**New Patient Intake Paperwork Walnut Valley Chiropractic Center**

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| **Patient Information** |

Your completed intake paperwork helps our provider get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (620) 221-3630 if you have any questions or are unsure how to complete any section of this form.

Your Name:  Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: Date of Birth: Age:

City/State/Zip: Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_

Gender: ❑ Male ❑ Female

Physical Address Same as Mailing? ❑ Yes ❑ No If not: \_\_\_

Preferred Phone: ❑ Home ❑ Mobile ❑ Work

Secondary Phone: ❑ Home ❑ Mobile ❑ Work

Email:

Preferred Contact Method for appointment confirmation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: Phone: Relationship:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other

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| **Referral** |

How were you referred to our clinic? ❑ Another Physician ❑ Internet ❑ Insurance Company ❑ Family ❑ Friend ❑ Facebook ❑ Other

Referring Physician: Primary Care Physician:

Phone: City: Phone: City:

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| **Onset and Mechanism of Injury** |

Approximately when did this pain begin?

Briefly describe what caused your current pain complaints?

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

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| **Physical Activity / Goals** |

Do you Exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Type of Exercise? ❑ Weightlifting ❑ Cardio ❑ Running ❑ Crossfit ❑ At Home Fitness

If no, what is preventing you from exercising? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your goals while seeking care at Walnut Valley Chiropractic Center? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Pain Location** |

 What number on the pain scale (0-10) best describes your pain **right now**?

Use this pain scale to rate your pain for the questions below:

0 – Pain-free

1 – Very minor annoyance, occasional minor twinges

2 – Minor annoyance, occasional strong twinges

3 – Annoying enough to be distracting

4 – Can be ignored if you are really involved in your work/task, but still distracting

5 – Cannot be ignored for more than 30 minutes

6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities

7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort

8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.

9 – Unable to speak, crying out or moaning uncontrollably, near delirium

10 – Unconscious, pain makes you pass out

What number on the pain scale (0-10) best describes your **worst pain**?

What number on the pain scale (0-10) best describes your **least pain**?

What number on the pain scale (0-10) best describes your **average pain over the last month**?

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

**“N”** = numbness

**“S”** = stabbing

**“B”** = burning

**“P”** = pins and needles

**“A”** = aching

**“T”** = tingling

**“X”** = spasm

**“R”** = radiating

Where is your worst area of pain located?

Does this pain radiate? If so, where?

Please list any additional areas of pain:

What makes your pain worse? ❑ Sitting ❑ Standing ❑ Walking ❑ Lying down ❑ Work ❑ other\_\_\_\_\_\_\_\_\_\_

What makes your pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Pain Interference** |

Check all of the following activities that your pain interferes with:

❑ **Nothing** ❑ Driving ❑ Intercourse ❑ Leisure Activities

❑ Personal Grooming ❑ Relationships ❑ Sleep

❑ Walking ❑ Work duties ❑ Other:

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| **Prior Pain Treatments** |

Mark all of the following treatments you have had prior to today’s visit for your current pain complaints:

❑ Acupuncture ❑ Chiropractic ❑ Pain Medications ❑ Physical Therapy ❑ Psychological Therapy

❑ Epidural Steroid Injection(s) ❑ Trigger Point Injections ❑ Joint Injection(s) ❑ Nerve Blocks

❑ Radiofrequency Ablation ❑ Spinal Cord Stimulator – (circle one) Trial Only / Permanent Implant

❑ Vertebroplasty / Kyphoplasty – Level(s)

❑ Spine Surgery – What type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When? \_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Other:

❑ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.

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❑ MRI of the Date: Facility:

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| **Diagnostic Tests and Imaging** |

❑ X-ray of the Date: Facility:

❑ CT scan of the Date: Facility:

❑ EMG/NCV study of the Date: Facility:

❑ Other diagnostic testing:

❑ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

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| **Past Medical History** |

Mark the following conditions/diseases that you are being or have been treated for:

❑ Anemia ❑ Anxiety ❑ Arthritis ❑ Asthma

❑ Back Problem ❑ BPH ❑ Breast CA ❑ CAD

❑ Cancer ❑ CHF ❑ High Cholesterol ❑ COPD

❑ Dementia ❑ Depression ❑ Diabetes❑ Epilepsy ❑ GERD

❑ Glaucoma ❑ Gout❑ Headache ❑ Hepatitis ❑ HIV

❑ Hypertension ❑ MI ❑ Migraine ❑ Pneumonia

❑ Kidney Stones ❑ Stroke ❑ TB ❑ Thyroid Disease

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| **Past Surgical History** |

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

**Surgery: (include date, and type of surgery):**

**Pertinent Details:**

❑ I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE

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| **Review of Systems** |

**PLEASE CIRCLE THE SYMPTOMS THAT APPLY TO YOU:**

**Constitutional:** No Problems, Lack of energy, Unexplained weight gain or weight loss, Loss of appetite, Fever,

Night sweats

**Head, Ears, Eyes, Nose, Throat:** No Problems, Difficulty hearing, Ringing in ears, Bleeding gums, Blurred

vision, Difficulty swallowing

**Cardiovascular:** No Problems, Irregular heartbeat, Racing heart, Chest pains, Swelling of feet or legs

**Respiratory:** No Problems, Shortness of breath, Cough, Wheezing, Sputum production, Prior tuberculosis

**GI:** No Problems, Heartburn, Diarrhea, Abdominal pain, Difficulty swallowing, Nausea, Vomiting, Blood in stool, Unexplained change in bowel habits, Incontinence

**Genitourinary:** No Problems, Painful urination, Frequent urination, Urinary urgency, Prostate problems

**Musculoskeletal**: No Problems Joint pain, Muscle aches

**Skin**: No Problems, Persistent rash, Itching, New/worsening lesion

**Neurologic**: No Problems, Headaches, Weakness, Numbness, Tingling, Difficulty with walking or balance, Dizziness, Tremor, Loss of consciousness

**Endocrinologic:** No Problems, Cold/heat intolerance, Sweating, Flushing

**Hematologic**: No Problems, Easy bleeding, Easy bruising, Anemia, Swollen glands

**Psychiatric:** No Problems, Depressed mood, Feeling anxious, Stress problems, Suicidal thoughts, Suicidal planning, Thoughts of violence

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| **Attestation and Consent for Treatment** |

I certify that the information I have supplied is accurate, complete and true.

I authorize Walnut Valley Chiropractic Center and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Walnut Valley Chiropractic Center to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Walnut Valley Chiropractic Center’s Notice of Privacy Practices, which is displayed for public inspection. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize Walnut Valley Chiropractic Center to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to.

I understand that Walnut Valley Chiropractic Center will not release my Protected Health Information to any other party (including family) without my completing a written “Patient Authorization for Use and Disclosure of Protected Health Information” form, available at its facility.

Printed Name: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

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| **No-Show Policy** |

I hereby acknowledge that I fully understand Walnut Valley Chiropractic Center has a $25 fee for not showing up for a scheduled visit without 24 hours prior notice. If there is an emergency, please call our clinic at your earliest convenience and the fee may be dropped depending on the circumstances.

Printed Name: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

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| **My Authorization** |

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment.

Printed Name: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

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| **Financial Responsibility** |

I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan. If I do not have insurance, I understand that I am personally financially responsible for all services rendered.

Printed Name: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

**INFORMED CONSENT**

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physiotherapy, exercises, nutritional supplementation, or acupuncture may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

**TREATMENT RESULTS**

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty I will achieve these benefits.

I realize that the practice of medicine, along with chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

**ALTERNATIVE TREATMENTS AVAILABLE**

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

To attest to my consent to these procedures, I hereby affix my signature to the authorization for treatment.

Signature of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent

or Guardian (if a minor)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_