

**New Patient Intake Form**



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Phone: 701-364-9355 Fax: 701-364-4032

**About You**

First Name: \_\_\_\_\_  
Last Name: \_\_\_\_\_  
Nickname: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Sex: ( ) Male ( ) Female  
( ) Single ( ) Married ( ) Divorced ( ) Widowed  
( ) Separated  
Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
(C) \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
E-Mail: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_  
In case of an emergency please contact:  
Name: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Occupation: \_\_\_\_\_  
Names and Ages of Children:  
\_\_\_\_\_  
\_\_\_\_\_  
Insurance: ( ) Work Comp ( ) Auto ( ) MA  
( ) Medicare ( ) Private: \_\_\_\_\_  
Who may we thank for referring you to our  
office? \_\_\_\_\_  
( ) Yellow pages ( ) Lecture  
( ) Drive by ( ) Coupon  
( ) Screening Where?: \_\_\_\_\_  
( ) Mailing Which one?: \_\_\_\_\_  
( ) Website ( ) Other \_\_\_\_\_

**Your Health Profile**

**Why This Form Is Important**

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your present and future health.

What are your health goals? \_\_\_\_\_  
\_\_\_\_\_

Is your current condition the result of: ( ) an auto accident? ( ) a work related injury? ( ) neither  
Date of injury? \_\_\_\_\_

Have you had previous chiropractic care? Y N

If yes, what was the doctor's name? \_\_\_\_\_

What was the approximate date of your last visit? \_\_\_\_\_

What was the duration of your care? \_\_\_\_\_

**Please describe below, in the following 3 sections, your primary, secondary and additional reasons for seeking care in our office:**

**Primary complaint** (List ONE only): \_\_\_\_\_

When did you first experience this problem? \_\_\_\_\_

Describe what happened or how they began? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How often do you experience this problem? ( ) 1-2x/week ( ) 3-4x/week ( ) 5-6 x/week ( ) daily  
 ( ) other: \_\_\_\_\_

During a day you do experience this problem, how often do you experience it on average?  
 ( ) Constantly (76%-100% of the day) ( ) Frequently (51%-75% of the day)  
 ( ) Occasionally (26%-50% of the day) ( ) Intermittently (0%-25% of the day)

On a scale of 0-10 and 10 representing the most severe pain imaginable, use the scale below to rate the severity of your pain for the following questions:

0	1	2	3	4	5	6	7	8	9	10
None	Minimal	Very Mild	Mild	Mild to Moderate	Moderate	Moderate to Severe	Moderately Severe, restricts some activity	Severe, Limits most activity	Very Severe	Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0-10? (Please circle)  
 0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?  
 0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?  
 0 1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? Y N  
 When? \_\_\_\_\_

How would you describe the symptoms? ( ) achy ( ) burning ( ) stabbing ( ) sharp ( ) shooting  
 ( ) weakness ( ) stiffness ( ) throbbing ( ) numb ( ) tingling ( ) cramps

Other: \_\_\_\_\_

Please describe the location of the pain. \_\_\_\_\_  
\_\_\_\_\_

Does this problem cause pain to travel to any other area? Y N If yes, where? \_\_\_\_\_  
\_\_\_\_\_

Is this problem getting: ( ) worse? ( ) better? ( ) staying the same?

What seems to aggravate this problem? \_\_\_\_\_  
\_\_\_\_\_

What have you tried to relieve this problem (i.e. interventions, treatments, medications, surgery)?  
\_\_\_\_\_  
\_\_\_\_\_

Have you seen any other doctors for this problem? Y N If yes, who? \_\_\_\_\_  
\_\_\_\_\_

What treatment was given? \_\_\_\_\_

How effective was the treatment? \_\_\_\_\_

**Secondary Complaint** (List one only): \_\_\_\_\_

When did you first experience this problem? \_\_\_\_\_

How did this problem first begin? \_\_\_\_\_  
\_\_\_\_\_

How often do you experience this problem? ( ) 1-2x/week ( ) 3-4x/week ( ) 5-6 x/week ( ) daily  
( ) other: \_\_\_\_\_

During a day you do experience this problem, how often do you experience it on average?

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

On a scale of 0-10 and 10 representing the most severe pain imaginable,  
use the scale below to rate the severity of your pain for the following questions:

0	1	2	3	4	5	6	7	8	9	10
None	Minimal	Very Mild	Mild	Mild to Moderate	Moderate	Moderate to Severe	Moderately Severe, restricts some activity	Severe, Limits most activity	Very Severe	Excruciating

Dr. Initial \_\_\_\_\_

Sitting here today, right now, what is the intensity of your pain on a scale of 0-10? (Please circle)

0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? Y N

When? \_\_\_\_\_

How would you describe the symptoms? ( ) achy ( ) burning ( ) stabbing ( ) sharp ( ) shooting  
( ) weakness ( ) stiffness ( ) throbbing ( ) numb ( ) tingling ( ) cramps

Other: \_\_\_\_\_

Please describe the location of the pain. \_\_\_\_\_

\_\_\_\_\_

Does this problem cause pain to travel to any other area?: Y N If yes, where? \_\_\_\_\_

\_\_\_\_\_

Is this problem getting: ( ) worse? ( ) better? ( ) staying the same?

What seems to aggravate this problem? \_\_\_\_\_

\_\_\_\_\_

What have you tried to relieve this problem (i.e. interventions, treatments, medications, surgery)?

\_\_\_\_\_

\_\_\_\_\_

Have you seen any other doctors for this problem? Y N If yes, who? \_\_\_\_\_

\_\_\_\_\_

What treatment was given? \_\_\_\_\_

How effective was the treatment? \_\_\_\_\_

***Additional Complaints – if any please ask for additional paperwork***

**Lifestyle/Social History**

What physical activities do you perform at work? (example: prolonged sitting, computer/desk, lifting, prolonged standing, etc...) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How many hours per week do you work? \_\_\_\_\_

What recreational activities/hobbies do you regularly engage in? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you smoke cigarettes? Y N If yes, how much? \_\_\_\_\_  
Do you drink alcohol? Y N If yes, how much? \_\_\_\_\_  
Do you drink coffee? Y N If yes, how much? \_\_\_\_\_  
Do you drink tea? Y N If yes, how much? \_\_\_\_\_

How regularly do you exercise? ( )daily ( )\_\_\_\_x/week ( )occasionally ( )never  
What kind of exercise do you do? \_\_\_\_\_

How many hours of sleep do you get on average? \_\_\_\_\_

On a scale of 0-10 please rate your stress level (0=none and 10=extreme):

Occupational \_\_\_\_\_

Personal \_\_\_\_\_

**Women Only**

Pregnancies and outcomes:

Date of pregnancy	Outcome
_____	_____
_____	_____
_____	_____
_____	_____

When was your last period? \_\_\_\_\_

Are you pregnant? ( ) Yes ( ) No ( ) Not sure

## Family Health Profile

At our office we are not only interested in your health and well being, but also that of your family and loved ones. Please review the conditions listed below and indicate those that are current health problems of a family member by writing “C” under his/her column. Please write “P” to indicate a problem that has occurred in the past. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this page.

CONDITION	Father	Mother	Spouse	Brothers		Sisters		Children		
	Age ___	Age ___	Age ___	Age ___	Age ___	Age ___	Age ___	Age ___	Age ___	Age ___
Allergies										
Arthritis										
Asthma										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Digestive Trouble										
Disc Problem										
Emphysema										
Fatigue										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Irritability										
Kidney Trouble										
Liver Trouble										
Migraines										
Mood Swings										
Neck/Shoulder Pain										
Pinched Nerves										
Scoliosis										
Seizures										
Sinus Trouble										
Sleep Disturbances										
TMJ/Jaw Pain										
Weight Issues										
Other:										

Please list the cause of death and age of any immediate family members (parents or siblings):

Cause of death	Age at death
_____	_____
_____	_____
_____	_____

**Medical History**

Please check any of the following illnesses you have had:

_____ Pneumonia	_____ Mumps	_____ Influenza
_____ Rheumatic Fever	_____ Small Pox	_____ Pleurisy
_____ Polio	_____ Chicken Pox	_____ Arthritis
_____ Tuberculosis	_____ Diabetes	_____ Epilepsy
_____ Whooping Cough	_____ Cancer	_____ Mental Disorders
_____ Anemia	_____ Heart Disease	_____ Lumbago
_____ Measles	_____ Thyroid Disorder	_____ Eczema

Surgeries:

Date	Type and reason for surgery
_____	_____
_____	_____
_____	_____
_____	_____

Previous injuries or trauma (please give type and date): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

Nutritional Supplements You Are Currently Taking:

\_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please check any of the following you have had in the last six months:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM

- Anxiety
- Depression
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress
- Hearing Difficulty

GENERAL

- Fatigue
- Allergies
- Headaches
- Fever

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating after Meals
- Heartburn
- Black/Bloody Stools
- Colitis

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

CARDIO-VASCULAR-RESPIRATORY

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Stuffed Nose

MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems:

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**CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS**

“Protected health information” means information about you, including demographic information such as your address and phone, age, gender, etc., that may identify you and relates to your past, present, or future physical or mental health or condition and related healthcare services.

**In signing this document I consent to the use or disclosure of my protected health information by Dynamics Chiropractic & Rehab LLC for the purpose of diagnosis or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of the clinic. I understand that the doctors of Dynamics Chiropractic & Rehab LLC may refuse to diagnose or treat me if I do not consent to the use or disclosure of my protected health information for the above stated purposes.**

The “Notice of Privacy Practices” is a document that describes the type of uses and disclosures of your protected health information that will occur in your treatment, payment of your bills, and in the performance of healthcare operations of the clinic.

**In signing this document I acknowledge that a copy of the Notice of Privacy Practices has been made available to me and I have been informed that I have the right to review the Notice prior to signing this document.**

**I understand that I have the right to request that the clinic restrict how my protected health information is used and/or disclosed to carry out treatment, payment and/or healthcare operations. I understand that the clinic is not required to agree to any restrictions that I have requested, but if the clinic agrees to a requested restriction, then the restriction is binding on the clinic.**

**I understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that such revocation shall not apply to actions already taken by the clinic based on this consent document.**

Dynamics Chiropractic & Rehab LLC reserves the right to change the privacy practices described in the “Notice of Privacy Practices” document. Any revisions to the Notice will be made available to you at your request and will be posted in the reception area.

**I have read and understand the foregoing notice and my questions have been answered to my full satisfaction.**

\_\_\_\_\_  
Name of patient

\_\_\_\_\_  
Signature of patient/legal representative

\_\_\_\_\_  
Date Signed

**Informed Consent for Examination and Treatment**

This document explains some potential risks associated with chiropractic care. Please read this information carefully, and let our staff know if you have questions.

The doctors and staff of Dynamics Chiropractic & Rehab LLC will do everything to assist you with your health, or your condition. Please be aware that, as with all healthcare systems, we cannot guarantee a cure or resolution of your problem.

While chiropractic care is remarkably safe, there are some risks associated with it, and we feel you need to be fully informed about these risks before consenting to treatment.

**Soreness** – Chiropractic adjustments and associated therapies may sometimes cause post-treatment soreness. While soreness is usually mild and temporary, please advise your doctor if you experience this.

**Soft Tissue Injury** – Rarely, chiropractic treatment may aggravate a disk injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

**Rib Injury** – Adjustments to the mid back, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk for fracture. Treatment is performed carefully to minimize such risk.

**Physical Therapy Burns** – Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs you should report it to your doctor.

**Stroke** – Stroke is the most serious complication of chiropractic care, but fortunately its occurrence is extremely rare. The most recent studies estimate that the incidence of this type of stroke is one in five million neck adjustments.

**Other Complications** – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

We will make every reasonable effort during examination to screen for potential risks. Please be aware that if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

**I, the undersigned, agree that I have read, or have had read to me, and understand the information stated above. I hereby authorize the doctors and staff of Dynamics Chiropractic & Rehab to perform examination procedures and administer treatment to me, or to the person listed below for whom I serve as legal guardian. I understand that all procedures and treatment will be explained to me before they are performed, and that I have the right to refuse any such procedures.**

\_\_\_\_\_  
Patient's Name

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of parent or guardian