intouchchiropractic

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Marital Status: S M W D Spouse's Name: _____ Children's Name(s): _____

Emergency Contact:_____Phone:_____

How did you hear about our office? _____Height_____Weight_____

***Please note that our services are not covered by insurance companies.**

What is your main health concern / condition today? _____

When did this begin? _____

What makes it worse? _____

What makes it better? _____

How would you describe your symptoms? *(circle all that apply)*

Dead Feeling Limping Swelling Stabbing Sharp Grinding Throbbing Ache Electric Shocks

Weakness Stings Tiredness Numbness Cold Burning Cramping Stiff Pins & Needles

Is this condition interfering with any of the following? (*circle all that apply)*

Daily Activities Work Hobbies Exercise Standing Walking Relationships Lifting Sleep

Frequency of your Pain:

Constant (76 – 100%) _____ Frequent (51 – 75%) _____ Occasional (25 – 50%) _____ Intermittent (24% or less) _____

On average what level would you rate your overall knee pain?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Have you had back, knee, or leg surgeries? If yes, please **list procedure(s) and date(s)**: _____

_____

Have you had an MRI of your legs/knees/feet? Yes No Dates:_____

Has your doctor ever drained excess fluid from your symptomatic knee(s)? Yes No

On a scale of 0 – 10, How serious and committed are you about fixing your condition?

Not Serious 1 2 3 4 5 6 7 8 9 10 Totally Committed

Have you taken **pain and/or anti-inflammatory medications or supplements** without gaining long-term relief from your knee symptoms? (e.g., Tylenol, Aspirin, Aleve, Advil, Meloxicam, pain creams) If yes, what have you tried?

_____

Have you received **physical therapy** without long-term relief from your knee symptoms? Yes No

Have you used a **knee brace** without long-term relief of your symptoms? Yes No
What type of knee brace?_____

Have you received **steroid/cortisone Injection(s)** to the knee without long-term relief? Yes No
How many?_____ Dates?_____

List **other treatments or therapies** you have received without long-term relief from your symptoms:_____

_____

Have the treatments listed above helped you? ☐ Yes, a lot ☐ Yes, some ☐ No, not at all ☐ Indifferent

Name of your Primary Care Physician: _____ Clinic: _____

May we contact him/her with updates regarding your treatment? Yes No

COMPREHENSIVE HEALTH HISTORY (circle all that apply)

Low Back Pain	Vascular Leg Problems	Heart Attack	Shingles
Sciatica	Vascular Surgery	Stroke	Kidney Disease
Leg or Foot Pain/Numbness	Joint Replacement	High Blood Pressure	Dialysis
Neck Pain	Knee Surgery	High Cholesterol	Gout
Hand Pain/Numbness	Leg Fracture	Cancer	Other: _____
Herniated/Bulging Disc	Foot Surgery	Neuropathy	
Spinal Arthritis	Spinal Surgery	Diabetes (last A1c =_____)	

Please list all prescription medications or supplements you are currently taking (or you may attach a list):

Name	Dosage per Day

- I hereby authorize release of any medical information necessary to evaluate my case.
- I understand that Intouch Chiropractic doctors are out-network providers, and do not bill insurance companies.

_____ _____

Patient/Guardian Signature Date

Functional Goals Survey

Please be as detailed as possible, so we can best help you.

How many doctors have you seen for this condition? _____

What are 3 to 5 different activities you can no longer do or are struggling to do because of this condition?
Please be specific:

1._____
2._____
3._____
4._____
5._____

What is your honest vision of your life in the next few years if this problem continues to progress?

_____
_____
_____

What would be different and/or better in your life without this problem? ***Please be specific.***

_____
_____
_____

What is your biggest fear if this condition continues to progress? _____

_____
_____
_____

What would success mean to you in our office? _____

_____

Knee Function Questionnaire

These questions ask about limitations you may be experiencing due to your knee pain during the last 10 days. For each question, please circle only ONE answer that best describes your degree of limitation.

In the past 10 days, how has your knee pain affected you?	**Not affected/ Able to complete**	**A little/ Affected but still able to complete**	**Quite a bit/ Unable to complete some days**	**Moderately/ Unable to complete most days**	**Extremely/ Unable to complete task**
Your ability to walk without assistance (cane or walker)?	1	2	3	4	5
Your ability to walk without a limp?	1	2	3	4	5
Your ability to walk long distances?	1	2	3	4	5
Your ability to go up stairs?	1	2	3	4	5
Your ability to go down stairs?	1	2	3	4	5
Your ability to fall asleep or stay asleep through the night	1	2	3	4	5
Your balance or stability when walking or standing? (falling, unsure of footing)	1	2	3	4	5
Your ability to get up from a seated position?	1	2	3	4	5
Your ability to complete daily activities around your home? (laundry, dishes, cooking, etc.)	1	2	3	4	5
Your ability to complete errands? (grocery shopping, doctor appts, etc.)	1	2	3	4	5
Your ability to get in and out of a vehicle?	1	2	3	4	5
Your ability to stand for long periods of time?	1	2	3	4	5

Consent to Physical Examination and X-Rays

Prior to receiving care in our office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, and your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you.

During the consultation, the doctor may determine that an examination and x-rays are required for my care. I consent to an examination an x-rays in order to diagnose my condition. I accept and acknowledge ultimate responsibility for all charges incurred. Payment is due at time of service.

Patient/Guardian Signature: _____Date: _____

Patient Consent for Use & Disclosure of Protected Health Information

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with healthcare providers who may be involved directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

We use an 'open adjusting' area. If at any time you prefer or need a 'closed' adjusting area or would like to discuss your health in the privacy of a closed room, please communicate this to a member of our staff. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient/Guardian Signature: _____Date: _____

Females Only: Regarding the Possibility of Pregnancy

This is to certify that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this time that I am pregnant. If determined at a later date that I am pregnant, I do not hold the doctor, doctor's associates, association, corporation, partnership, employees, agents and estate of this establishment accountable in any way. I give the doctor and his/her associates my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Patient/Guardian Signature: _____Date: _____

Children Under 18: Consent to Evaluate and Adjust a Minor

I, _____ being the parent or legal guardian of _____ have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care, even when I am not present to observe such care.

Patient/Guardian Signature: _____Date: _____

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As part of our commitment to quality care, we are pleased to offer several adjunct therapies. These therapies are safe and effective options to manage your symptoms, improve mobility, and help you return to normal activities faster.

These therapies stimulate the tissues to kick start the healing process. These can reduce recovery time, even post-operatively, leading to a quicker return to work or other important activities.

Please circle Yes or No for each of the following:

Use of Immuno-Suppressant Drugs (e.g. prednisone)	Y	N	Seizure Disorder Triggered by Light (e.g. epilepsy&	Y	N
Use of Blood Thinners (potential bruising)	Y	N	Steroid Injections (in the last month)	Y	N
Pregnancy	Y	N	Pacemaker	Y	N
Active Cancer	Y	N	Neurostimulation Device	Y	N
Laminectomy (at level of complaint)	Y	N	Joint Replacement	Y	N

I understand that treatment recommendations will be based on my health history and current health needs. This consent covers the entire course of care from all providers and staff in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office. I will notify the doctor(s) of any changes.

Patient/Guardian Signature_____ Date_____

Witness Signature_____