

**For Office Use Only**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acct #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Height \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Weight \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient BMI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Blood Pressure \_\_\_\_\_\_\_

Patient Intake Form

**General Information**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Middle Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Called Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Insurance: Y N Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race** (circle only 1) American Indian Alaska Native Marital status: Single

Asian White Married

Black or African American Divorced

Native Hawaiian Other Pacific Islander Widow

Declined to State

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ethnicity** (circle only 1) Declined to State Hispanic or Latino

Not Hispanic or Latino

**Preferred Language** **\_\_\_\_\_\_\_\_\_\_Family Members\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are your present problems due to an injury? Yes No Enter the date of the injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the injury?  Job Related Auto Accident Personal Injury Other:

Has the accident been reported? Yes No If so, to whom? To Employer Auto Carrier Other:

Briefly describe what symptoms brought you in today:

 NAME:\_\_\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List symptoms experienced today:

Choose the severity level associated with each symptom

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

 Frequency of Pain Occasional Intermittent Frequent None

 Type of Pain Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing None

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

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List any tests, studies or medications received for this condition:

Tests/Studies:

Medications:

Where you admitted to the hospital due to this condition: Yes No

 If yes, what hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Transported by? Ambulance Police Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date Admitted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Released: \_\_\_\_\_\_\_\_\_\_\_\_ Length of Stay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Do you have any current work restrictions due to this condition?

# Off work: Yes No Previously From: To:

 Light duty: Yes No Previously (If yes, what are/were your restrictions?)

What type of work do you do?

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any past conditions you may have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HABITS

Current Every Day Smoker Current Some Day Smoker

Former Smoker Never Smoker

Drinking Alcohol: (Cups/day): \_\_\_\_\_ Coffee Cups/Day: \_\_\_\_\_\_\_

Soft Drink Bottles or Cans/Day: \_\_\_\_\_ Water Cups/Day: \_\_\_\_\_\_\_

 EXERCISE None Moderate Daily

 FAMILY HISTORY NAME: \_\_\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Diabetes Cancer Back Pain Other

Mother 

Father 

Sibling(s)  

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?

Please check the box for each CURRENT or PAST symptom listed. NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 EYE/EAR

 GENERAL SYMPTOMS GASTRO-INTESTINAL NOSE/THROAT RESPIRATORY

 Allergy(What) \_\_\_\_  Belching or Gas  Asthma  Chest Pain

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Colon Trouble  Deafness  Chronic Cough

 Bronchitis  Constipation  Earache  Difficulty Breathing

 Chills (Constant)  Diarrhea  Ear Discharge  Spitting Blood

 Convulsions  Gall Bladder Trouble  Ear Noises  Spitting Phlegm

 Dizziness  Hemorrhoids (piles)  Thyroid Problems

 Fainting  Jaundice  Frequent Colds GENITO-URINARY

 Fatigue  Liver Trouble  Hay Fever  Bed Wetting

 Headache  Nausea  Nasal Obstruction  Blood in Urine

 Loss of Sleep  Stomach Pain  Nose Bleeds  Frequent Urination

 Loss of Weight  Vomiting  Pain in Eyes  Inability to Control

 Nervousness  Vomiting Blood  Poor Vision Urine

 Night Sweats  Heart Burn  Blurred Vision  Kidney Infection

 Numbness or Pain  Bloody Stools  Sinusitis  Kidney Stones

 in arms/legs/hands  Acid Reflux  Sore Throats  Painful Urination

 Wheezing  Irritable Bowel  Tonsillitis  Prostate Trouble

Muscles & Joints Cardio-Vascular Skin or Allergies For Females Only

 Backache  High Blood Pressure  Bruising Easily  Cramps

 Foot Trouble  Low Blood Pressure  Dryness  Hot Flashes

 Hernia  Chest Pain  Eczema  Irregular Cycle

 Pain Between  Heart Trouble  Hives or Allergy  Painful Periods

Shoulders  Poor Circulation  Itching  Vaginal Discharge

 Painful Tail Bone  Rapid Heart  Sensitive Skin  Pregnant Now?

 Stiff Neck  Slow Heart  Skin Eruptions \_\_\_\_\_\_\_ Last Pap Date

 Spinal Curvature  Strokes \_\_\_\_\_\_\_ Last Menstrual Cycle

 Swollen Joints  Swelling Ankles

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



**Pain Drawing**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Examiner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TELL US WHERE YOU HURT.**

***Please read carefully:***

*Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.*

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o

Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o

Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~

Patient #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If we will be filing insurance for you, please sign, date and sign the following form. 

**PLEASE INITIAL NEXT TO EACH POLICY:**

 **Acknowledgement of Financial Policy**

I have read and understand the payment policy of Lakeside Chiropractic & Rehab.  I understand that my insurance is an arrangement between myself and my insurance company, NOT between Lakeside Chiropractic & Rehab and my insurance company.  I request that Lakeside Chiropractic & Rehab prepare the customary forms at no charge so that I may obtain insurance benefits.  I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Lakeside Chiropractic & Rehab, those fees will be due and payable immediately.\*

 **Informed Consent for Chiropractic Care**

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis.  The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems.  In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury.  The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated.  Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician.  The Chiropractic Physician provides a specialized, non-duplicating health care service.  Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Lakeside Chiropractic, I am authorizing them to proceed with any treatment that may be necessary.  Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

 **Patient Acknowledgement and Receipt of Notice of Privacy Practices**

(Pursuant to HIPPA and Consent for Use of Health Information)

The undersigned does hereby acknowledge that he or she has receicved a copy of this office’s Notice of Provacy Practices Pursuant to HIPPA and has been advised that a full copy of the office’s HIPPA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPPA, the HIPPA Compliance Manual, State Law and Federal Law.\*

 **Pregnancy Waiver**

I hereby acknowledge that doctors of Lakeside Chiropractic has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

**\*For a complete copy of policy, please ask the front desk and you will be provided one at no charge.**

Print Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian/Represenitive Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_

 **Circle one**

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

