



ADULT INTAKE FORM

PATIENT INFORMATION

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 E-mail Address: _____ Cell Phone: _____
 Marital Status: Single Married Divorced
 Employer: _____ Occupation: _____
 Spouse's Name _____ Number of children, ages: _____
 Name & Number of Emergency Contact: _____ Relationship: _____

HOW DID YOU HEAR ABOUT US? _____

HISTORY OF CURRENT HEALTH CONCERNS

Please list the Health Concerns that prompted your first visit

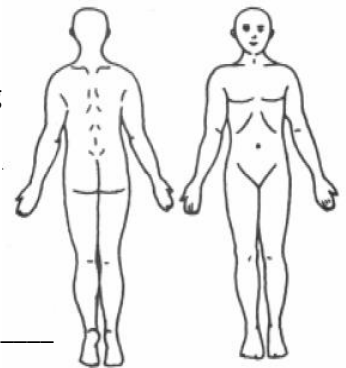
	List Concerns According to Severity	Rate of Severity 0 = No Pain 10 = Unbearable	When did this problem start?	Have you had this problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary	_____	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? Yes No Who? _____

If Yes: Chiropractor Medical doctor Other _____

What relieves your symptoms? _____ What makes your symptoms feel worse? _____

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
Indicate where pain travels with arrows



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

List all the medications you are taking:

Please Mark "P" For in The Past OR Mark "C" For Currently Have:

<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Epilepsy/Convulsions	<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Sleep Issues	PAIN
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Spinal Bone Fracture	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Nausea	<input type="checkbox"/> Spinal Surgery	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Food Sensitivity	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Sports Injury	
<input type="checkbox"/> Arthritis/Joint Pain	<input type="checkbox"/> GERD/Gastric Reflux	<input type="checkbox"/> Numb/Tingling in Arms/Hands	<input type="checkbox"/> Stiffness	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Headaches	<input type="checkbox"/> Numb/Tingling in Legs/Feet	<input type="checkbox"/> Thyroid Issues	
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Stroke	<input type="checkbox"/> Tight/Sore Muscles	
<input type="checkbox"/> Bladder Issues	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Plantar Fasciitis	<input type="checkbox"/> Tremors	
<input type="checkbox"/> Chronic Colds	<input type="checkbox"/> Heart Issues	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Ulcers	
<input type="checkbox"/> Constipation	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Poor Posture	<input type="checkbox"/> Weight Loss/Gain	
<input type="checkbox"/> Depression	<input type="checkbox"/> Infertility	<input type="checkbox"/> Prostate Issues	<input type="checkbox"/> Vertigo	
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Irritability	<input type="checkbox"/> Ringing in the Ears		
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Kidney Issues	<input type="checkbox"/> Sciatica		
<input type="checkbox"/> Digestive Issues	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Scoliosis		
<input type="checkbox"/> Disc Issues	<input type="checkbox"/> Loss of Energy	<input type="checkbox"/> Seizures	Pacemaker: Y N	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Sexual Dysfunction	Pregnancy Due Date:	
<input type="checkbox"/> Double/Blurry Visio	<input type="checkbox"/> Menstrual Issues	<input type="checkbox"/> Shortness of Breath		
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Migraines	<input type="checkbox"/> Sinus Issues		

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS) / PAIN ASSESSMENT

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ **Back pain** _____ **Headaches** _____ Worst possible pain

0 1 2 **3** 4 5 6 7 **8** 9 10

1. How would you rate your pain RIGHT NOW?
 0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?
 0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST?
 0 1 2 3 4 5 6 7 8 9 10
 What percentage of your hours awake is your pain at its best? _____%

4. What is your pain level at its WORST?
 0 1 2 3 4 5 6 7 8 9 10
 What percentage of your hours awake is your pain at its worst? _____%

PAST HISTORY

Have you ever been in an auto accident? Yes No List all: _____

Please list any additional traumas you have undergone, that have NOT been previously mentioned:

Please check any condition you have currently, or have had in the past:

- Stroke Cancer Heart Disease Spinal surgery Seizures
- Spinal Bone Fracture Scoliosis Diabetes: Type _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentration (Reading)	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

QUALITY OF LIFE

How would a change in your health positively impact your health? *Please be specific with the goals you are hoping to achieve through your care at our office. (i.e 'I could work out again, I could play with my grandchildren, etc.')

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature

Date Completed

X-RAY/IMAGING STUDIES:

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Apex Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, you are agreeing to the above terms and conditions.

Printed Name _____

Signature _____

Date Completed _____

FEMALES ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at Apex Chiropractic.

LMP (Date) _____

Signature: _____

Date: ____ - ____ - ____

INFORMED CONSENT: FOR CHIROPRACTIC CARE, MODALTIIES AND THERAPUETIC PROCEDURES:

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Benjamin Sevlie D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Printed Name _____

Signature _____

CHILD/MINOR INFORMED CONSENT

Name of practice member who is a minor/child: _____

I authorize Dr. Benjamin Sevlie and any and all Apex Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my child/minor. As of this date, I have the legal right to select and authorize health care services for my child/minor. If my authority to select and authorize care is revoked or altered, I will immediately notify Apex Chiropractic.

Guardian Signature: _____

Date: ____ - ____ - ____

Relationship to Child/Minor: _____