



# NEW PATIENT INTAKE

Chiropractic [adult]

Account #: \_\_\_\_\_

*Thank you for choosing Bountiful Life Chiropractic Center. We are committed to providing you and your family the highest quality of chiropractic care so you may enjoy an active and healthy lifestyle. Prior to your consultation, please complete the following paperwork as thoroughly as possible in order for us to gain a clear understanding of your health goals.*

*We will require a photocopy of your **driver's license** (or government identification) for our records.*

*We comply with all federal privacy standards. As such, all information you provide is confidential.*

***Are you on Medicaid? If yes, please provide your card to our front desk staff member.***

Legal Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Nickname / Name you go by: \_\_\_\_\_

Caretaker's Name (if applicable): \_\_\_\_\_

Gender:  Male  Female

Primary Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_  Cell  Home

Secondary Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_  Cell  Home

*By providing us with a cell number, you will automatically be enrolled in **text appointment reminders**.*

Email: \_\_\_\_\_

Email appointment reminders *in addition* to text reminders?  Yes  No

Preferred method(s) of communication:  Phone Call  Text  Email

Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status:  Single  Married  Domestic Partner  Divorced  Widowed

Spouse/Partner's Name (if applicable): \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Emergency Contact Name (if other than spouse): \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Do you have children?  Yes  No If yes, how many? \_\_\_\_\_

How did you hear about our clinic? (check all that apply)

Google Search  Facebook  Instagram  Referral from: (name) \_\_\_\_\_

*(We will thank them with a special gift!)*

Driving by  Other (please describe): \_\_\_\_\_

# SYMPTOM SURVEY

Please mark each applicable symptom with a 1 or 2

1 – Currently experiencing (in the last 6-8 weeks) | 2 – Have experienced in the past

## GENERAL

- Chills
- Convulsions
- Dizziness/loss of balance
- Fainting
- Fever
- Headaches/migraines
- Insomnia
- Weight loss/gain
- Nerve pain
- Nervousness/anxiety
- Depression
- Numbness
- Sweats
- Tremors
- Cancer
- Diabetes - type 1 or type 2?
- Stroke
- Seizures

## EYES

- Corrective lenses or contacts
- Far sighted
- Near sighted
- Cataracts
- Blind spots
- Sensitivity to light
- Eye pain

## EARS, NOSE, & THROAT

- Allergies
- Colds
- Deafness
- Hearing loss
- Ear aches
- Ear discharge
- Ear ringing (tinnitus)
- Enlarged glands
- Enlarged thyroid
- Dental decay
- Gum trouble
- Loss of taste
- Hoarseness
- Nose bleeds
- Sore throats
- Sinus infections

Nasal obstruction

Loss of smell

## MUSCULOSKELETAL

- Arthritis
- Bursitis
- Hernia
- Low back pain
- Mid back pain
- Neck pain/stiffness
- Arm pain
- Shoulder pain
- Leg pain
- Knee pain
- Foot pain
- Muscle cramps
- Fractures
- Sciatica
- Spinal curvature

## GENITO-URINARY

- Bed wetting
- Blood in urine
- Frequent urination
- Inability to control bladder
- Kidney infection
- Kidney stones
- Painful urination
- Pus in urine

## CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Heart disease
- Pain over heart
- Rapid heart rate
- Slow heart rate
- Poor circulation
- Cold extremities (hands/feet)
- Bruise easily
- Swelling of ankles
- Pacemaker
- Varicose veins

## RESPIRATORY

- Asthma
- Bronchitis
- Chest pain

Chronic cough

Difficulty breathing

Spitting up blood

Spitting up phlegm

Wheezing

## GASTROINTESTINAL

- Belching or gas
- Abdominal pain
- Constipation
- Diarrhea
- Difficult digestion
- Poor appetite
- Ulcers
- Vomiting
- Vomiting blood
- Abdominal bloating
- Excessive hunger
- Heartburn/reflux
- Hemorrhoids
- Jaundice/liver issues
- Nausea
- Gallbladder issues
- Colitis
- Irritable bowel syndrome

## WOMEN ONLY

- Pregnant (currently)
- Possibly pregnant
- Painful menstruation
- Menstrual cramps
- Hot flashes
- Irregular cycle
- PCOS
- Lumps in breast(s)
- Vaginal discharge
- Nipple discharge
- Pregnancy complications
- Miscarriage
- Infertility

## MEN ONLY

- Prostate problems
- Erectile dysfunction
- Hesitancy/dribbling
- Infertility

Have you seen a chiropractor before?  Yes  No If yes, when? \_\_\_\_\_

Surgeries (with approx. dates): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Illnesses (with approx. dates): \_\_\_\_\_

\_\_\_\_\_

Accidents, Falls, Traumas (with approx. dates): \_\_\_\_\_

\_\_\_\_\_

Have you had a concussion?  Never  One time  Multiple times  I think so, but not sure

Do you smoke or use other tobacco products?  Never  Occasionally  Regularly  I've quit

Do you drink alcohol?  Never  Occasionally  Regularly  I've quit

Do you drink caffeinated beverages?  Never  Occasionally  Regularly  I've quit

Please list current medications: \_\_\_\_\_

\_\_\_\_\_

Please list current vitamins or supplements: \_\_\_\_\_

\_\_\_\_\_

Are you allergic to any medications?  Yes  No If yes, which ones? \_\_\_\_\_

Are you allergic to any foods?  Yes  No If yes, which ones? \_\_\_\_\_

\_\_\_\_\_

What condition(s) led you to seek chiropractic care? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did you first notice it? \_\_\_\_\_

What were you doing when you first noticed it? \_\_\_\_\_

\_\_\_\_\_

Have you had this condition / these symptoms before?  Yes  No If yes, when? \_\_\_\_\_

Do the symptoms radiate or travel to another area?  Yes  No  Not sure

If yes, please describe: \_\_\_\_\_

How frequently do you experience symptoms? (circle one)

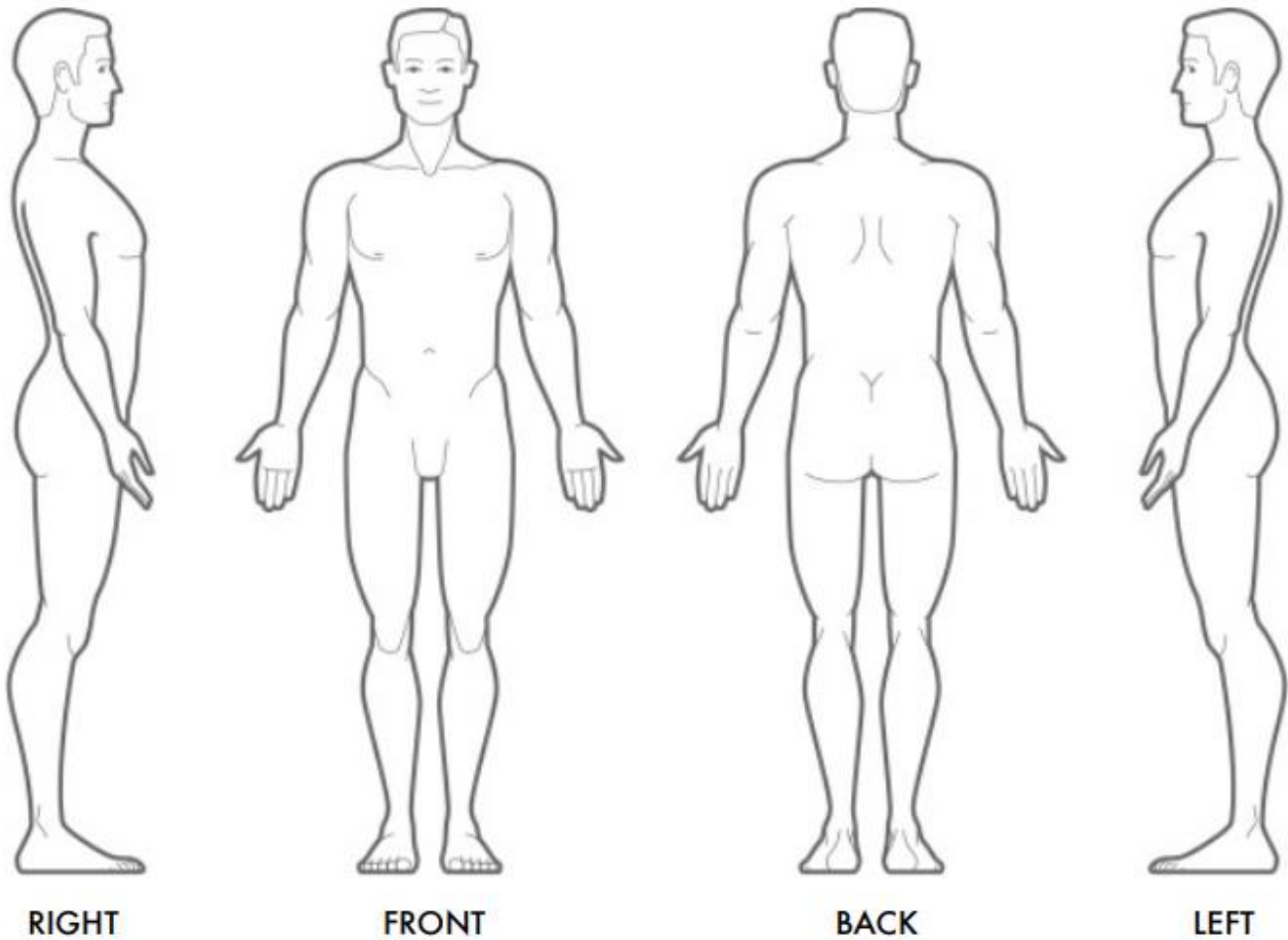
Intermittently  
[0-25% of day]

Occasionally  
[26-50% of day]

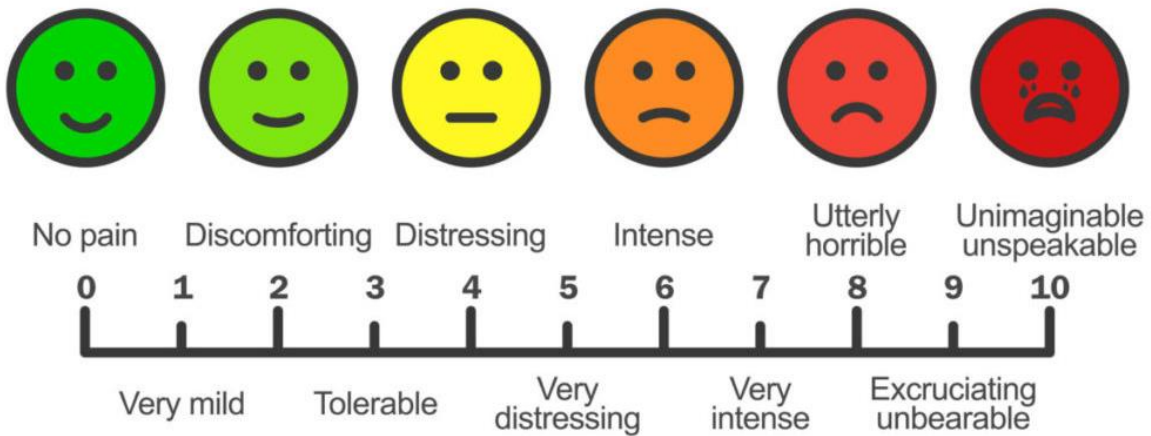
Frequently  
[51-75% of day]

Constantly  
[76-100% of day]

Place an "X" on the diagram below in the locations you are experiencing symptoms:



How would you rate the intensity of your pain? (circle a number)



Is the pain (circle all that apply): Sharp Dull Aching Burning Numb Throbbing Pins & Needles

What makes your symptoms better? \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

What movements/activities are difficult with your condition? \_\_\_\_\_

\_\_\_\_\_

## TERMS OF ACCEPTANCE

Chiropractic has only one goal - to serve the health needs of you, the patient. When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral or extremity subluxation. Our chiropractic method of correction is by specific adjustments of the spine, as well as extremities.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Extremity Subluxation: A misalignment of an extremity causing edema, fixation and or joint irregularity. The aim of extremity adjusting is to assess the extremity, then do an analysis, and then develop a treatment for the extremity and synchronize this plan with the plan for the spinal treatment.

We may diagnose any condition or disease that comes into our office in addition to the vertebral and extremity subluxations. It is our goal to refer a patient to their health care practitioner, or in urgent matters, to the closest emergency room if we feel their health, or our diagnosis, warrants the referral.

We do not treat diseases or conditions in our office beyond the spine or extremities; however, other diseases may improve with chiropractic care. In doing so, it's important to work with you, the patient, on reaching your optimal health. Our only practice objective is to serve you, the patient.

## PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

## X-RAY RELEASE

This is to certify that Dr. LaBounty & Dr. Miller have my permission to perform an X-ray evaluation.

**To the best of my knowledge, I am not pregnant, and I understand that x-ray can be hazardous to an unborn child.**

Date of last menstrual cycle: \_\_\_\_\_

## PAYMENT / INSURANCE

I understand that Bountiful Life Chiropractic Center will provide a receipt to assist me in making collection from any insurance company. I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I have read and understand the above, and I agree to these policies and procedures. All questions about this page have been answered to my satisfaction, and I therefore accept care at Bountiful Life Chiropractic Center on this basis.

Patient Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_