

CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
LAST NAME

FIRST NAME MIDDLE INITIAL

Address _____

City _____ State _____

Home Phone _____

Cell Phone _____

Email _____

Sex M F Age _____ Birthday _____

Married Widowed Single Minor

Separated Divorced Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

If you are already experiencing a symptom, what is it? _____

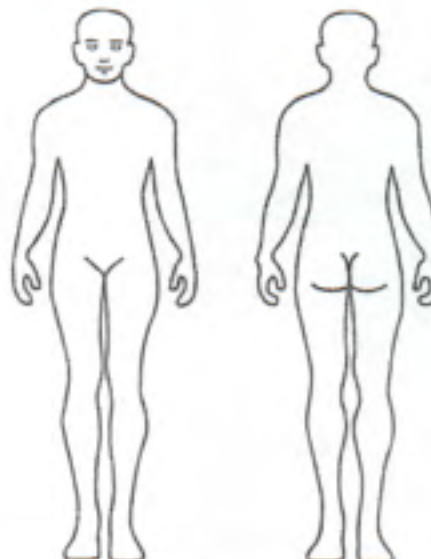
How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10
NO SYMPTOMS INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:

What does it feel like? (check where appropriate)

- | | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Nagging | <input type="checkbox"/> Other _____ |



IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

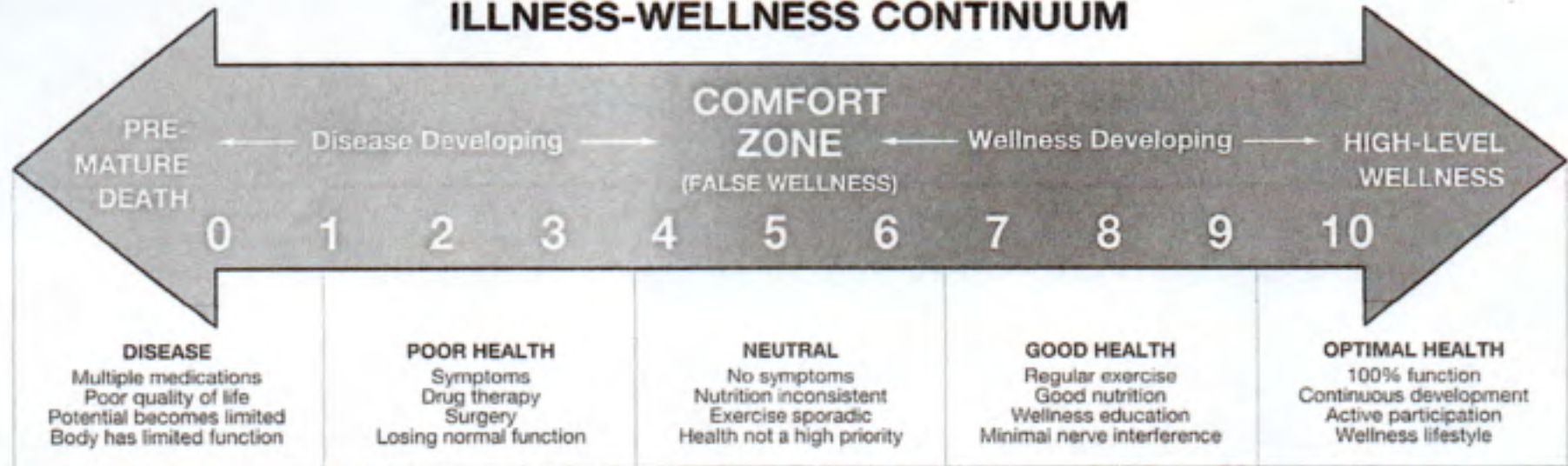
| | No Effect | Mild Effect | Moderate Effect | Severe Effect | | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Energy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Attitude | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Recreation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Patience | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Relationships | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Productivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Creativity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-Care | <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"/> |

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10
NOT COMMITTED VERY COMMITTED

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM



On the arrow diagram above:

- A. What number do you think represents your health today? _____
- B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Children's ages? _____

Children's health concerns? _____

Are you currently pregnant? No Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anxiety <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma/Allergies <input type="checkbox"/> Back Pain <input type="checkbox"/> Cardiovascular Issues <input type="checkbox"/> Cancer | <input type="checkbox"/> Circulation Issues <input type="checkbox"/> Childhood Illness <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Digestive Issues (Constipation/Diarrhea/GERD/IBS) <input type="checkbox"/> Elbow/Wrist/Hand Issues <input type="checkbox"/> Endocrine Issues (Thyroid) <input type="checkbox"/> Foot/Ankle Issues <input type="checkbox"/> Gout | <input type="checkbox"/> Headaches / Migraines <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hip Issues <input type="checkbox"/> Immune Issues <input type="checkbox"/> Lymphatic Issues <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Neck Pain <input type="checkbox"/> Reproductive Issues | <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Scoliosis <input type="checkbox"/> Shoulder Issues <input type="checkbox"/> Stroke <input type="checkbox"/> TMJ Issues <input type="checkbox"/> Urinary Issues <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other _____ |
|---|--|---|--|

ALLERGIES, MEDICATIONS & SUPPLEMENTS

| | | |
|---|---|---|
| ALLERGIES (list) _____ _____ _____ | MEDICATIONS (list) _____ _____ _____ | SUPPLEMENTS (list) _____ _____ _____ |
|---|---|---|

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

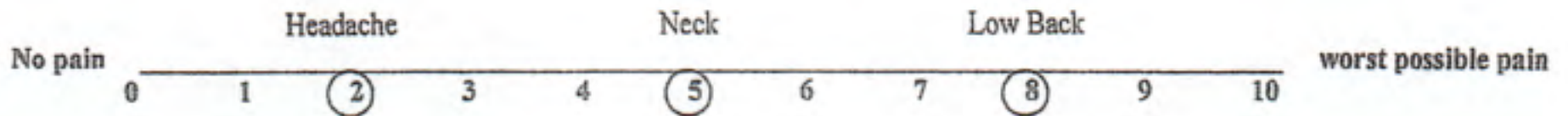
Date _____

Please read carefully:

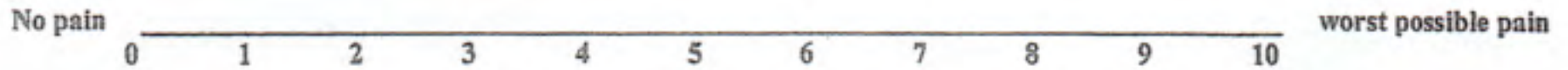
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

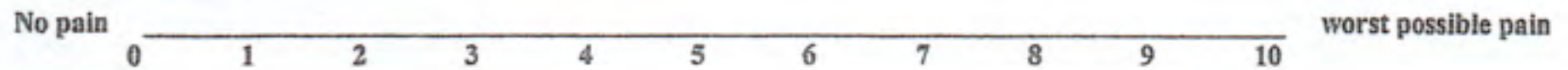
Example:



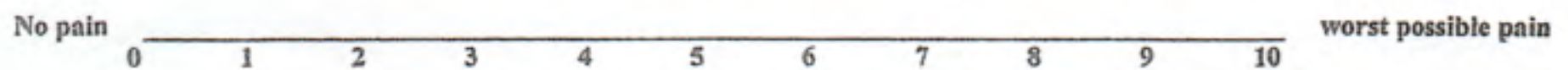
1 – What is your pain RIGHT NOW?



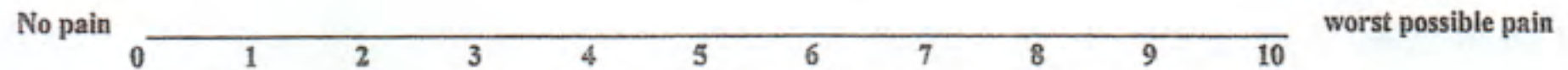
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner _____

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INSURANCE INFORMATION:

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Co: _____ ID# _____

Subscriber Name _____ DOB : _____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Justin Steinhauser all insurance benefits, if any, otherwise payable to me for serviced rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan s completed or one year from the signed date below.

Signature of Patient, Parent, or Guardian or Personal Representative Date

Please print name of above signature Relationship to Patient

FINANCIAL RESPONSIBILITY:

Dear Patient,
Chiropractic USA provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so we may properly credit your account.
I have read and understood the above information.

Patient Initials Date

X-RAY CONSENT:

I hereby give my consent to Chiropractic USA and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.
I have read and understood all the above information.

Patient Initials Date



INFORMED CONSENT

Dear Patient,

Every type of health care is associated with some risk of a potential problem. This indicates chiropractic health care. We want you to be informed about the potential problems associated with chiropractic health care before consenting to treatment. This is a legal requirement in Nebraska. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device or machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we used trained staff personnel to assist the doctor with portions of your consultation, examination, X-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc.

Stroke: Stroke means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with stroke or not. Recent evidence suggest that it is not (2008, 2015, 2016), although the same evidence suggests that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous dissection of the vertebral artery. If we think this is happening, you will immediately be referred to emergency services.

Anecdotal stories suggest that chiropractic adjustments may be associated with strokes that arise from the vertebral artery; this is because the vertebral artery is actually located inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called the "extension-rotation-thrust atlas adjustment." We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incidence of this type of stroke ranges between 1 per every 400,000-3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Two other potential problems that are not quantifiable because they are extremely rare and may have no association with chiropractic adjustments are carotid artery injury and spinal dural tear resulting in a leak of cerebral spinal fluid.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. These problems occur so rarely that there are no available statistics to quantify their incidence.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may overstretch some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their incidence.

Rib and other Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your X-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their X-rays. These problems occur so rarely that there is no available statistics to quantify their incidence.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell the Doctor about it.

Other problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

If you have any questions on the above, please ask the Doctor. When you have a full understanding, please sign and date below.

Patient's Name Printed

Date

Patient's Signature

Parent/Guardian Signature for Minor