New Patient Intake Form

The Standard Chiropractic
807 A1A
New Smyrna Beach, Fl 32169
386 410-3292

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code _____

DOB: _____ Sex: _____ Marital Status: _____

Cell Phone: _____ Home/work phone _____

Email: _____

Employer: _____ Ocupation: _____

Spouse Data

First Name: _____ MI: _____ Last Name: _____

Home Phone: _____ Work Phone: _____

Emergency Contact

Contact Name: _____ Relationship with Patient: _____

Cell Phone: _____ Home Phone: _____

Medication you currently taken: _____

How did you hear about us: _____

General Notes: _____

_____

Medical Conditions

☐	Arthritis	☐	Cancer	☐	Diabetes	☐	Heart Disease
☐	Hypertension	☐	Psychiatric Illness	☐	Skin Disorder	☐	Stroke
☐	Fibromyalgia	☐	Asthma	☐	Osteoporosis		

Other: _____

Surgeries

☐	Appendectomy	☐	Carpal Tunnel	☐	Brain	☐	Knee
☐	Join Replacement	☐	Thoracic Spine	☐	Shoulder	☐	Hernia
☐	Gastro-intestinal	☐	Cervical Spine	☐	Uro-genital	☐	Prostate
☐	Cardiovascular procedure	☐	Lumbar Spine	☐	Gall Bladder	☐	Hysterectomy
☐	Breast		Other:				

Allergies

☐	Mold	☐	Seasonal	☐	Milk or Lactose	☐	Animal
☐	Chemicals	☐	Sulfites	☐	Wheat/Gluten		

Other: _____

Social History

Caffeine Use	☐	occasional	☐	Often	☐	Never	
Drink Alcohol	☐	occasional	☐	Often	☐	Never	
Exercise	☐	occasional	☐	Often	☐	Never	
Drink Water							
Cigarettes							
Hours of Sleep							

Family History (witch family member)

Arthritis	_____	Heart Disease	_____
Cancer	_____	Hypertension	_____
Diabetes	_____	Stroke	_____
Thyroid	_____	Other	_____

Occupational Activities (witch one describes your job description)

☐	Administration	☐	Executive/Legal	☐	Housekeeper		
☐	Business Owner	☐	Health Care	☐	Construction		
☐	Computer User	☐	Home Services	☐	Manufacturing		
☐	Secretary/Clerical	☐	Daycare/Childcare	☐	Manual Labor		Light/Medium/Heavy

Other: _____

General

- [ ] Recent Weight Change
- [ ] Fever
- [ ] Fatigue

Musculoskeletal

- [ ] Low Back Pain
- [ ] Mid Back Pain
- [ ] Neck Pain
- [ ] Painful Joints
- [ ] Stiff/Swollen Joints
- [ ] Sore/Weak Muscles or Joints
- [ ] Muscle Spasms/Cramps
- [ ] Broken Bones
- [ ] Arm Problems
- [ ] Leg Problems
- [ ] Other:

Neurological

- [ ] Numbness or tingling sensation
- [ ] Dizziness or light Headed
- [ ] Frequent/ Recurrent Headaches
- [ ] Convulsions or Seizures
- [ ] Tremors
- [ ] Strokes
- [ ] Have you ever had a Head Injury?

- [ ] Ever been in an auto accident?

Mind/Stress

- [ ] Nervousness
- [ ] Depression
- [ ] Sleep Problems
- [ ] Memory loss or confusion
- [ ] Other:

Genitourinary

- [ ] Sexual Difficulty
- [ ] Kidney Stones
- [ ] Gallbladder Stones
- [ ] Burning/painful Urination
- [ ] Change in force/strain urination
- [ ] Frequent Urination
- [ ] Blood in Urine
- [ ] Bed Wetting/Incontinence
- [ ] Other

Gastrointestinal:

- [ ] Loss of Appetite
- [ ] Blood in Stool
- [ ] Change in Bowel Movements
- [ ] Painful Bowels Movements
- [ ] Nausea or Vomiting
- [ ] Abdominal Pain
- [ ] Frequent Diarrhea
- [ ] Constipation
- [ ] Other:

CardioVascular & Heart

- [ ] Chest Pain
- [ ] Rapid or Heartbeat changes
- [ ] Blood Pressure Problems
- [ ] Swelling of Hands, Ankles, Feet
- [ ] Hearts Problems
- [ ] Other:

Respiratory

- [ ] Difficult Breathing
- [ ] Persistent Cough
- [ ] Asthma or Wheezing
- [ ] Lung Problems
- [ ] Other:

Eyes & Vision

- [ ] Wear contact/glasses
- [ ] Blurred or double vision
- [ ] Glaucoma
- [ ] Eye disease or injury
- [ ] Other:

Ears, Nose & Thorat

- [ ] Bleeding gums
- [ ] Bad breath/ Taste
- [ ] Mouth sores
- [ ] Dental Problems
- [ ] Swollen throat
- [ ] Swollen glands
- [ ] Ringing in the ears
- [ ] Ear ache/drainage
- [ ] Sinus/Allergy problems
- [ ] Nose bleeds
- [ ] Hearing Loss
- [ ] Other:

Skin and Breast

- [ ] Rash or Itching
- [ ] Change in Skin Color
- [ ] Change in hair or nails
- [ ] Non-healing sores
- [ ] Change appearance Mole
- [ ] Breats Pain
- [ ] Breast Lump
- [ ] Breast Discharge
- [ ] Other:

Endocrine, Hematologic and Lymphatic

☐	Thyroid problems	☐	Heat or Cold intolerance	☐	Swollen Glands
☐	Diabetes	☐	Change in Hat or Glove size	☐	Anemia
☐	Excessive Thirst or Urination	☐	Dry Skin	☐	Easily Bruise or Bleed
☐	Cold Extremities	☐	Glandular or hormone problem	☐	Phlebitis
☐	Other:	☐	Immune System disorder	☐	Transfusion

_____

WOMEN ONLY

Are you Pregnant? yes Due Date: _____

No Last Menstruation Period: _____

☐ Painful or Irregular periods:

☐ Vaginal Discharge ☐ Other: _____

☐ Infertility Pregnancies with Outcomes & Dates: _____

_____

AVARAGE PAIN INTENSITY

Last 24 Hours: No pain 1 2 3 4 5 6 8 9 10 Worst Pain

Past Week: No pain 1 2 3 4 5 6 8 9 10 Worst Pain

Does anything improve your pain? Yes or No If yes, please list

When did your symptoms begin? _____

How did your symptoms begin?

Are your symptoms a result of?: ☐ Motor Vehicle Accident ☐ Work Related

Other:

How Often do you experience your symptoms?

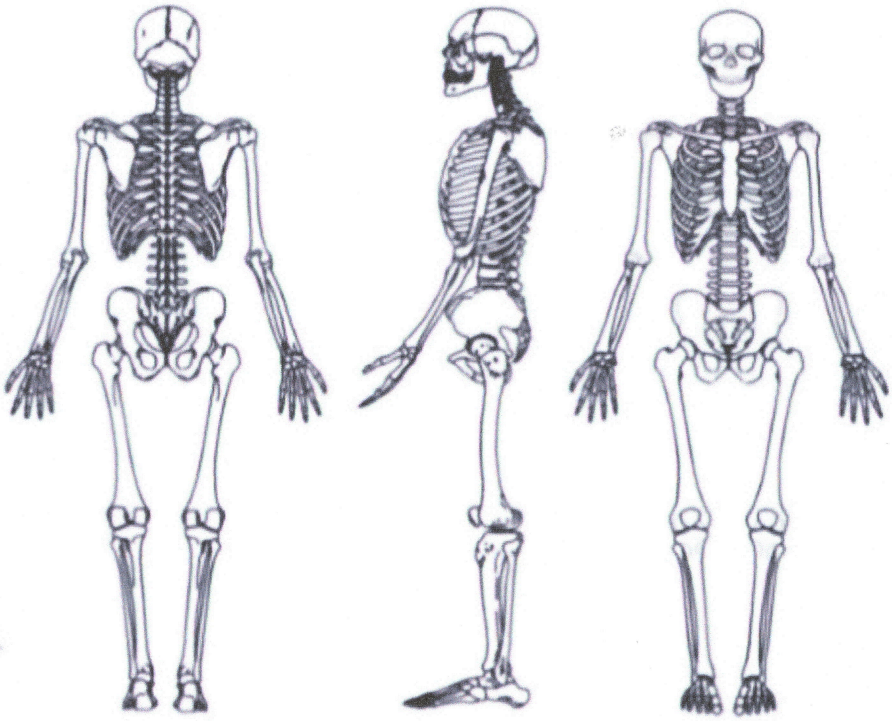
☐ Constantly (76-100% of day) ☐ Frequently (51-75% of day) ☐ Occasionally 50-25% of day

What describes the nature of your symptoms?

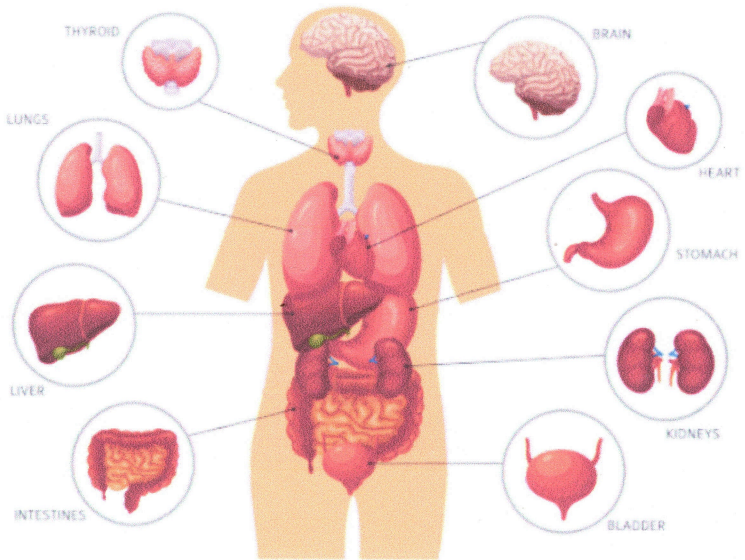
☐	Sharp	☐	Ache	☐	Shooting
☐	Burning	☐	Tingling	☐	Other
☐	Numb	☐	Throbbing		

Please, Indicate on the body diagram where you are experiencing the following symptoms

N= Numbness B= Burning S= Sharp T= Tingling A= Dull Ache



HUMAN ORGANS



INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me _____
(or when the patients named below for whom I am legally responsible for)
_____. by the chiropractic physician and/ or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here, Dr. Ignacio Gavaldon, and/or other licensed physicians of chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Ignacio Gavaldon and or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risk to treatment; included, but not limited to: **fractures, disc injuries, strokes (CVA), dislocations, and sprains.** I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interest at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover th entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patients Name

_____
Signature of Patient

To be completed by the patients representative:

_____
Print Representatives Name

_____
Signature of Representative

Date _____

HIPAA NOTICE

I understand and agree to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know your patient health information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your patient health information. If there is anyone you do not want to receive your medical records please inform our office staff.

_____ _____

Patients signature or Parent if minor Date