Ashforth Chiropractic New Patient Intake Form

Patient Name **Date** ____

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _______

First Name ___________________ **Middle Initial** ____ **Last Name** __________________________

Address ____

City _______________________________ **State** ___________________ **Zip Code** ______________

Home Phone (_____) ________-__________ **Work Phone (_____) _________-____________**

Cell Phone (_____) ________-___________ **Email** ___________________________________

Date of Birth ______/______/_______ **Sex:** Male Female

Marital Status: Single Married Other

How did you hear about our office? ____

Spouse Data ____

First Name ___________________ **Middle Initial** _____ **Last Name** _________________________

Home Phone (_____) _______-__________ **Work Phone (_____) _________-____________**

Emergency Contact____

Contact Name ____________________________ **Relationship to Patient** ___________________

Contact Home Phone (_____) _______-________ **Cell Phone (_____) ________-______________**

Doctor's Signature ____

Patient Name____**Date**___________________

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other ______________			

Medications you are currently taking:

Hypertension/Blood Pressure Cholesterol Blood Thinners Diabetes NSAIDS/Pain Muscle Relaxers
Steroids Sleeping Pills Other(s)____

Surgeries: (Check all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Cosmetic	Other ______________		

Accidents: Single Auto Multiple Auto Slip & Fall Multiple Slip &Fall Boating Motorcycle

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Other ________________			

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling
Other _________________		

Work History:

Full Time	0-20 hours
Part Time	20-40 hours
Home Maker	40+ hours
Retired	
Unemployed	

Doctor's Signature ____

Patient Name____**Date**_________________

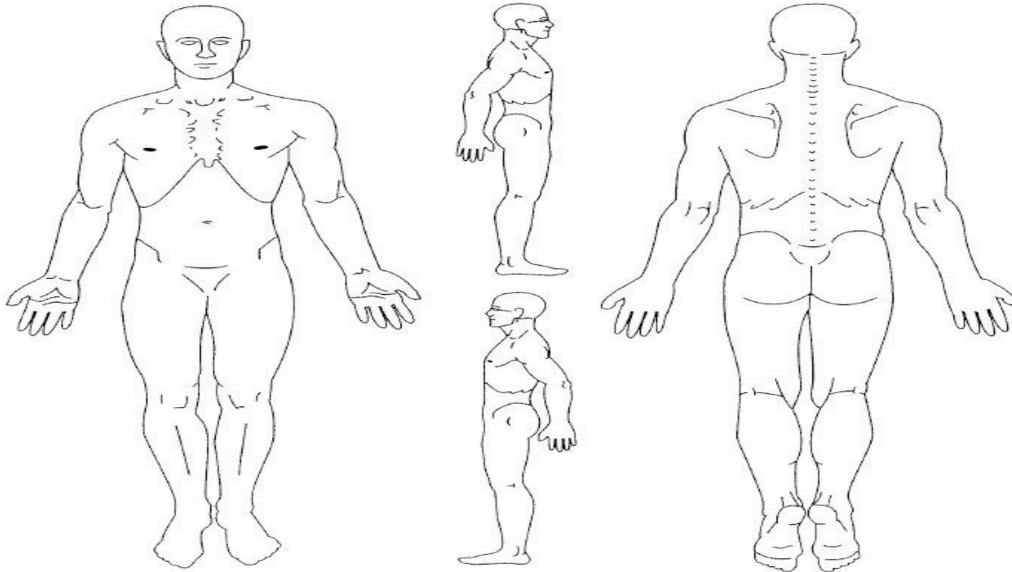
Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No				
	Past	Present			Past	Present					
Poor Circulation				Asthma							
Hypertension				Tuberculosis							
Aortic Aneurism				Short Breath							
Heart Disease				Emphysema							
Heart Attack				Cold/Flu							
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain									Past	Present	
Irregular Heartbeat				**Endocrine**	Past	Present	No	Difficulty Swallowing			
Swelling of legs				Thyroid				Dizziness			
				Diabetes				Hearing Loss			
Genitourinary			No	Hair Loss				Sore Throat			
	Past	Present		Menopausal				Nosebleeds			
Kidney Disease				Menstrual				Bleeding Gums			
Burning Urination								Sinus Infections			
Frequent Urination				**Hematologic**	Past	Present	No				
Blood in Urine				Hepatitis				**Gastrointestinal**			No
Kidney Stones				Blood Clots					Past	Present	
Lower Side Pain				Cancer				Gall Bladder Problems			
				Bruising				Bowel Problems			
Neurologic			No	Bleeding				Constipation			
	Past	Present		Fever, Chills				Liver Problems			
Stroke				Sweating				Ulcers			
Seizures				Hives				Diarrhea			
Head Injury				Allergy Shots				Nausea/Vomiting			
Brain Aneurysm				Skin				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches											
Pinched Nerves				**Musculoskeletal**	Past	Present	No				
Parkinson's				Gout							
Carpal Tunnel				Arthritis							
Vertigo				Joint Stiffness							
				Muscle Weakness							
				Osteoporosis							
				Broken Bones							
				Joints Replaced							

Doctor's Signature ____

Patient Name____**Date**__________________________

Indicate on the body diagram where you are experiencing symptoms:



What describes the nature of your symptoms?(check all that apply)

Sharp	Dull ache	Numb	Shooting
Burning	Tingling	Stabbing	Other _____

On a 1-10 scale (1-least-10 severe) how would you rate your discomfort:

1 2 3 4 5 6 7 8 9 10

When did your symptoms begin? Month_____________ **Day**___________**Year** ______________

Was the onset: Sudden Gradual Traumatic Unknown

What aggravates your symptoms: Any Movement Climbing Stairs Sitting Standing
Turning Twisting Bending None Other________________________

What makes your symptoms better: Ice Heat Rest Medication Other______________

Have you had previous episodes of the same condition? Yes No

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How are your symptoms changing?
Getting better Not changing Getting worse

How often do you experience your symptoms?

Constantly (76-100% of the day)	Frequently (51-75% of the day)	Occasionally (26-50% of the day)	Intermittently (0-25% of the day)

Doctor's Signature ____

Patient Name ______________________________ **Date** ______________

Employment, ADL, and Recreation Information

Condition's Effect On Job Performance*:* **No Effect** **Mild** (painful can do) **Mod** (painful limited ability) **Mod/Severe** (limited duty) **Severe** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Care –Infirm Family:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Carrying Groceries:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Change Posn–Sit-Stand:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Climb Stairs:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Driving:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Extended Computer Use:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Feeding:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Household Chores:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Kneeling:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Lift Children:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Lifting:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Pet Care:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Reading (Concentration):	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Self Care–Bathing:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Self Care–Dressing:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Self Care–Shaving:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Sexual Activities:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Sleep:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Static Sitting:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Static Standing:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Walking:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Yard Work:	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (Limited)	**Sev** Unable to Perform
Exercise	No Effect	Mild **Painful (Can do)**	Mod **Painful (limited)**	Sev **Unable to Perform**
__________________	**No Effect**	**Mild** Painful (Can do)	**Mod** Painful (limited)	**Sev** Unable to Perform

Social History

Your preferred sleeping position: _____ on my back ____ on my side ____ on my stomach
Dietary supplements you currently take: _____ Fish oil ____ Vitamin D ____ Probiotic
____ Magnesium ____ Greens Drink ____ Multi-Vitamin _____ other___________________

What are your short and long term goals regarding your health?

____

Doctor's Signature ____

INFORMED CONSENT FORM

PATIENT NAME: ____________________________ DATE: __________________

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *Dr.Ashforth* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: ______________

______________________________	______________________________
Patient name	**Signature**

Electronic Health Records Intake Form

In compliance with requirements for the government EHR program

First Name:_________________________ **Last Name**:_________________________
Email address: _________________@_________________
Preferred method of communication for patient reminders (Circle one): Email / Phone / Text Message

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** __________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer
Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____Date:________________