Healing Hands Community Chiropractic

Patient Intake Form

We offer a unique service to individuals and families. We are happy you have chosen to use our services. We will make every effort to make your experience supportive, informative and healing.

Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Marital Status S M W D

Best Phone Number _____ Email Address _____

Partner's Name _____ Ages of Children _____

Previous chiropractic care (please circle one) Y N If Yes, with whom: _____

For How Long _____ Date of Last Visit _____

Why did you stop care? _____

How did you learn about our office? _____

Signature _____ Date _____

Our mission is to promote and support the overall health, well-being and highest quality of life of all individuals and families in our community through natural and affordable chiropractic care.

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Confidential Health Entrance Form

In order for us to better understand your current level of health, please CIRCLE any of the body signals which you are CURRENTLY experiencing:

Allergies Anxiety Arthritis Asthma Back Pain Body Image Breech Baby	Constipation Depression Dizziness/Vertigo Ear Infections Frequent Cold/ Flu Headaches/Migraine Heartburn/Reflux	Hernia Hip Pain/ Leg Pain Infertility IBS Menstrual/ Menopausal Neck Pain Numbness and Tingling	Poor Posture Sciatica Sinus Problems Stress Relief TMJ Problems Pregnancy Other_____

Please CIRCLE the following conditions that you have or have had:

Autoimmune Disease Cancer _____ Diabetes Epilepsy/Seizures	Heart Disease High Cholesterol HIV Hypertension Hyper/Hypothyroidism	Kidney Disease Lung Disease Lyme Disease Multiple Sclerosis	Scoliosis Stroke Ulcers Other_____

Please list ALL prescription and OTC medications as well as vitamins/supplements you are currently taking:

Are any of your medications blood thinners? (circle one) **Y N**	

Signature_____Date_____

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Patient Health History

Motor Vehicle

Have you *ever* been in a motor vehicle accident? Y N

If yes, please tell us about the MOST significant motor vehicle accident you were involved in:

Year it occurred	Impact of Collision (circle ONE)	Speed of Collision	Treatment Received
	Front I Rear Side I Rollover		

Is your reason for being here today related to a **current** motor vehicle case? Y N (circle one)

Work

Current occupation (if retired please list previous line of work):_____

Primary work position (please circle the **ONE**): STANDING SITTING LIFTING BENDING

How long is your TOTAL daily commute?_____

Is your reason for being here related to a **current** worker's compensation case? Y N

SPORTS/RECREATIONAL ACTIVITIES

Please list current activities:_____

INJURIES

Please check off which injuries (if any) you have had.

☐ Broken or fractured bone Where/Side_____ When_____

☐ Sprain or tear Where/Side_____ When_____

☐ Concussion or Loss of Consciousness _____ When_____

☐ Surgery Type _____ When_____

Signature:_____ Date:_____

CHIEF COMPLAINT

Primary reason for being here today (please list only ONE AREA):_____

How long have you had this?_____

Is it daily or intermittent?_____

How would you describe your symptom? (Please circle ALL that apply):
DULL ACHE STIFF BURNING NUMBNESS TINGLING STABBING SHOOTING TIGHT PRESSURE OTHER:_____

On a scale of 0-10, how would you best rate your symptom? (With 0 being no pain and 10 being the worst pain) _____

Does your symptom travel anywhere? (Example: into head, down arm or leg, etc.) Y N
If yes, please explain where your symptom radiates to:_____

Has this symptom gotten BETTER WORSE SAME since it began? (please circle ONE)

What time of day is it worse? (please circle ONE) MORNING AFTERNOON EVENING RANDOM

What do you do to make it feel better? (please circle ALL that apply)
HEAT ICE STRETCH OTC MEDS PRESCRIPTION MED. OTHER:_____

ADDITIONAL INFORMATION

Are you or have you been in the military? Y N Branch:_____

Are you a student? Y N If yes, Grade/Year:_____

Are you (please circle ONE): RIGHT handed, LEFT handed or AMBIDEXTROUS?

What's your current stress level? (please circle ONE) MILD MODERATE EXTREME

Who else have you seen your **chief complaint**? (Please circle ALL that apply)

Medical Doctor Naturopath Acupuncturist Homeopath Massage Therapist Psychotherapist

Reiki/ Energy Healer Dentist Physical/Occupational Therapist Other: _____

Signature:_____ Date:_____

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Pregnancy Questionnaire

Are you pregnant? Y N

If yes, please answer the following questions.

If no, please circle N and sign and date at bottom

What is your Estimated Due Date (EDD)?:_____

Who is prenatal care provider?_____

Are you planning a HOSPITAL BIRTH CENTER or HOME BIRTH? (please circle ONE)

Do you have a doula? Y N If yes, please list who your doula is:_____

What type of childbirth class have you taken or plan to take? (circle):
BRADLEY BRIO NATURAL CHILDBIRTH HYPNOBIRTHING OTHER:_____

Have you heard of the Webster Chiropractic Pregnancy Technique? Y N

Are you taking a prenatal vitamin? Y N If yes, which one?_____

Are you taking a prenatal DHA supplement? Y N If yes, which one?_____

Are you taking an iron supplement? Y N If yes, which one?_____

Are you taking a prenatal yoga or prenatal fitness class? Y N If yes, where?_____

Is your baby vertex (head down)? Y N If no, what is your baby's position?_____

Are you expecting twins? Y N

Signature:_____ Date:_____

Notice of Privacy Practices

Privacy Policies of Healing Hands Chiropractic, LLC

I give Healing Hands Chiropractic permission to treat me in an open concept area where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, I may schedule a private consultation with the doctor for these conversations upon my request.

Terms of Acceptance

When a patient seeks chiropractic care, and when a chiropractor accepts a patient for such care it is essential that they both be seeking the same goals. It is not the goal of this office to treat, nor cure physical, mental, or emotional ailments; nor to diagnose or give advice about such ailments.

Our only goal and intention is to keep the body as free from vertebral subluxations as we can. We do this because our absolute conviction is that every human being functions better on all levels when no subluxations are present.

I _____undertake chiropractic care at Healing Hands Chiropractic on the understanding of and agreement with the above explanation.

Release of Information

I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner(s) named above to other health care professionals to whom I am referred for treatments.

Patient Signature _____Date _____

If patient required assistance to complete information forms, please sign below and state your relationship to the patient.

Signature_____ Date_____ Relationship_____