CORNERSTONE CHIROPRACTIC

INTAKE FORM

Date:_____

PERSONAL INFORMATION

Name _____ Gender ❑ M ❑ F Birthdate _____

If Female, are you pregnant? ❑ Yes ❑ No

Address _____

City _____ State _____ Zip _____

Phone Number _____ _____

How did you hear about us? ❑ Social Media ❑ Google Search ❑ Referred by_____

❑ Other _____

What do you do for a living? _____

Email Address _____

Have you seen a chiropractor? ❑ Yes ❑ No

If yes, Who was the last chiropractor you saw? _____

Emergency Contact Name _____ Phone Number _____

OFFICE VISIT REASON

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth:_____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by entering the value in the box:

Primary complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____

When is the problem at its worst? ❑ AM ❑ PM ❑ mid-day ❑ late PM

How long does it last? ❑ It is constant ❑ I experience it on and off during the day ❑ It comes and goes throughout the week

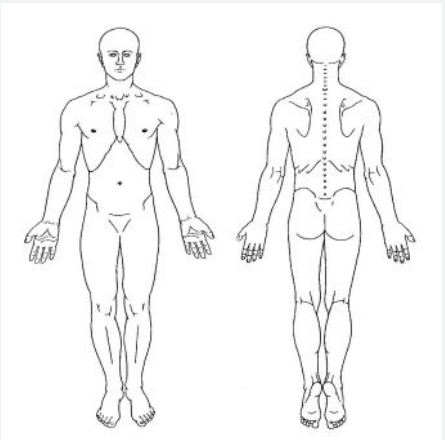
How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ❑ No ❑ Yes

If yes, when: _____ by whom:_____

How long were you under care: _____What were the results? _____

*Please mark the areas on the Diagram with the following **letters** to describe your symptoms:*
***R** = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness*
***S** = Sharp/Stabbing **T** = Tingling*



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

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GENERAL HEALTH HISTORY

Do you have or have you had any of the following conditions? (Check if Yes)

❑ Chronic Kidney Disease (CKD)
❑ Obstructive Pulmonary Disease
❑ Clotting Disorder
❑ Congestive Heart Failure
❑ Crohn's Disease
❑ Depression
❑ Diabetes
❑ Emphysema
❑ Endocrine Problems
❑ Gastrointestinal Reflux Disease (GERD)
❑ Hepatitis
❑ HIV/AIDS
❑ *Hypertension*
❑ *Irritable Bowel Syndrome (IBS)*
❑ *Kidney Disease*
❑ *Migraine*
❑ *Anemia*
❑ *Arthritis*
❑ *Asthma*
❑ *Chronic Fatigue Syndrome (CFS)*

PERSONAL SURGICAL HISTORY

Have you had any surgeries?

❑ No ❑ Yes, Explain _____

INJURY HISTORY

Is there a history of any other injuries? ❑ No ❑ Yes

Please describe:_____

FAMILY HISTORY

Are there any relevant diseases in your family? ❑ No ❑ Yes,

Please describe:_____

Was this injury due to a Work or Car accident? ❑ No ❑ Yes (If yes, please fill out below)

WORK ACCIDENT

Date of accident? _____

Please describe what happened:

_____

_____

_____

_____

_____

Claim #?_____

Who is handling your case?_____

What is their Phone #?_____

CAR ACCIDENT

Date of accident? _____

Adjusters name? _____

Adjusters Number?_____

Insurance Company?_____

Number of passengers? _____

Were you at fault? ❑ No ❑ Yes ❑ Unknown

Claim #? _____

Do you have an attorney? ❑ No ❑ Yes

*If yes, whom? _____

PATIENT SIGNATURE

*Patient Signature*_____*Date*_____

I agree that the above information is all correct and up to date

CORNERSTONE CHIROPRACTIC

INFORMED CONSENT FOR CHIROPRACTIC CARE

THE NATURE OF CHIROPRACTIC TREATMENT

Chiropractic treatment primarily involves the manual manipulation of the treated area using the chiropractor's hands or mechanical devices. During treatment, you may experience sensations like clicks, pops, and movement. Additionally, our office may utilize various modalities in your care, as recommended by your chiropractor based on their professional judgment.

POSSIBLE RISKS

Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slightly increased pain in the treated area, possibly due to minor muscle, tendon, or ligament strain. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

It's important to note that serious bodily harm is extremely rare and not an inherent risk of chiropractic treatments. Various factors can influence one's health, including prior injuries, medications, and underlying medical conditions like osteoporosis, cancer, and other illnesses. When such conditions are present, chiropractic treatment may carry the risk of serious adverse events, including fractures, dislocations, or the exacerbation of previous injuries to ligaments, intervertebral discs, nerves, or the spinal cord. It's essential for patients to remain vigilant and seek medical and/or chiropractic care if they experience symptoms suggestive of stroke or cerebrovascular injury. Your chiropractor is well-informed about this association and will assess for relevant symptoms when appropriate. It is imperative to disclose your full medical history, including medications, surgeries, and all relevant health conditions like osteoporosis, heart disease, cancer, stroke, fractures, or prior severe injuries.

OTHER OPTIONS FOR THE TREATMENT OF PAIN INCLUDE

Apart from chiropractic care, alternative approaches to managing pain include: over-the-counter medications, physical therapy, medical interventions, injections, or surgery. There is a multitude of pain management options, each carrying potential benefits and risks. We encourage you to ask any questions you may have about the potential risks associated with chiropractic treatment.

I, the undersigned, confirm that I have read and understood the information provided above, including the potential risks associated with chiropractic treatment, and have had the opportunity to inquire about any concerns I may have. I have disclosed my relevant medical history, as well as any conditions that have previously caused me pain.

Patient Name	Signature	Date