**ADULT INTAKE**

**OFFICE USE ONLY  
ID#: \_\_\_\_\_\_\_\_\_**

***\*Please fill out the following information completely and to the best of your ability. Initial the bottom of page\****

Who may we thank for referring you / how did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you served in the military / are you a first responder? ❏ No ❏ Yes

Have you received chiropractic care in the past? ❏No ❏Yes If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL INFORMATION**

FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PREFERRED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ AGE: \_\_\_\_ HEIGHT: \_\_\_\_\_\_\_\_ WEIGHT:\_\_\_\_\_\_\_lbs GENDER: ❏M ❏F SSN: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS: ❏ S ❏ M ❏ D ❏ W

STREET ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT/UNIT: \_\_\_\_\_\_\_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION & JOB DUTIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have Medicare? ❏YES ❏NO

SPOUSE’s NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME(s) and AGE(s) OF CHILDREN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF LAST VISIT: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ REASON: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE NOTE ANY SIGNIFICANT FAMILY MEDICAL HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT | name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT HEALTH CONDITION**

**MAIN SYMPTOM/PAIN/COMPLAINT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any bowel or bladder problems since this problem began? ❏No ❏Yes

**DIRECTIONS:** Fill in your primary problem/concern. Please put an **X** next to the number that best describes the question being asked.

What is your pain RIGHT NOW?

no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst possible pain

What is your TYPICAL or AVERAGE pain?

no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst possible pain

What is your pain AT ITS BEST (How close to “0” is your pain at its best)?

no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst possible pain

What is your pain level AT ITS WORST (How close to “10” is your pain at its worst)?

no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst possible pain

Quadruple Visual Analog Scale (QVAS) Examiner Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

**PLEASE IDENTIFY** **ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **HOW LONG AGO** | **EXPLAIN** | **TYPE OF CARE** | **PROVIDED BY WHOM** |
| **INJURIES** |  |  |  |  |
| **SURGERIES** |  |  |  |  |
| **CHILDHOOD DISEASES** |  |  |  |  |
| **ADULT DISEASES** |  |  |  |  |
| **GENETIC DISORDER / DISABILITY** | ------ |  |  |  |

**INITIAL \_\_\_\_\_\_**

**PAST HISTORY**

If you have ever been diagnosed with any of the following conditions, please indicate with: **P** = Past **C** = Currently have **N** = Never have had

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer \_\_\_ Night Sweats

\_\_\_ Stroke \_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other serious conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACTIVITIES OF LIFE**

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

**ACTIVITIES: EFFECT:**

Carry Children/Groceries ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Sit to Stand ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Climb Stairs ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Pet Care ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Extended Computer Use ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Lift Children/Groceries ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Read/Concentrate ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Getting Dressed ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Shaving ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Sexual Activities ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Sleep ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Static Sitting ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Static Standing ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Yard work ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Walking ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Washing/Bathing⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Sweeping/Vacuuming ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Dishes ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Laundry ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Garbage ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Driving ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⭘ No Effect ⭘ Painful (can do) ⭘ Painful (limits) ⭘ Unable to Perform

**REVIEW OF SYSTEMS** **Please mark: P = in the Past C = Currently have N = Never**

\_\_\_ Headache \_\_\_ Pregnant (Now) \_\_\_ Dizziness \_\_\_ Prostate Problems \_\_\_ Ulcers

\_\_\_ Neck Pain \_\_\_ Frequent Colds/Flu \_\_\_ Loss of Balance \_\_\_ Impotence/Sexual Dysfun. \_\_\_ Heartburn

\_\_\_ Jaw Pain, TMJ \_\_\_ Convulsions/Epilepsy \_\_\_ Fainting \_\_\_ Digestive Problems \_\_\_ Heart Problem

\_\_\_ Shoulder Pain \_\_\_ Tremors \_\_\_ Double Vision \_\_\_ Colon Trouble \_\_\_ High Blood Pressure

\_\_\_ Upper Back Pain \_\_\_ Chest Pain \_\_\_ Blurred Vision \_\_\_ Diarrhea/Constipation \_\_\_ Low Blood Pressure

\_\_\_ Mid Back Pain \_\_\_ Pain w/Cough/Sneeze \_\_\_ Ringing in Ears \_\_\_ Menopausal Problems \_\_\_ Asthma

\_\_\_ Low Back Pain \_\_\_ Foot or Knee Problems \_\_\_ Hearing Loss \_\_\_ Menstrual Problem \_\_\_ Difficulty Breathing

\_\_\_ Hip Pain \_\_\_ Sinus/Drainage Problem \_\_\_ Depression \_\_\_ PMS \_\_\_ Lung Problems

\_\_\_ Back Curvature \_\_\_ Swollen/Painful Joints \_\_\_ Irritable \_\_\_ Bed Wetting \_\_\_ Kidney Trouble

\_\_\_ Scoliosis \_\_\_ Skin Problems \_\_\_ Mood Changes \_\_\_ Learning Disability \_\_\_ Gall Bladder Trouble

\_\_\_ Numb/Tingling arms, hands, fingers \_\_\_ ADD/ADHD \_\_\_ Eating Disorder \_\_\_ Liver Trouble

\_\_\_ Numb/Tingling legs, feet, toes \_\_\_ Allergies \_\_\_ Trouble Sleeping \_\_\_ Hepatitis (A,B,C)

**MEDICATIONS (PRESCRIBED and OVER-THE-COUNTER / VITAMINS / SUPPLEMENTS**

|  |  |
| --- | --- |
| **NAME** | **REASON FOR TAKING** |
|  |  |
|  |  |
|  |  |

**INITIAL \_\_\_\_\_\_**

**TERMS OF ACCEPTANCE**

Please read the below and if you have any questions, feel free to ask one of our staff members.

**HARMONY FAMILY CHIROPRACTIC NOTICE OF PRIVACY POLICY**

I have received a copy of Harmony Family Chiropractic Patient Privacy Notice. I understand my rights as well as the practice’s duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this “Notice of Privacy Practice” at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this “Notice” is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

**Print Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Completed** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_

**AUTHORIZATION FOR X-RAY**

X-rays are utilized in the office to help locate and analyze vertebral subluxations. These x-rays are not to be used to investigate for medical pathology. The doctors of Harmony Family Chiropractic do not diagnose or treat medical conditions; however if any abnormalities are found, they will be brought to your attention so that you can seek proper medical advice. By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

At your request, we will provide you with a copy of your x-rays in our file. The fee for copying your x-rays on a disc is **$15.00**. This fee must be paid in advance. Digital x-rays on CD will be available within **72 hours** of prepayment on any regular practice hours day. Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations.

In the event that there are findings considered to be abnormal, your films will be sent to a board certified chiropractic radiologist. If it is necessary to submit your films you will be responsible for the charges. The charge will be no greater than $25.00. You will be notified of abnormal findings prior to your films being sent.

***(Females Only)*** Please check the box that applies to you - To the best of my knowledge:

❏ I AM NOT pregnant at this time   
 ❏ The first day of my last menstrual cycle was on \_\_\_\_-\_\_\_\_-\_\_\_\_ (Date)

❏ I AM/believe I MAY BE pregnant, therefore I DO NOT authorize Harmony Family Chiropractic to X-ray me at this time.

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Completed** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I authorize Harmony Family Chiropractic to release all necessary information concerning my health condition to my billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize Harmony Family Chiropractic to release any information regarding my health condition to other health care providers involved in my care. In addition, I authorize Harmony Family Chiropractic to disclose all necessary information to individuals I permit to accompany me during my visits. It is my responsibility to not allow individuals to accompany me in the event I do not want information disclosed to them. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Harmony Family Chiropractic to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Completed** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_

**PHOTO AND SOCIAL MEDIA CONSENT**

We love to have pictures in our office! If you would allow us to have your picture in the office, please sign below.

For valuable consideration, I herby irrevocably consent to and authorize the use and reproduction by Harmony Family Chiropractic, or anyone authorized by Harmony Family Chiropractic, of any and all photographs/videos which were taken of my child, for the purpose of promotional TV, website, social media and/or print as whatsoever, without further compensation to me. All negative and positives, together with the prints shall constitute the property of Harmony Family Chiropractic, solely and completely. Any information voluntarily provided by a patient, including first name, shall also be used in conjunction with the above listed information for the purposes previously mentioned. Confidentially, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Harmony Family Chiropractic, to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws). Do not sign if you would like for photos not to be taken. Thank you!

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Completed** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_

**INFORMED CONSENT**

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed so that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where on or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary foal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic, and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and/ or laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility, and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware for the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I have read the above paragraphs. I understand the information provided. all questions I have about this information have been answered to my satisfaction. Having this knowledge, I knowingly authorize Harmony Family Chiropractic to proceed with chiropractic care.

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Completed** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_ **DOCTORS SIGNATURE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parental Consent for Minor Patient:**

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

Name of person legally authorized to sign for patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian or Authorized Person’s Signature**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Completed** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care. ONLY AUTHORIZED FOR THOSE 16 YEARS OF AGE OR OLDER.

**Guardian or Authorized Person’s Signature**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Completed** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_