NEW PATIENT INTAKE FORM

TODAY'S DATE _____ / _____ / _____

NAME: (LAST) _____ (FIRST) _____

BIRTH DATE: _____ / _____ / _____ AGE: _____ GENDER: _____

HEIGHT: _____ FT. _____ IN. WEIGHT: _____ LBS

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (_____) _____ E-MAIL: _____

REASON FOR SEEKING CHIROPRACTIC CARE

REASON(S) FOR CARE (circle all that apply) : Wellness Care Neck Pain Mid Back Pain

Low Back Pain Shoulder Pain Elbow Pain Wrist Pain Hip Pain Knee Pain

Ankle Pain Headaches Sore / Tight Muscles Weakness Decreased Range of Motion

THE PAIN STARTED _____ DAY(S) / WEEK(S) / MONTH(S) / YEAR(S)

THE PAIN IS GETTING (Circle One) BETTER / WORSE / STAYING THE SAME

QUALITY OF PAIN (I.E. ACHY, NUMB, SHARP) _____

WHAT MAKES IT FEEL BETTER: _____

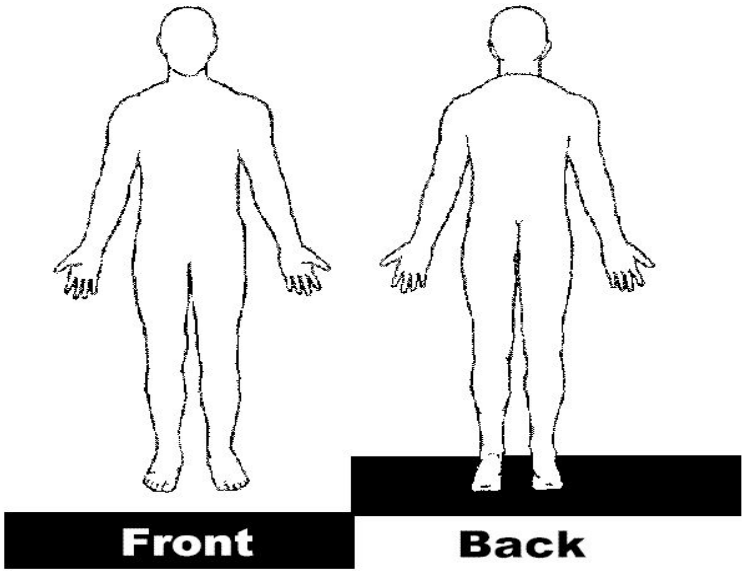
WHAT MAKES IT FEEL WORSE: _____

PAIN SCALE (1 = NO PAIN / 10 = WORST PAIN I HAVE EVER FELT)

1 2 3 4 5 6 7 8 9 10

THE PAIN IS WORSE IN: (I.E. MORNING, EVENING) _____
PAIN OCCURS (circle one): 1-25% / 26 - 50% / 51% -75% / 76%- 100% of the time

CIRCLE AREA(S) OF PAIN ON BODY
INDICATE IF PAIN MOVES TO OTHER AREAS BY DRAWING AN ARROW



PREVIOUS CHIROPRACTIC CARE

PREVIOUS CHIROPRACTOR: _____

SPINAL X-RAYS TAKEN: Y N DATE OF SPINAL X-RAYS _____ / _____ / _____

REASON FOR CARE: _____

OTHER HEALTHCARE PROVIDERS

NAME: _____ TYPE (MD, DO, PT): _____

REASON FOR CARE: _____

RESULTS: _____

REFERRAL INFORMATION

HOW DID YOU DISCOVER POFF CHIROPRACTIC & REHABILITATION?

_____

CURRENT EMPLOYER

NAME: _____ JOB TITLE: _____

ADDRESS: _____

PHONE: (_____) _____

RESPONSIBILITIES: _____

HOBBIES / LEISURE ACTIVITIES

TYPE OF ACTIVITY FREQUENCY

_____

_____

_____

SOCIAL HISTORY

MARITAL STATUS: _____ NUMBER OF CHILDREN: _____

SMOKER: Y N IF YES, HOW MANY PACKS PER DAY: _____

CONSUME ALCOHOL: Y N IF YES, HOW MANY DRINKS PER WEEK: _____

HOURS OF SLEEP PER NIGHT: _____ QUALITY OF SLEEP: GOOD / FAIR / POOR

ABNORMAL WEIGHT CHANGES: Y N IF YES, HOW MANY LBS: _____ ↑ OR ↓

FAMILY HISTORY

DIABETES: Y N FAMILY MEMBER: _____

CANCER: Y N TYPE: _____ FAMILY MEMBER: _____

HEART CONDITIONS: Y N FAMILY MEMBER: _____

ANY OF THESE FAMILY MEMBERS DECEASED: Y N NAME: _____

Initial Exam Form

Date _____ / _____ / _____

Patient Name: _____

What Happened:

Key Value (specific goal):

Surgeries: No Yes _____

Hospitalizations: No Yes _____

Infections / Immunizations: No Yes _____

Recent / Past Traumas (Falls): No Yes _____

Currently taking any Medications: _____

Currently taking any Supplements: _____

Tell Me about your Occupation (Sit @ Desk, On Phone, Stand, Manual Labor)

_____

Anything Else you: _____

Previous Chiropractor? Expectations? Understanding of Chiropractic?

Poff Chiropractic & Rehabilitation LLC
315 E. Broad St
Greenville, SC 29601

INFORMED CONSENT TO CHIROPRACTIC CARE

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 on the patient named below, for whom I am legally responsible: (_____) 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 Poff Chiropractic & Rehabilitation 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. Poff and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment; including, 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 judgment during the course of the procedure which the physician feels are in my best interests 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 the 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 Patient's Name

_____
Signature of Patient

_____/_____/_____
Date

To be completed by patient's representative: (e.g. if the patient is a minor or is physically or mentally incapacitated)

_____
Print Name of Representative

_____
Signature of Representative

_____/_____/_____
Date

Physician Signature _____ Date _____/_____/_____