# Bloomington-Normal Spine Clinic Intake Form

Name ________________________________________________ Date ____________________________

Address ________________________________ City __________________ State ______ Zip____________

H. Phone (________) _____________ Mobile Phone (_______) ____________ Date of Birth ______________

Would you like text message reminders? ___ Yes ___No Mobile Phone Carrier ____________________

Email: ___________________________________________________ Sex: ______Male ______Female

Referred by __________________________________ Social Security # _________________________

Occupation __________________________________ Employer ______________________________

Marital Status: S, M, D, W Spouses Name ___________________________

Spouses Occupation ___________________________ Number of Children and Ages_______________

Have you ever received Chiropractic? ___ Yes ___No **or** Acupuncture ___ Yes ___No

Are you interested in: Chiropractic ___ Yes ___No

Acupuncture ___ Yes ___No

Approximate Height: _____________ Approximate Weight: _____________

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What brings you to our office today?(briefly explain) _______________________________________________

Is this related to a car accident or workers compensation claim? ___No ___Yes (Date of claim:_____________)

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## Health History

*Slips, falls, and other injuries and trauma can cause small problems at the time of injury, but may show up later on in life as chronic problems or problems that seem to appear for no reason.*

Did you suffer any birth trauma that you know of? ___No ___Yes _____________________________________

Did you suffer any injuries or trauma as a child? ___No ___Yes (if yes, please briefly explain)

_____________________________________________________________________________

Did you suffer any injuries or trauma as an adult? ___No ___Yes (if yes, please briefly explain)

_____________________________________________________________________________

Have you had any minor car accidents (less than 8 miles per hour)? ___No ___Yes If so how many:________

Have you had any more significant car accidents (9 miles per hour or over?) ___No ___Yes

*Normal headaches occur **4 times or less per year** and are mild.*

Do you get headaches more than 4 per year? ___No ___Yes If so how often?_________________________

Do you get migraines? (These are typically more severe and debilitating than headaches) ___No ___Yes

Have you had any surgeries? ___No ___Yes

If so, what surgeries________________________________________________________________

Have you had recent X-rays: ___No ___Yes If so what part of your body:___________________

Have you had MRI, CT, EMG? ___No ___Yes If so what part of your body:___________________

Do you have any Autoimmune diseases? ___No ___Yes If so what?____________________________________

Do you have any genetic diseases? ___No ___Yes If so what?____________________________________

Have you been diagnosed with any other diseases? If so what?____________________________________

Are you Pregnant: ___No ___Yes If so what is the due date:____________________

Do you have a family History of: ___Heart Disease ____Arthritis ____Cancer ___Diabetes

**Major Complaint:** ______________________

**How long have you had the problem?** ____________Days/Months/Years

**Cause:**____________ or not sure

**What makes it worse?** laying down, sitting, standing, walking, other:________

**What makes it better?** laying down, sitting, standing, walking, other:________

**What type of pain is it?** dull/achy, sharp, shooting, burning, stabbing, or ________

**Does it radiate:** Yes/No

**How severe is it? (circle a number)**

**No symptoms (0) —————> (10) severe**

Current: 0 1 2 3 4 5 6 7 8 9 10

Worst: 0 1 2 3 4 5 6 7 8 9 10

**How often do you feel it?**

Constant, frequent, sometimes, rare

Other:______________________

Who have you seen for this?__________

**2nd Complaint:** ______________________

**How long have you had the problem?** ____________Days/Months/Years

**Cause:**____________ or not sure

**What makes it worse?** laying down, sitting, standing, walking, other:________

**What makes it better?** laying down, sitting, standing, walking, other:________

**What type of pain is it?** dull/achy, sharp, shooting, burning, stabbing, or ________

**Does it radiate:** Yes/No

**How severe is it? (circle a number)**

**No symptoms (0) —————> (10) severe**

Current: 0 1 2 3 4 5 6 7 8 9 10

Worst: 0 1 2 3 4 5 6 7 8 9 10

**How often do you feel it?**

Constant, frequent, sometimes, rare

Other:______________________

Who have you seen for this?__________

**3rd Complaint:** ______________________

**How long have you had the problem?** ____________Days/Months/Years

**Cause:**____________ or not sure

**What makes it worse?** laying down, sitting, standing, walking, other:________

**What makes it better?** laying down, sitting, standing, walking, other:________

**What type of pain is it?** dull/achy, sharp, shooting, burning, stabbing, or ________

**Does it radiate:** Yes/No

**How severe is it? (circle a number)**

**No symptoms (0) —————> (10) severe**

Current: 0 1 2 3 4 5 6 7 8 9 10

Worst: 0 1 2 3 4 5 6 7 8 9 10

**How often do you feel it?**

Constant, frequent, sometimes, rare

Other:______________________

Who have you seen for this?__________

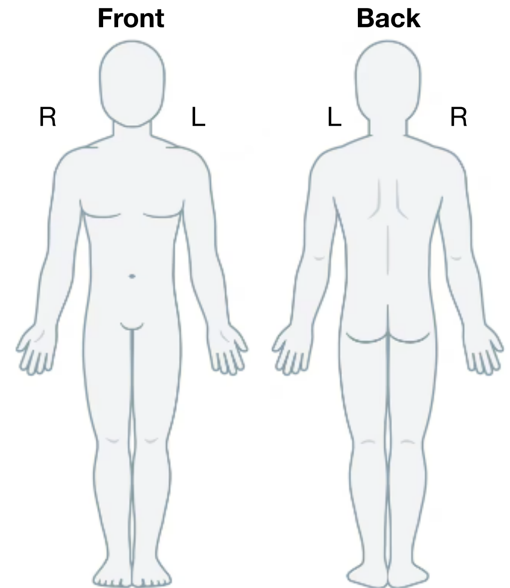
Do you have any other problems you hope we can help you with?

______________________________________________

**Symptoms: (Check all that apply)**

- ▫ Neck Pain/Stiffness
- ▫ Mid back pain
- ▫ Low Back Pain
- ▫ Tingling in Arms
- ▫ Tingling in Legs
- ▫ Numbness in Fingers
- ▫ Numbness in Toes
- ▫ Shortness of Breath
- ▫ Chest Pains
- ▫ Rapid pulse
- ▫ High Blood Pressure
- ▫ Hearing Loss
- ▫ Ringing in Ears
- ▫ Dizziness
- ▫ Vertigo
- ▫ Sinus Problems
- ▫ Allergies
- ▫ Jaw Pain
- ▫ Fatigue
- ▫ Heartburn
- ▫ Constipation
- ▫ Diarrhea
- ▫ Trouble Sleeping
- ▫ Hot Flashes
- ▫ Painful/Irregular Cycle
- ▫ Anxiety
- ▫ Depression
- ▫ Shoulder Pain
- ▫ Elbow Pain
- ▫ Wrist/Hand Pain
- ▫ Hip Pain
- ▫ Knee Discomfort
- ▫ Ankle/Foot Discomfort

**Please mark on the drawing where your pain/symptoms are:**




List any medications below:

1.______________ Reason:________

2.______________ Reason:________

3.______________ Reason:________

4.______________ Reason:________

5.______________ Reason:________

6.______________ Reason:________

For office use:

## Please check the types of care you are interested in:

- ☐ **Relief Care -** Relief of acute or chronic symptoms
- ★ ☐ **Corrective Care -** Strengthening and correcting imbalances in your spine and body for structural change
- ☐ **Wellness Care -** Care to improve overall wellbeing and function

## Informed consent for Chiropractic, Physiotherapy and Acupuncture:

Chiropractic utilizes adjustments of the spine and other joints to improve the function in the body primarily through reducing stress on the nervous system. Adjustments are made to primarily vertebral subluxations to reduce interference to the nervous system. Adjustments may be done by hand or with an instrument. Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/ strain, and in extremely rare cases fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association. I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness or tingling near the needle sight, which may last a several days. An unusual risk of acupuncture includes spontaneous miscarriage, nerve damage and organ puncture. Infection is another possible risk, however, since this office uses only sterilized, disposable needles while maintaining a clean and safe environment, this is unlikely. Burns and scarring are potential risks of using moxibustion (heat therapy). I do not expect the acupuncturist and chiropractor to be able to anticipate and explain all possible risks and complications of treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION.

★ **Patient Signature** ____________________________________ **Date**________________

**If under 18 or if representation is needed**

(Signature of parent or guardian):______________________________________ Date:_____________

(Print parent or guardian name:)_______________________________________

## HIPPA Policy:

I understand that the practitioner and administrative staff may review my medical records and reports, but all of my records will be kept confidential and will not be released without my written consent.

★ **Patient Signature** ____________________________________ **Date**________________

## Financial and Insurance Policy:

I understand the health and accident insurance policies are an agreement between an insurance carrier and myself. Any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are my responsibility and that I am also responsible for their payment.

★ **Patient Signature** ____________________________________ **Date**________________

I have Health Insurance: ___ Yes ___No

If yes, who is the Health insurance Company:_______________________________________