POFF CHIROPRACTIC

NEW PATIENT INTAKE FORM

Date: _____ / _____ / __________

Name:____ **Birth Date:** ____ / ____ / ______

Age:__________ **Gender:**_______ **Height:**_________ **ft.** ________ **in.** **Weight:**______________ **lbs**

Address:____

City:____________________________ **State:** ______ **Zip:**_________ **Phone:**__________________________

E-mail: ____

Occupation:___________________________________ **Employer:** _____________________________________

Describe your occupation (Sit at desk, on the phone, standing, manual labor, etc.):

____

AREAS OF CONCERN FOR SEEKING CHIROPRACTIC CARE

Chief Complaint: ______________________________ **Second:** _______________________________________

Third:____ **Fourth:**____

Rate your above areas of concern (0 - no pain; 10 - take me to the hospital) by circling the number:

Primary: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 **Second**: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 **Fourth**: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin:____

Problem(s) is worst? □ AM □ PM □ midday **Duration?** □ Constant □ On/Off during day □ On/Off during week

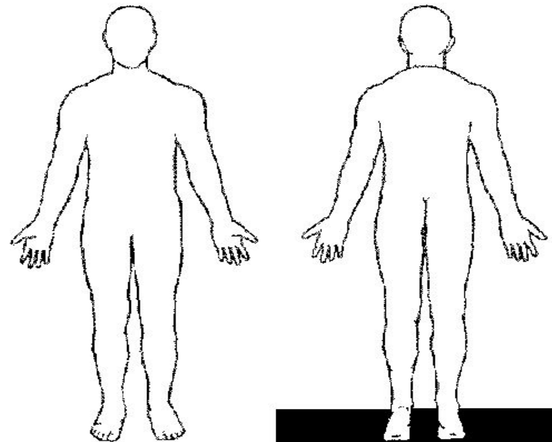
What caused problem(s)?____

Have these problem(s) been treated before? □ No □ Yes **Pain is getting**: □ better □ worse □ staying the same

If yes, when: __________ **by whom:** ____

Have you tried other forms of treatment:
□ Massage Therapy □ Physical Therapy □ Acupuncture
□ Other:____

MARK the areas on the diagram with the following letters to describe your symptoms:
R = Radiating **B** = Burning **D** = Dull **A** = Achy **N** = Numb
S = Sharp/ Stabbing **T**= Tingling



What makes your symptoms worse? ______________________

____

What makes your symptoms better? ______________________

____

MEDICAL HISTORY

Surgeries ☐ No ☐ Yes:____

Hospitalizations ☐ No ☐ Yes:____

Infections / Diseases ☐ No ☐ Yes:____

Recent / Past Traumas ☐ No ☐ Yes:____

Medications ☐ No ☐ Yes:____

Supplements ☐ No ☐ Yes:____

Please indicate if you have been diagnosed with any of the following conditions.

☐ Fractures ☐ Dislocations ☐ Types of Arthritis ☐ Types of Cancer ☐ Diabetes

☐ Tumors ☐ Blood Pressure ☐ Heart Conditions ☐ Other conditions:___________________

If yes, please explain:____

FAMILY HISTORY

1. Has anyone in your family been diagnosed with the following:

☐ Heart Conditions ☐ Diabetes ☐ Tumor ☐ Cancer ☐ Autoimmune Diseases

☐ Other conditions:____

If yes, whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ siblings ☐ children

If yes, please explain:____

SOCIAL HISTORY

1. Marital Status: ________________ **Number of Children: ________________**

2. Smoker: ☐ No ☐ Yes → **Packs per day?** ____________________

3. Alcohol Consumption: ☐ No ☐ Yes → **How often?** ☐ Occasionally ☐ Weekends ☐ Daily

4. Hours of sleep per night: ________________ **Quality of sleep:** ☐ Good ☐ Fair ☐ Poor

5. Abnormal Weight Changes: ☐ No ☐ Yes **If yes:** ↑ or ↓

6. Hobbies / Recreational Activities: ____

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:	**To be completed by patient's representative: (e.g. if the patient is a minor or is physically or mentally incapacitated)**
________________________________	________________________________
Print Patient's Name	**Print Name of Representative**
________________________________	________________________________
Signature of Patient	**Signature of Representative**
_______/________/________________	_______/________/________________
Date	**Date**

Physician Signature ___________________________ **Date** _____/_____/__________