Columbia Family Chiropractic Intake

At the moment, my pain is in….

☐ My back only ☐ My back and Rt. leg ☐ My back and Lt. leg ☐ My back and both legs
☐ My neck only ☐ My neck and Rt. arm ☐ My neck and Lt. arm ☐ My neck and both arms

How long have you had this problem? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 6-10 ☐ days ☐ weeks ☐ months ☐ years

Is your pain related to a home injury, work injury or car accident? Yes No

Pain changed in location or intensity lately? Yes No explain.._____

Is there any numbness or tingling? Yes No if yes, where?_____

Is there any weakness? Yes No if yes, where? _____

Increased pain when you cough / sneeze? Yes No if yes, where? _____

Increased pain when lifting? Yes No if yes, where? _____

Increased pain when you bend? Yes No if yes, where? _____

Increased pain when you stand or walk? Yes No if yes, where? _____

Increased pain when you sit in chairs? Yes No if yes, where? _____

Increased pain when you get up or down? Yes No if yes, where? _____

Had any loss of bowel or bladder control? Yes No

Had any pelvic floor pain? Yes No

Had any numbness or tingling around the groin? Yes No

Does sitting down help your pain? Yes No

Does lying down help your pain? Yes No

How long can you stand without sitting? Less than… ☐ 5 min ☐ 10 min ☐ 15 min ☐ 30 min ☐ 1 Hr ☐ >1 Hr

How far can you walk? ☐ < 20 ft ☐ 20-100 ft ☐ about a block ☐ ¼ mile ☐ > a mile

Is this your first chiropractic experience? Yes No

Would you like us to inform your medical doctor of your visit? If yes, name of doctor _____

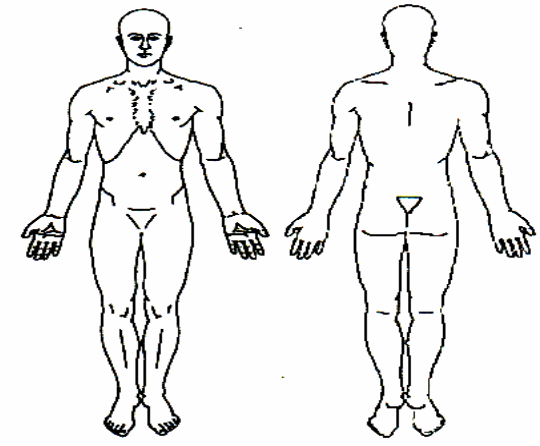
Have you had any of the following tests or treatments for this problem? ☐ X-Rays ☐ Bone Scan ☐ MRI ☐ CT ☐ EMG
☐ Blood Test ☐ Steroid Shots ☐ Medication ☐ Physical Therapy ☐ Pain Clinic

Does your pain affect your? ☐ Sleep ☐ Job ☐ Personal Care ☐ House Work

Do you have any metal implants, breast implants, surgical clips or pacemaker? Yes No

Are you right or left handed? R L

Show us where your pain is located, please note if the pain is, sharp, achy, numb, burning, tingling, stiffness, pressure



Columbia Family Chiropractic

Patient # _____

Page completed by:
__ patient __ nurse/MA
__ family __ physician
__ caretaker

New patients: Complete entire page.
Return patients: 1. Complete Symptoms section.
2. Update any changes to your medical, family, or social history below.
If no changes since your last visit here, no need to fill out those sections. Thank you.

Symptoms: Please circle any current symptoms.

General: fever, chills, fatigue, weight gain/loss (___lbs)

Eyes: redness, crusty, pain, itching, dry, watery, discharge, vision change, foreign body left/right/both

Ears: pain, discharge, ringing, clogged up left/right/both

Nose: congestion, runny, sinus pain, sinus pressure, nose bleed

Throat/: Mouth sore throat, stiff neck, swollen glands, ulcers, bad teeth

Skin: rash, itching, redness, swelling, hives, bruising, bite, mass/lump

Heart: chest pain, palpitations

Lungs: cough, wheezing, shortness of breath, tightness, painful breathing

Stomach: pain, nausea, vomiting, diarrhea, constipation, appetite change, blood in vomit, blood in stools, hemorrhoids

Other symptoms: _____

Urinary: pain, frequency, urgency, bloody urine

Female: irregular/heavy/missed/painful periods, itching, discharge, pelvic pain, breast lump

Male: discharge, scrotal/testicular mass, testicular pain

Muscles/: Bones muscle ache, joint pain, back pain, sprain, swelling, redness weakness, chest wall pain

Neuro: headache, dizziness, loss of consciousness, weakness, numbness tingling, migraines, seizures, memory trouble, radiating pain

Psychiatric: depression, anxiety, panic, difficulty sleeping, suicidal thoughts

Endocrine: energy loss, excessive hunger/thirst/urination, heat/cold intolerance

Blood/: Lymph swollen glands, unusual bruising/bleeding

Allergy: seasonal allergies , current allergic reaction

I have reviewed all of these symptoms and circled the ones that are current. There are no other current symptoms.

Signature: _____ Date: _____

Past Medical History

Asthma/COPD	Y / N
Diabetes	Y / N
Heart Disease	Y / N
High Blood Pressure	Y / N
Cancer	Y / N
Blood clot/PE	Y / N
Anxiety/Depression	Y / N
Genetic disease	Y / N

Other:_____

Surgery: ___Appendix ___Gallbladder ___Heart
___Tonsils Other: _____

Family Medical History

Asthma/COPD	Y / N
Diabetes	Y / N
Heart Disease	Y / N
High Blood Pressure	Y / N
Cancer	Y / N
Blood clot/PE	Y / N
Anxiety/Depression	Y / N
Genetic disease	Y / N

Other:_____

Social History

Employer: _____
Student? Y / N
Smoking? Y / N How many packs per day? _____
Alcohol use: __never __occasional __moderate __heavy
Street drugs: Y / N _____

COLUMBIA
familychiropractic

PATIENT REGISTRATION

Patient #_____

Last Name_____
First Name_____
Preferred Name_____
Middle Name_____ Suffix_____
Former Name_____

Sex_____
Date of Birth_____
Social Security Number_____

Address_____
(College students, please use your permanent mailing address.)
Address (line 2)_____
Zip_____
City_____
State_____

Home phone_____
Mobile Phone_____
Work Phone_____
Email_____
____No Email

Language_____
Marital Status_____

Guardian Last name_____
First name_____

Emergency Contact
Name_____
Relationship_____
Phone_____

Guarantor Information (Policy Holder)
Patient's relationship to guarantor_____

Guarantor (name to whom statements are sent)
Last Name_____
First Name_____
Middle Name_____ Suffix_____
Date of Birth_____

Mailing Address ____(same as patient)
Address_____
Zip_____
City_____
State_____

Consent: I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) by the chiropractic physician and/or other licensed health care professionals who work at Columbia Family Chiropractic (CFC). I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of such chiropractic procedures. I understand that results are not guaranteed. I understand and am informed that in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely upon the doctors reasonable and prudent judgment during the course of the treatment which he or she feels at the time, based upon the facts then known to him or her, is in my best interest. I have read, or have had read to me, the above consent and have had an opportunity to ask questions regarding its content. By signing below, I am consenting to the entire course of treatment for any and all chiropractic related conditions, both present and future.

Insurance: I hereby authorize the release of any information regarding the treatment or diagnosis of my condition which the doctor considers appropriate in order to file a claim with my insurance. I further, hereby assign any payment due for my treatment be made directly to CFC. I also request any authorized Medicare benefits for such treatment be made on my behalf to CFC. I authorize any holder of my protected health information (PHI) to release said information to the Health Care Financing Administration (HCFA) and its agents, for the purpose of determining benefits or benefits payable for related services. I also authorize Medicare to release any information regarding my Medicare claims to CFC, in accordance with Title XVIII of the Social Security Act.

Financial Responsibility: I understand that I am financially responsible for any deductibles, co-pays or other items not covered by my insurance/Medicare. (Please initial: _____)

Privacy Practices: By signing this form, I am granting consent to Columbia Family Chiropractic (CFC) to use and disclose my protected health information (PHI) for the purposes of treatment, payment and other health care operations. CFC's Notice of Privacy Practices provides more detailed information about how my PHI may be used or disclosed. I have a legal right to review the Notice of Privacy Practices before signing this consent. I also understand that it is subject to change. I have the right to request CFC to restrict how my PHI may be used or disclosed, though they are not required by law to grant my request. If, however, my request is granted, this agreement shall be binding. I have the right to revoke this consent in writing, except to the extent that my PHI has already been used or disclosed for the purposes of treatment, payment or other health care operations. By signing below, I accept and agree to these terms.

Signature_____ Date: _____