Initial Visit Forms

Life in Motion Chiropractic & Wellness

205 Main St.
Ridgway, PA 15853
(814) 772-6903

Patient Name: _____

Patient Intake Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____)_____ Cell #: (_____)_____ Work #: (_____)_____

E-mail: _____ Preferred method of contact: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M ❑ F ❑

Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

Spouse's Name: _____

Spouse's DOB: _____/_____/_____

Your Employer/School: _____ Occupation: _____

Employer/ School Address: _____

Whom may we thank for referring you: _____

Emergency Contact: _____ Relation: _____ Phone: (____)_____

Health Insurance Information: ❑ BC/BS ❑ UPMC ❑ Other:_____

Patient Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other **If not "self", Name of Insured:_____**

Insured DOB: ____/____/____ Ins. ID#: _____ Group #: _____

Do you have additional ins.? ❑ Yes ❑ No **Subscriber's Name: _____**

DOB:____/____/____ Patient Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Co: _____ Group #: _____

Accident Information: Date of Accident:____/____/____ Type of Accident: ❑ Auto ❑ Work ❑ Other

Claim #: _____ Ins. Carrier: _____Policy #: _____

Claim Adjuster: _____ Phone #: (____)_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to **Life in Motion Chiropractic & Wellness** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient: _____

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Patient Name: _____ **Date:** _____

Primary Reason for your visit today: _____

When did the problem begin? _____ **Did it begin:** ❑ Suddenly ❑ Gradually

What was the cause of your problem? _____

Has anything like this happened before? ❑ Yes ❑ No If yes, when? _____

Since your **symptoms began**, indicate the **average intensity of your pain: (0= none to 10= gunshot wound/giving birth)**

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 / What is the intensity of your **pain right now? (0-10)** _____

What **percentage of the time you are awake** do you experience your symptoms **at the pain intensity indicated above?**

❑ 5 ❑ 10 ❑ 15 ❑ 20 ❑ 25 ❑ 30 ❑ 35 ❑ 40 ❑ 45 ❑ 50 ❑ 55 ❑ 60 ❑ 65 ❑ 70 ❑ 75 ❑ 80 ❑ 85 ❑ 90 ❑ 95 ❑ 100

What provokes your symptoms? ❑ Sitting ❑ Standing ❑ Driving ❑ Sit to Stand ❑ Walking ❑ Running ❑ Lifting ❑ Bending ❑ Other:_____

What makes your symptoms better? ❑ Rest ❑ Ice ❑ Heat ❑ Stretching ❑ Exercise ❑ Pain Meds ❑ Nothing ❑ Other:_____

How are your symptoms changing? ❑ Getting Better ❑ Not changing ❑ Getting Worse

Since your symptoms began, amount of interference with your activities of daily living? (Work, recreation, sleep, etc.)

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

In general, would you say your overall health right now is: ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

Who have you seen for your symptoms? ❑ No one ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist ❑ Other

If "other", please explain: _____

What treatment did you receive for your symptoms? ❑ Adjustments ❑ Medication(s) ❑ Exercise ❑ Surgery ❑ Other

If "other", please explain: _____

When did you receive this treatment? ❑ In the last month ❑ 2-3 months ago ❑ 3-6 months ago ❑ 6 months – 1 year ago ❑ > 1 year ago **Was the treatment effective?** ❑ Yes ❑ No If NO, why:_____

What tests have you had for your symptoms? ❑ X-rays ❑ MRI ❑ CT Scan ❑ Laboratory Analysis (blood, urine, etc.) ❑ Other **If "other", please explain:** _____

When were these tests done? ❑ In the last month ❑ 2-3 months ago ❑ 3-6 months ago ❑ 6 months – 1 year ago ❑ > 1 year ago

Have you had numbness, tingling or pins & needles in your legs or feet? ❑ **Yes** ❑ **No** In your groin area? ❑ **Yes** ❑ **No**

Have you had numbness, tingling or pins & needles in your arms or hands? ❑ **Yes** ❑ **No** In your neck or face? ❑ **Yes** ❑ **No**

Have you had weakness in your legs or have you noticed one or both feet dragging when you walk? ❑ **Yes** ❑ **No**

Is there any position you can sit or lay in that relieves your pain? ❑ **Yes** ❑ **No** Is your pain worse at night? ❑ **Yes** ❑ **No**

Have you had unexplained weight loss? ❑ **Yes** ❑ **No** Are you generally stiff in the morning? ❑ **Yes** ❑ **No**

Can you feel pulsations in your abdomen? ❑ **Yes** ❑ **No** Have you generally been feeling ill? ❑ **Yes** ❑ **No**

Have you had fever or chills? ❑ **Yes** ❑ **No** Difficulty with urination, painful urination, blood in urine? ❑ **Yes** ❑ **No**

Have you had bleeding, spotting, bouts of diarrhea, or unusual discharge? ❑ **Yes** ❑ **No**

What would you normally be doing that you can't do or avoid doing because of your pain? _____

_____

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Patient Name: _____ **Date:** _____

Is there a **SECOND** reason for your visit today**:** _____

When did the problem begin? _____ **Did it begin:** ❑ Suddenly ❑ Gradually

What was the cause of your problem? _____

Has anything like this happened before? ❑ Yes ❑ No If yes, when? _____

Since your **symptoms began,** indicate the **average intensity of your pain: (0= none to 10= gunshot wound/giving birth)**

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 / What is the intensity of your **pain right now? (0-10)** _____

What **percentage of the time you are awake** do you experience your symptoms **at the pain intensity indicated above?**

❑ 5 ❑ 10 ❑ 15 ❑ 20 ❑ 25 ❑ 30 ❑ 35 ❑ 40 ❑ 45 ❑ 50 ❑ 55 ❑ 60 ❑ 65 ❑ 70 ❑ 75 ❑ 80 ❑ 85 ❑ 90 ❑ 95 ❑ 100

What provokes your symptoms? ❑ Sitting ❑ Standing ❑ Driving ❑ Sit to Stand ❑ Walking ❑ Running ❑ Lifting ❑ Bending ❑ Other:_____

What makes your symptoms better? ❑ Rest ❑ Ice ❑ Heat ❑ Stretching ❑ Exercise ❑ Pain Meds ❑ Nothing ❑ Other:_____

How are your symptoms changing? ❑ Getting Better ❑ Not changing ❑ Getting Worse

Since your symptoms began, amount of interference with your activities of daily living? (Work, recreation, sleep, etc.)

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

Other than the Primary & Secondary reasons above, are there any other issues you wish to address during your treatment here?: _____

_____

_____

Review of Systems:

Have you had any of the following **pulmonary (lung-related)** issues? ☐ **NO**

☐Asthma/Difficulty breathing ☐COPD ☐Emphysema ☐Other:_____

Have you had any of the following **cardiovascular (hear-related)** issues or procedures? ☐ **NO**

☐ Heart surgeries ☐ Congestive heart failure ☐ Murmurs or valvular disease ☐ Heart attacks/MIs ☐ Heart disease/problems ☐ Hypertension ☐ Pacemaker ☐ Angina/chest pain ☐ Irregular heartbeat ☐Other:_____

Have you had any of the following **neurological (nerve-related)** issues? ☐ **NO**

☐ Visual changes/loss of vision ☐ One-sided weakness of face or body ☐ History of seizures ☐ Headaches ☐ One-sided numbness/tingling on face or body ☐ Memory loss ☐ Tremors ☐ Vertigo ☐ Strokes/TIAs ☐ Loss of smell ☐Other:_____

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures? ☐ **NO**

☐ Thyroid Disease ☐ Hormone replacement therapy ☐ Injectable steroid replacements ☐ Diabetes ☐Other:_____

Have you had any of the following **renal (kidney-related)** issues or procedures? ☐ **NO**

☐ Renal calculi/stones ☐ Hematuria (blood in urine) ☐ Incontinence (can't control) ☐ Bladder infections ☐ UTI ☐ Difficulty urinating ☐ Kidney disease ☐ Dialysis ☐ Other:_____

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Have you had any of the following **gastrointestinal (digestive-related)** issues? ☐ **NO**

☐ Nausea ☐ Difficulty swallowing ☐ Ulcers ☐ Frequent abdominal pain ☐ Hiatal hernia ☐ Constipation
☐ Pancreatic disease ☐ Irritable bowel/colitis ☐ Hepatitis or liver disease ☐ Bloody or black tarry stools ☐ Vomiting blood
☐ Bowel incontinence (can't control) ☐ Acid reflux/constant heartburn ☐ Other:_____

Have you had any of the following **hematological (blood-related)** issues? ☐ **NO**

☐ Anemia ☐ **Regular** anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Acetaminophen/Aleve) ☐ HIV positive
☐ Abnormal bleeding/bruising ☐ Sickle-cell anemia ☐ Enlarged lymph nodes ☐ Hemophilia ☐ **High Blood Pressure**
☐ Deep venous thrombosis/history of blood clots ☐ Anticoagulant therapy ☐ **Regular** aspirin use ☐ **High Cholesterol**
☐ Other:_____

Have you had any of the following **musculoskeletal (bone/muscle related)** issues? ☐ **NO**

☐ Rheumatoid arthritis ☐ Gout ☐ Osteoarthritis ☐ Broken bones ☐ Spinal fracture ☐ Fibromyalgia ☐ Spinal surgery
☐ Joint surgery ☐ Arthritis (**unknown type**) ☐ Scoliosis ☐ Osteo**porosis** ☐ Metal implants
☐ Other:_____

Have you had any of the following **psychological** issues? ☐ **NO**

☐ Psychiatric diagnosis ☐ Depression ☐ Suicidal ideations ☐ Bipolar disorder ☐ Schizophrenia ☐ Anxiety
☐ Psychiatric hospitalizations ☐ Homicidal ideations ☐ Other:_____

Is there **anything else in your past medical history** that you feel is important to your care here?
[i.e. cancer, genitourinary (prostate, ovary, etc.), tumors/growths, eye conditions, eating disorder, Surgeries, Hospitalizations,
Major Trauma (fracture, concussion, etc.)]_____

_____

_____

Allergies: ❑ Environmental ❑ Food ❑ Latex ❑ Medication ❑ Seasonal ❑ Other
If "other", please explain: _____

What is your occupation? ❑ Professional/Executive ❑ White Collar/ Secretarial ❑ Tradesperson ❑ Laborer
❑ Homemaker ❑ Student ❑ Other: _____

Daily Activities: N = never M = Moderate F = Frequent ← Place one of these letters next to **your** related activities

❑ Bending _____ ❑ Computer Use _____ ❑ Heavy Lifting _____ ❑ Light Lifting _____ ❑ Machine Operator _____
❑ Overhead Work _____ ❑ Reaching _____ ❑ Sitting _____ ❑ Standing _____ ❑ Walking _____

Social History:

Alcohol:	❑ **never**	❑ **moderately**	❑ **frequently**	Tobacco:	❑ **never**	❑ **moderately**	❑ **frequently**
Caffeine:	❑ **never**	❑ **moderately**	❑ **frequently**	Stress:	❑ **never**	❑ **moderately**	❑ **frequently**
Exercise:	❑ **never**	❑ **moderately**	❑ **frequently**	Other: _____			

Are you pregnant? ❑ Yes ❑ No **Due Date:** _____

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Patient Name: _____ Date: _____

List <u>ALL</u> Medications you are currently taking & <u>their dosage</u>:_____

_____

_____

_____

_____

Pharmacy Name: _____ Pharmacy Phone #: _____

List <u>ALL</u> Vitamins/Herbs/Minerals you are taking & <u>how often</u>:_____

_____

_____

_____

_____

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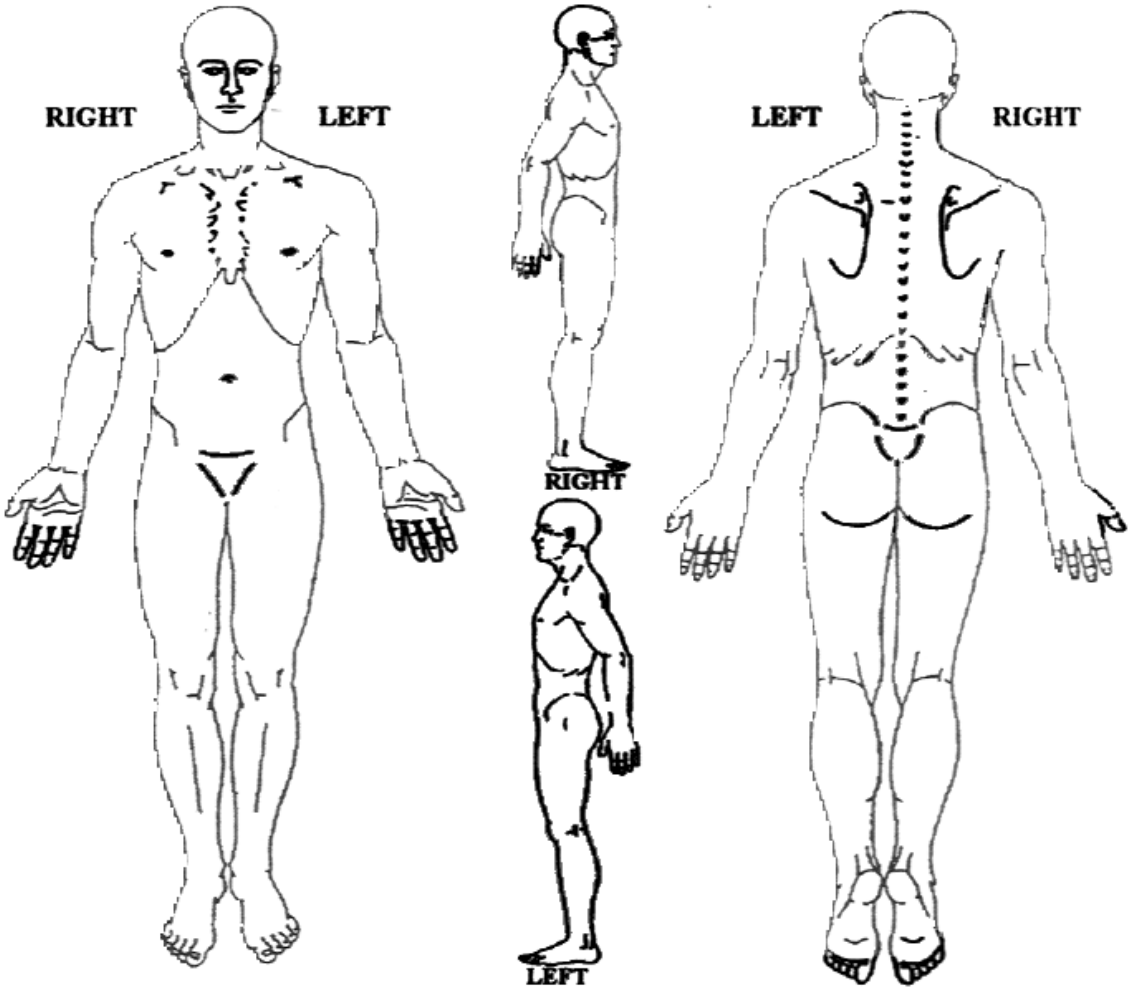
Pain Scale

Patient Name: _____ Date: _____

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **P** = PINS & NEEDLES
S = STABBING **X** = STIFFNESS **T** = THROBBING **O** = OTHER



How severe is your pain today? Place an "X" on the line below to indicate how bad you feel <u>your pain is today</u>.

No Pain |_____| Very Severe Pain

<u>Additional Comments</u>

_____

_____

_____

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Informed Consent and Authorization for Chiropractic Care

Nature and Purpose of Chiropractic Procedures

The practice of chiropractic includes many standard examination, testing, and therapeutic procedures. These include physical examination, orthopedic and neurological testing, specialized chiropractic examinations, radiological (X-ray) examinations, and laboratory testing (when clinically indicated). Procedures performed by chiropractors include various physical therapy and rehabilitation procedures, and the procedure unique to the chiropractic profession – the chiropractic adjustment.

Chiropractic adjustments are delivered to patients by chiropractors to correct spinal or extremity (knee, shoulder, wrist, etc.) joint dysfunction. This condition exists when one or more bones of the spine (or extremity) are misaligned sufficiently to cause lack of motion within corresponding joints. Generally speaking, these misalignments also cause abnormal nervous system function. The primary goal of the chiropractor is to restore joint motion and nervous system function to normal.

It is not enough that you understand the benefits of chiropractic care in restoring normal joint motion and nervous system health; you must also be aware of the risks involved and inherent limitations to chiropractic care. Every type of treatment (medical, chiropractic, dentistry, or otherwise) carries some form of potential risk associated with it. Risks associated with chiropractic care may include muscular sprain/strain, neurological deficit, osseous fracture, vertebral artery dissection (stroke), dislocations, and disc injury. While incidence of injury due to chiropractic care is exceedingly low, and only seldom are the risks significant enough to contraindicate care, these facts will be considered in making the decision to deliver chiropractic care in your case. If you are at risk, as determined by your chiropractor, you will be notified. It is possible, however, that risks may not be apparent to your chiropractor, and as such there is a chance of injury with commencement of chiropractic procedures.

Authorization for Chiropractic Care

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the potential risks of chiropractic care; including the risk that care I receive in this clinic may not accomplish the desired objective. I acknowledge that no guarantees have been provided to me with regard to the results of the care I will receive.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED AND ANY QUESTIONS I HAVE ASKED HAVE BEEN EXPLAINED TO MY SATISFACTION.

I KNOWINGLY AUTHORIZE **LIFE IN MOTION CHIROPRACTIC & WELLNESS** TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Signature: _____ Date: _____

Print Name: _____

If patient is a minor, Parent or guardian signature: _____

Relationship to patient: _____

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I, _____

Understand that I am responsible to provide Life in Motion Chiropractic & Wellness with a **MINIMUM** of **12 hours' notice** if I am unable to make my scheduled appointment for any reason. Failure to do so, I understand that I am responsible for a **CHARGE OF $25** that will be applied at the time of my next visit or on my credit card of record at the end of business the day of your scheduled appointment.

Patient Signature: _____

Date: _____

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