Health Intake Form

Connected Chiropractic

32 S. Rutherford Ave.
Johnstown, CO 80534
(970) 587-7029

Name:____ Date:____________

Address:________________________________City:__________State:____Zip:_______

Cell Ph:_________________ Home Ph:_________________Work Ph:__________________

Best Number to contact you: Home Work Cell Social Security #:________________________

Email Address:____

Birth date:__________Age:_____Sex: M F circle one: single married partnered widowed divorced separated

Occupation & Employer:__________________________________ # of hours worked per week:_____

Significant Other's Name & Occupation:____

Name(s) and Age(s) of Kid(s):____

Who can we thank for referring you to Connected Chiropractic:_____________________________

Main reason for consulting our office today:____

Any information about your spine and nerve system we should know: ________________________

____

What is your level of commitment to yourself, your life and wellbeing? ___High ___Medium ___Low

Have you ever sought the services for this or any other health concern from the following:

___Massage therapist ___Acupuncturist ___Naturopath ___Yoga Studio ___Physical Therapist
___Personal Trainer ___Nutritionist ___Rolfer ___Pilates ___Other__________
___Chiropractor

Have you been adjusted by a chiropractor before? ____Yes ____No
Office:____ Date of last Adjustment:__________________
Frequency of care: __________ x per week/month Duration of care: ______ weeks/months/yrs

- What is your daily fluid intake: Coffee____/week Alcohol____/week Water____/day Soda____/week
- Sleep/Rest Habits: Daytime naps: Y N Hours a night:_____/hrs Do you wake up refreshed? Y N
- Exercise Habits: (please describe what you do and how often)

- What type of work do you do?________________________________ Satisfied/Enjoy your work? Y N
- Do you use prescription, over the counter and/or recreational drugs/medications? Y N (If yes, please list on back)
- What are your current play and relaxation activities?

Check any of the symptoms or conditions below that you experience.

___Headaches	___Carpal Tunnel	___Asthma	___Digestive Problems/Heartburn
___Neck Pain	___Problem Sleeping	___Vertigo	___Pain Between Shoulder Blades
___Mid-Back Pain	___Ringing in Ears	___ Cancer	___Shortness of Breath
___Low-Back Pain	___Loss of Balance	___ Allergies	___Tension Across Top of Shoulders
___Sciatic Pain	___High or Low Blood Pressure	___ Dizziness	___ Numbness in Arms/Legs
___Leg or Hip Pain	___Weight Trouble	___Depression	___ Menstrual Pain
___Jaw Pain/TMJ	___Scoliosis	___Seizures/Convulsions	___Shoulder/Arm Pain
___Low Energy/Fatigued	___Other________________________________		

Which one of the above symptoms is worst?________________________ How long have you had it?_______________

When it is at its worst, how does it feel?____

The following 3 areas can contribute to nerve interference and diminished quality of life.

Circle the areas that apply to you and when.

C=Child T=Teenager A=Adult N=Not at all

Physical Stress		**Emotional Stress**		**Chemical Stress**	
Birth Stress	C T A N	Relationships	C T A N	Environmental	C T A N
Slip/ fall	C T A N	Career	C T A N	Smoker	C T A N
Car Accident	C T A N	Family	C T A N	Second Hand Smoke	C T A N
Sports Injury	C T A N	Money	C T A N	Caffeine	C T A N
Physical Abuse	C T A N	Fast paced life	C T A N	Artificial Sweeteners	C T A N
Work Injury	C T A N	Hold in Feelings	C T A N	Prescription Drugs	C T A N
Poor Posture	C T A N	Quick Tempered	C T A N	Recreational Drugs	C T A N
Sitting on wallet	C T A N	Perfectionist	C T A N	Self-Medicate	C T A N
Stomach sleeper	C T A N	Procrastinator	C T A N	Poor Diet	C T A N
Computer work	C T A N	Loss of loved one	C T A N		
Repetitive lift/bending	C T A N				
Prolonged Driving	C T A N				
Prolonged Standing	C T A N				
Prolonged Sitting	C T A N				
Surgery/Broken bones	C T A N				
Lack of Physical Activity	C T A N				
Excess Physical Activity	C T A N				

- What do you feel is the primary stressor in your life?

- Rate (circle) your combined overall level of stress from all sources listed above:

  No Stress—1—2—3—4—5—6—7—8—9—10--High Stress

Terms of Service

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate wisdom/ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. If a lifetime of a better functioning body is what you want for you, your family, and friends then welcome, you are in the right place.

I,(Printed name)_______________________________ (Signature)____undertake any care with the understanding of, and agreement with, the above explanation. _________________(Date).

Consent to evaluate and adjust a minor and/or child: I, ____ (Print name) being the parent or legal guardian of ____(Print name) give permission for my child to receive any care.

Activities of Daily Living/Symptoms/Medications

Patient Name: ____________________________________ **Date:** _______________________

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activity				
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

How we protect your Health Information:

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR HEALTHCARE PURPOSES

By signing this Consent, I acknowledge and provide permission to Connected Chiropractic (Practice) as follows:

1. Connected Chiropractic's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:
a) telephoning my home and leaving a message on my answering machine or with the individual answering the phone;
b) an e-mail sent to the e-mail address provided by me; c) a text message sent to the cell phone number provided by me.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice reserves the right to not treat me.

I have read and understand the health information disclosure and protection in the foregoing notice,

____ ____
PRINTED Name SIGNATURE

____
DATE

____ ____
Signature of Legal Guardian Relationship to minor
(e.g. if a minor)

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Connected Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies:

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date