

VIP* PRACTICE MEMBER INTAKE FORM

Date _____ Referred By _____

Name (Last) _____ (First) _____

Address _____ City _____ Zip _____

Phone: Home () _____ Work () _____ E- Mail address: _____

Date of Birth _____ Age _____ Social Security # _____

Sex M _____ F _____ Marital Status Single _____ Married _____ Divorced _____ Other _____

Employer _____ Occupation _____

Name & Number of Emergency Contact _____ Relationship _____

Have you see a Chiropractor before? Y N Who? _____ When? _____

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____

Rate your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable

Other doctors you have seen for this condition: _____ MD _____ DC _____ DO _____ DDS _____ Other
Who _____

When did this condition begin? _____ If accident related, date of accident _____

Which of the following is your condition interfering with? Work _____ Sleep _____ Daily Routine _____

Has this condition occurred before: Yes _____ No _____

Is condition: Job Related? _____ Auto Accident? _____ Home Injury? _____ Fall? _____

Major recent life changes _____

How Long has it been since you really felt good? Days _____ Weeks _____ Months _____ Years _____

Which of the following do you take now? Nerve Pills _____ Pain Killers _____ Muscle Relaxants _____
Blood Pressure Medication _____ Other (please list) _____

List Previous Surgeries (Include type and date) _____

Do you suffer from any other condition(s) other than the one you are consulting us for? _____ If so, please describe. _____

PAST HEALTH CONDITION

Major Surgery/Operations: Appendectomy _____ Tonsillectomy _____ Gall Bladder _____

Hernia _____ Back Surgery _____ Broken Bone(S) _____ Other: _____

Hospitalizations (Other than Above) _____

Sports Injuries _____

Other major accidents or falls (starting from childhood) _____

**PLEASE CHECK ALL
PRESENT SYMPTOMS**

HEAD

- Headaches
- _____ Sinus _____ Migraine
- _____ Forehead _____ Temples
- _____ Entire head
- _____ Back of head
- Head feels heavy
- Loss of memory
- Light bothers eyes
- Blurred vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Buzzing in ears

NECK

- Neck pain (constant)
- Neck pain (with movement)
- _____ forward _____ backward
- _____ turn to left _____ to right
- _____ bend to left _____ to right
- Pinched nerve in neck
- Muscle spasms in neck
- Grinding sounds in neck
- Arthritis in neck

SHOULDERS

- Pain in shoulder joint (R L)
- Pain across shoulders
- Bursitis (R L)
- Can't raise arm
- _____ above shoulder level
- _____ over head
- Shoulder tension
- Pinched nerve (R L)
- Muscle Spasms

ARMS & HANDS:

- Upper arm pain (R L)
- Elbow pain (R L)
- Tennis elbow (R L)
- Forearm pain (R L)
- Hand pain (R L)
- Finger pain (R L)
- Sensation of pins and needles
- _____ in arms _____ in fingers
- Numbness in arms (R L)
- Numbness in fingers (R L)

- Fingers go to sleep
- Aggravated by movement
- Cold hands
- Swollen joints in fingers
- Sore joints in fingers
- Loss of grip strength

MID-BACK

- Mid-back pain
- Pain between shoulders
- _____ sharp stabbing
- _____ dull ache
- Pain from front to back
- Muscle Spasms
- Kidney pain

CHEST

- Chest pain
- Shortness of Breath
- Pain around ribs
- Irregular heartbeat

ABDOMEN/GI

- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK

- Low back pain
- _____ lumbar
- _____ sacroiliac
- Muscle spasms

Pain is worse when:

- _____ working
- _____ bending
- _____ lifting
- _____ coughing
- _____ stooping
- _____ standing
- _____ lying down
- _____ sitting
- _____ walking

Pain is relieved when:

HIPS, LEGS, FEET:

- Buttocks pain (R L)
- Hip joint pain (R L)
- Pain down leg (R L)
- _____ front
- _____ side
- _____ back
- Pain down both legs
- Knee pain (R L)
- Leg/ foot cramps (R L)
- Numbness in legs (R L)
- Numbness in feet (R L)
- Numbness in toes (R L)
- Feet feel cold

WOMEN ONLY

- Menstrual pain
 - Cramping
 - Irregularity
 - Abortions
 - Hysterectomy
 - Genital Cancer
 - Discharge
 - Tumors
 - Menopausal
- Method of birth control
- _____

MEN ONLY

- Urinary frequency
- Difficulty starting
- Night urination
- Prostrate pain/swelling

GENERAL

- Nervousness
 - Depressed
 - Fatigue
 - Feel Run Down
 - Irritable
 - Difficulty in sleeping
 - Weight Loss
 - Weight Gain
 - Diabetes
 - Hypoglycemia
- Daily Intake:
- Coffee _____
- Tea _____
- Cigarettes _____
- Alcohol _____
- Other _____

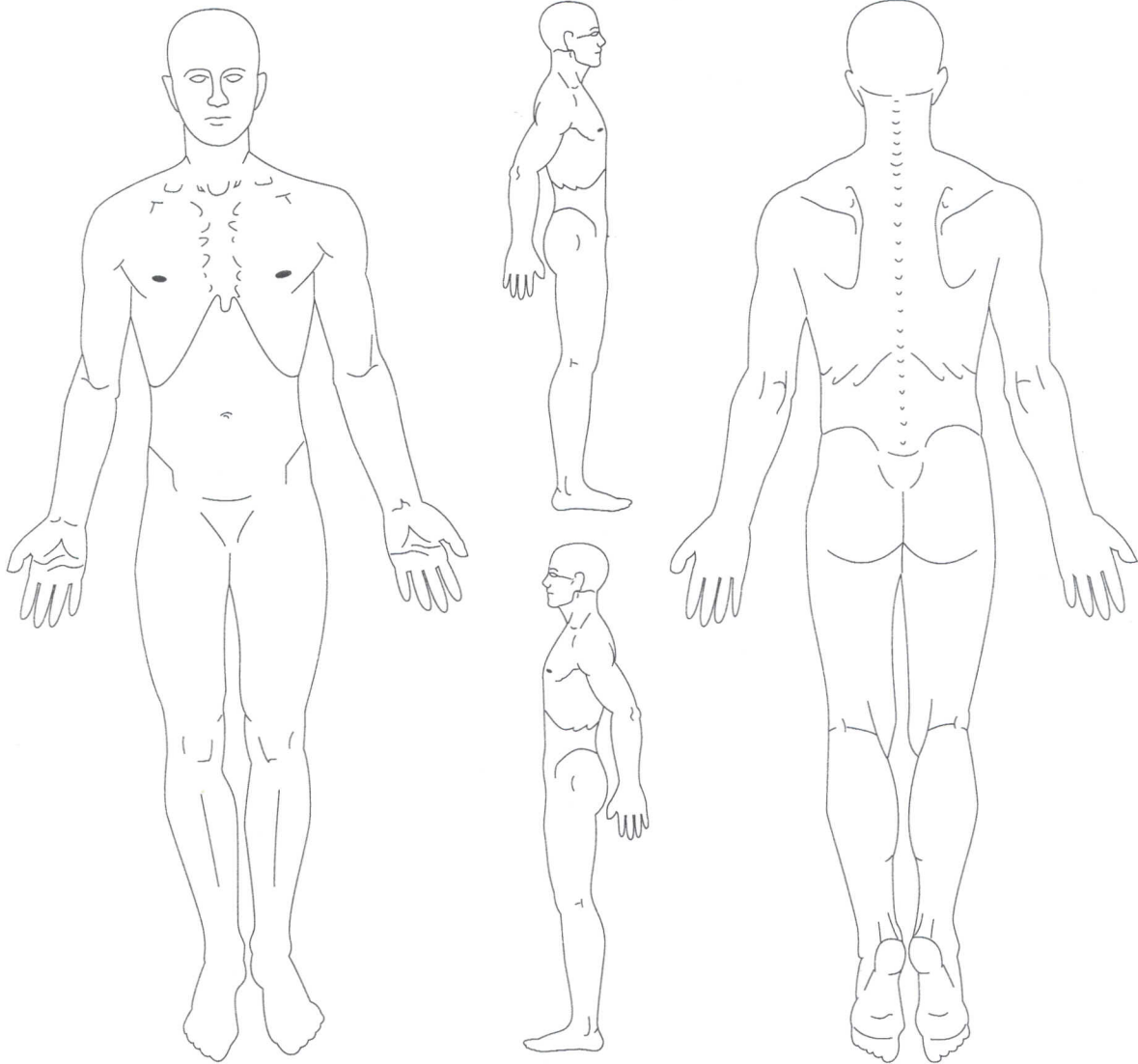
Patient Name(Print) _____ Date _____

Patient ID # _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb

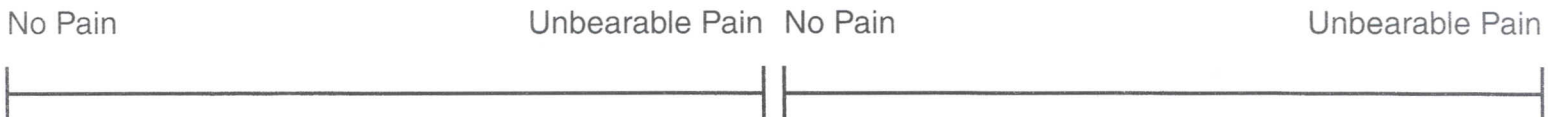
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

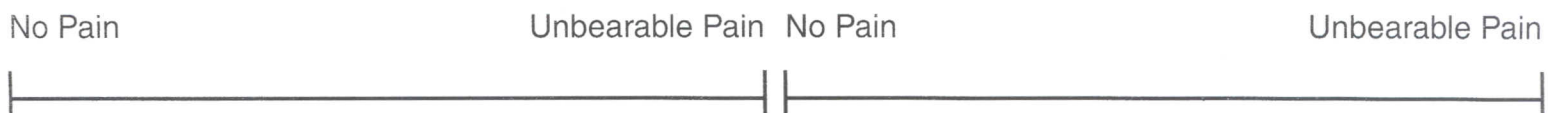
Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:



Rate your **average** pain in the past week:

Rate your **worst** pain in the past week:



Dr. Strawberry Weber, DC
Compassionate Chiropractic Care

Informed Consent To Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including examination tests, diagnostic x-rays, and physical therapy techniques on me by Dr. Weber.

I understand that, as with any health care provider, there are certain complications which may arise during a chiropractic adjustment. The complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and sprains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interests.

As a patient seeking chiropractic care, it is essential to be working towards the same goals and objectives. Chiropractic has only one goal. It is important that each patient understand both the objective and method used to obtain it. This will prevent any confusion or disappointment. Dr. Weber's objective is to locate and correct vertebral subluxations, which cause nerve irritation and interference of the transmission of mental impulses between the brain and the body, compromising the function of affected organs and tissues. Dr. Weber corrects the subluxations by adjusting the vertebrae, applying a specific force to the area.

Dr. Weber does not offer to diagnose or treat any disease or condition other than vertebral and extremity joint subluxations. However, if during the course of a chiropractic spinal examination, Dr. Weber encounters non-chiropractic or unusual findings, you will be advised. If you desire advice, diagnosis, or treatment for those findings, Dr. Weber will recommend that you seek the services of a health care provider that specializes in that area.

I have had the opportunity to discuss with Dr. Weber the nature, purpose, and risks of chiropractic adjustments and procedures and have had my questions answered to my satisfaction. I understand that results are not guaranteed.

By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(print name)

(signature)

(date)

**COMPASSIONATE CHIROPRACTIC CARE
NOTICE OF PRIVACY PRACTICES**

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, health care options, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to 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 effect the use of those records used 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 normal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature _____ Date _____

Guardian's Signature _____ Date _____