ESSENTIAL HEALTH CHIROPRACTIC

Chiropractic Intake Form

Dr. Elise DeCamp, DC, CCWP, CACCP

Patient Information:

Name: _____ Date: _____

Address: _____

Sex: Male Female Date of Birth: _____ Height:_____ Weight: _____

Patient SSN: _____ [Married / Single / Other] Spouse:_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Email:_____ Would you like our newsletter emailed to you: Y N

Whom may we thank for referring you? _____

Emergency Contact:_____ Phone: _____

Employer: _____ Is it okay to contact you at work? Y N

Employer Address: _____ Employer Phone: _____

Present Complaint: _____

When did this begin?_____ Was there an accident or injury involved? Y N

Was this due to a car accident? Y N Was this due to an accident from work? Y N

Have you had any past treatment for this complaint? Y N Describe:_____

Medications/supplements (Last 6 months to present): _____

How did this complaint start: _____

What is the nature of the symptoms: Dull Ache Burn Throb Deep Sharp Shooting _____

How often are you experiencing the symptoms: Constant (100 %) Frequent (75%) Often (50%) Intermittent (25%)

Since the symptoms started have they gotten: Better Worse Stayed the Same

On a scale of 0-10, 10 being the worst, how do you rate your discomfort: _____/10

Have the symptoms affected your ability to sleep? Y N Have they affected your appetite? Y N

Do you have any radiation of pain? Y N Is there anything that makes your discomfort Better or Worse? _____

How do you rate your health today: Excellent Very Good Good Poor

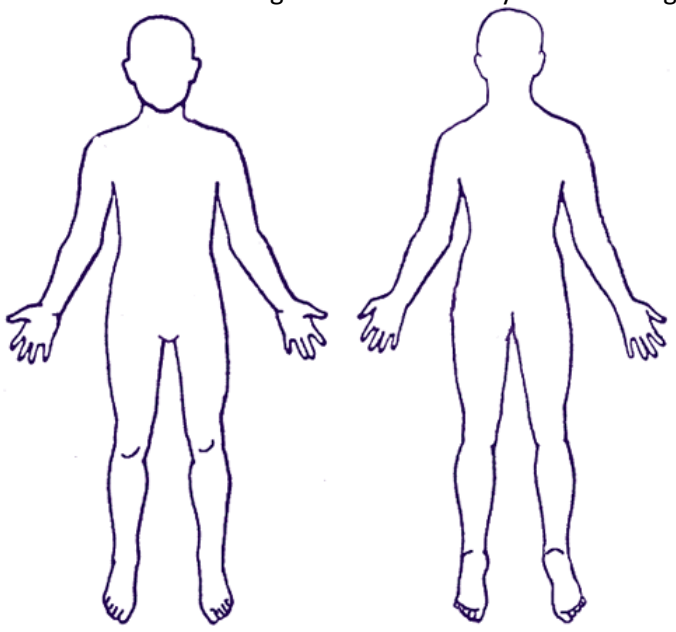
Have you been to a chiropractor before? Y N When was your last visit? _____

How would you rate your diet? ____ Well Balanced ____ Average ____High sugar/processed foods

Does you consume artificial sweeteners? Y N

How many times per week do you engage in physical activity: _____

Please mark on the diagram below where you are feeling the symptoms you described.



Women Only: General Questions

Are you nursing? Y N Are you taking birth control? Y N Have you had painful or irregular menstrual cycles? Y N
Are you pregnant? Y N How many weeks? _____ Any current complications: _____
How many ultrasounds have you had? _____ Have you had any round ligament pain: Right Side Left Side Both
Who is your OB/Midwife: _____ What is your estimated due date:_____

Women Only: Past History

Any complications during past pregnancy? Y N Explain: _____
Medications taken during pregnancy: _____ Cigarettes or alcohol during pregnancy: Y N
Complications during delivery? Y N Explain: _____
Genetic disorders or disabilities:_____

Review of Systems

Please check if you have had any of the following:

◯Allergies	◯Alcoholism	◯Anemia	◯Atherosclerosis
◯Arthritis	◯Asthma	◯Back Pain	◯Breast Lump
◯Bronchitis	◯Bruise Easily	◯Cancer	◯Chest Pain
◯Cold Extremities	◯Constipation	◯Cramps	◯Depression
◯Diabetes	◯Digestion Problems	◯Dizziness	◯Eating Disorder
◯Excessive Menstruation	◯Eye Pain/Difficulties	◯Fatigue	◯Frequent Urination
◯Headache	◯Hemorrhoids	◯High Blood Pressure	◯Hot Flashes
◯Irregular Heart Beat	◯Irregular Menses	◯Kidney Infection	◯Kidney Stones
◯Loss of Memory	◯Loss of Balance	◯Loss of Smell	◯Loss of Taste
◯Nosebleeds	◯Pacemaker	◯Polio	◯Poor Posture
◯Prostate Trouble	◯Sciatica	◯Shortness of Breath	◯Sinus Infection
◯Sleep Problems/Insomnia	◯Spinal Curvatures	◯Stroke	◯Swelling of Ankles
◯Swollen Joints	◯Thyroid Condition	◯Tuberculosis	◯Ulcers
◯Varicose Veins	◯Venereal Disease	◯Other	

Personal Incident History:

Surgeries: _____ Illnesses: _____
Traumas (falls, sprain/strains, broken bones, car accidents):_____
Did you seek treatment for this trauma? Y N Where:_____
Hospitalizations:_____

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Authorization for Treatment

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient: _____ Signature: _____
Print Name Patient/Legal Guardian