Vaughn Chiropractic New Patient Intake Paperwork

1 Patient Information

Legal Name: (last) _____ (First) _____ (middle Initial) _____

Email: _____ Primary Phone: _____ □ Home □ Cell

Address: _____ City: _____

State: _____ Zip: _____ Sex □ M □ F Age: _____ Birth Date: _____

□ Married □ Single □ Partnered □ Widowed

Occupation: _____ Patient Employer/School: _____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

Whom may we thank for referring you? _____

2 Medications / Vitamins/Supplements / Allergies

Medications	Vitamins/Supplements	Allergies
1) _____	1) _____	1) _____
2) _____	2) _____	2) _____
3) _____	3) _____	3) _____
4) _____	4) _____	4) _____
□ None	□ Daily □ Weekly □ Occasionally	How often do they occur?
	□ None	_____
		□ None

3 Family History

Autoimmune Dis.	□ Yes □ No	Diabetes	□ Yes □ No	Migraines	□ Yes □ No	□ Other_____
Bleeding Disorder	□ Yes □ No	Heart Disease	□ Yes □ No	Osteoporosis	□ Yes □ No	
Clotting Disorder	□ Yes □ No	High Blood Pres	□ Yes □ No	Stroke	□ Yes □ No	
Cancer	□ Yes □ No	Kidney Disease	□ Yes □ No	Thyroid Disease	□ Yes □ No	

4 Medical History

Date of last (if known): Physical Exam_____ Spinal X-ray _____ Spinal exam _____ Chest X-ray _____
MRI, CT-Scan, Bone Scan _____ Blood Test _____ Urine Test_____

Mark "Yes" or "No" to indicate whether you have experienced each of the following and complete information below:

AIDS/HIV	□ Yes □ No	Chemical Depend./ Alcoholism	□ Yes □ No	Hernia	□ Yes □ No	**Pinched Nerve**	□ Yes □ No
Allergies	□ Yes □ No			**Herniated Disk**	□ Yes □ No	Pneumonia	□ Yes □ No
Anemia	□ Yes □ No	Chicken Pox	□ Yes □ No	Hypertension	□ Yes □ No	Prostate Problem	□ Yes □ No
Anxiety/Depres.	□ Yes □ No	**Clotting Diso**	□ Yes □ No	Kidney Disease	□ Yes □ No	Psychiatric Care	□ Yes □ No
Appendicitis	□ Yes □ No	Diabetes	□ Yes □ No	Liver Disease	□ Yes □ No	Rheum. Arthritis	□ Yes □ No
Arthritis	□ Yes □ No	Eating Diso	□ Yes □ No	Migraines	□ Yes □ No	STD	□ Yes □ No
Asthma	□ Yes □ No	Emphysema	□ Yes □ No	Mononucleosis	□ Yes □ No	Stroke	□ Yes □ No
Autoimmune Dis	□ Yes □ No	**Epilepsy/Seizure**	□Yes□ No	**MS**	□ Yes □ No	Thyroid Disease	□ Yes □ No
Bleeding Dis	□ Yes □ No	Headaches	□ Yes □ No	Osteoporosis	□ Yes □ No	Tuberculosis	□ Yes □ No
Bronchitis	□ Yes □ No	Heart Dis	□ Yes □ No	Pacemaker	□ Yes □ No	Tumors/growths	□ Yes □ No
Cancer	□ Yes □ No	Hepatitis	□ Yes □ No	Parkinson's	□ Yes □ No	Ulcers	□ Yes □ No

Are you pregnant? □ Yes □ No If yes, how many weeks? _____ □ Other _____

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5 Motor Vehicle Accident

Please indicate any motor vehicle accidents below, making sure to note any minor accidents or those that have taken place 5+ years ago.

Date of accident (MO-YR): _____-_____

Impact: □ Front □ Rear □ Side/Passenger □ Side/Driver
□ Seat Belt □ Airbag(s)

Speed at which your car was travelling: _____

Speed at which the second car struck your car: _____

Medical Care Description:

_____

_____

Chiropractic Care Description:

_____

_____

6 Physical & Trauma Information

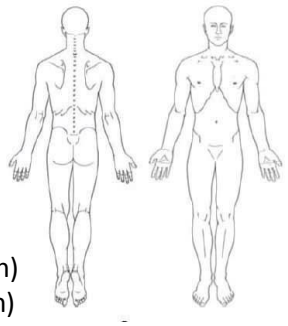
Please indicate any physical and/or trauma occurrences below, making sure to note any minor injuries as well by checking "Yes". Please describe when applicable.

Work Activities: □ Sitting □ Standing □ Light Labor □ Heavy Labor □ Retired _____
Work Injuries: □ Yes □ No If yes: _____
Sport Activities: _____
Sport Injuries: □ Yes □ No If yes: _____
Exercise: □ None □ Light □ Moderate □ Heavy _____
Falls: □ Yes □ No If yes: _____
Head Injuries: □ Yes □ No If yes: _____
Dislocations: □ Yes □ No If yes: _____
Broken Bones: □ Yes □ No If yes: _____
Surgeries: □ Yes □ No If yes: _____

7 Primary Complaint

Please note **ONE** complaint in the following section. The Primary Complaint is your chief complaint or most problematic concern at this time that brought you in today.

Primary complaint: _____
Please describe the condition: _____
When did your symptoms first appear? _____
Most recent occurrence date: _____
What do you think caused this problem: _____
Is this condition getting progressively worse? □ Yes □ No □ Unknown
Mark an X on the picture where you have pain, numbness or tingling:



Rate the severity of your pain …at its worst: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
…at its least severe (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
(please circle) …at present moment (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

Does the pain travel from one location to another? From where to where? _____
How often do you have this pain? □ Constantly □ Comes and goes □Infrequently □ Daily □ Weekly □ Monthly
Do activities make it worse in the AM or PM? □ AM □ PM □ N/A
Which activities are affected by this? □ Work □ Sleep □ Daily Routine □ Recreation □ N/A □ Other
□ Sitting □Standing □Walking □ Bending □ Lying Down
Past Treatments: □ Medications □Surgery □ Physical Therapy □ Chiropractic Services □ None □ Other _____
Were they successful? □ Yes □ No
Pain worsens with: _____ Pain improves with: _____
Notes: _____

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8 Additional Complaint 1

Please note **ONE** complaint in the following section. The Additional Complaint 1 is any other problem/complaint you may be experiencing that you would like the office to be made aware.

Additional complaint: _____
Please describe the condition: _____
How often does it occur? _____
Do activities make it worse in the AM or PM? □ AM □ PM □ N/A
Which activities are affected by this? □ Work □ Sleep □ Daily Routine □ Recreation □ N/A □ Other
□ Sitting □Standing □Walking □ Bending □ Lying Down
Past Treatments: □ Medications □Surgery □ Physical Therapy □ Chiropractic Services □ None □ Other _____
Were they successful? □ Yes □ No
Pain worsens with: _____ Pain improves with: _____
Notes: _____

9 Terms of Acceptance/Consent to Treat

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method what will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others, OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child.

I, _____, being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

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FOR OFFICE USE ONLY

Clinical Comments:

Examiner's Name: _____ Examiner's Signature: _____ Date: _____

Physician Name : _____ Physician Signature: _____ Date: _____