# *New Patient Intake Form*

**3575 45th St S #112 Fargo, ND 58104**
**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? ________________________________
( ) Website
( )Drive by
( ) Lecture Where?:_________________
( )Mailing Which one?:________________
( ) 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 it 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?
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
(Intermittently) (Occasionally) (Frequently) (Constantly)

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

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

Other: _____________________________________________________________________________________

Have you experienced these symptoms before? Y N
When? ______________________________________________________________________________________

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/health professionals 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 Age___ | Mother Age ___ | Spouse Age ___ | Brothers | | Sisters | | Children | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 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: ______________________________________________________________
______________________________________________________________________
______________________________________________________________________

*Dr. Initial* _____

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:
______________________________
______________________________
______________________________

*Dr. Initial* _____

## 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.**

**______________________________**    **Date:__________________________**
**Patient's Name**

**______________________________**    **________________________________**
**Signature**    **Signature of parent or guardian**

*Dr. Initial _____*