do you smoke cigarettes? Yes No Do you smoke? Yes No

If yes, how many cigarettes per day? _____

Do you chew tobacco? Yes No

If yes how often? _____

Do you drink caffeine? Yes No.

If yes how many cups a day? _____

How often do you exercise? Frequently Occasionally Rarely Never

Please describe what you do for exercise: _____

List any prescription medications you currently take:

Family History

Indicate any health issues your family members have, and enter the age of the corresponding individual. If the person is deceased, enter their age at death.

Condition	Father Age:___	Mother Age:___	Siblings Age:___	Children Age:___
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pinched Nerve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Goals

List three goals that you have for treatment.

- 1) _____
- 2) _____
- 3) _____

Please list any other relevant information not stated above.

ACKNOWLEDEMENT

By signing below, I hereby acknowledge, agree, and authorize all of the following:

- a) Accurate Information. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
- b) Patient Rights and Responsibilities. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I am financially responsible for the payment of the service received.
- c) Release of Medical Information. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
- d) Consent for Treatment. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my conservative chiropractic treatment as necessary. I understand the risks that come with treatment.
- e) Consent to Communication. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or other channels.
- f) Acknowledgment. By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: _____ Date: _____

Print Name: _____

Parent or Guardian Signature: _____ Date: _____

Print Name: _____

Patient Quality of Life Survey

Name: _____ Date: _____

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 How have you taken care of your health in the past?

- | | |
|--|---|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Nutrition/Diet |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Holistic Care |
| <input type="checkbox"/> Routine Medical | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Other (please specify): _____ | |

02 How did the previous method(s) work out for you?

- | | |
|--|---|
| <input type="checkbox"/> Bad Results | <input type="checkbox"/> Did Not Get Worse |
| <input type="checkbox"/> Some Results | <input type="checkbox"/> Did Not Work Very Long |
| <input type="checkbox"/> Great Results | <input type="checkbox"/> Still Trying |
| <input type="checkbox"/> Nothing Changed | <input type="checkbox"/> Confused |
| <input type="checkbox"/> Other (please Specify): _____ | |

03 How have others been affected by your health condition?

- | | |
|--|---|
| <input type="checkbox"/> No One Is Affected | <input type="checkbox"/> They Tell Me To Do Something |
| <input type="checkbox"/> Haven't Noticed Any Problem | <input type="checkbox"/> People Avoid Me |
| <input type="checkbox"/> Other (please Specify): _____ | |

04 What are you afraid this might be (or beginning) to affect (or will affect)?

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Job | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Kids | <input type="checkbox"/> Time |
| <input type="checkbox"/> Future Ability | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Freedom |
| <input type="checkbox"/> Self-Esteem | |
-

05 Are there health conditions you are afraid this might turn into?

- | | |
|---|--|
| <input type="checkbox"/> Family Health Problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Need Surgery |
| <input type="checkbox"/> Arthritis | |
-

06 How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

07 What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:

1. _____
2. _____
3. _____

08 What are you most concerned with regarding your problem?

09 Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

10 What would be different/better without this problem? Please be specific.

11 What do you desire most to get from working with us?

12 What would that mean to you?

WELLNESS EVALUATION

Name: _____

Date: _____

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:

- Headaches
- Migraines

Hormone Imbalance Including:

- PMS
- Emotional imbalance

Gastrointestinal Issues Including:

- Abdominal bloating, cramps or painful gas
- Irritable Bowel Syndrome
- Ulcerative Colitis
- Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- Chronic sinusitis
- Asthma
- Allergies

Joint Conditions Including:

- Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- Diabetes Mellitus
- Lupus
- Rheumatoid Arthritis
- Fibromyalgia
- Chronic Fatigue

Thyroid Conditions Including:

- Hashimotos
- Hypothyroidism
- Hyperthyroidism

Developmental and Social Concerns Including:

- Autism
- ADD/ADHD

Skin Conditions Including:

- Eczema
- Skin rashes
- Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	1	2	3	
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____