Progressive Chiropractic & Acupuncture
Patient Intake Form

Date _____ **First Name** _____ **Last Name** _____

DOB _____ **Sex** Male/Female **SSN** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Mobile # _____**Work/Home** _____ **Email** _____

Job Status: Employed / Not Employed / Retired / Student **Marital Status:** Single / Married / Other

Employer: _____ **Occupation:** _____

Appointment Reminders: Call / Text / Email **Referred by:** Provider / Friend / Family / Other _____

Race: _____ **Dominance:** Right / Left / Ambidextrous

Emergency Contact:
Name: _____ Phone: _____ Relationship: _____

Primary Care Provider: _____

Medications/Vitamins/Supplements:

Allergies: **Traumas/Scars:**

Surgeries:

Energy Level: Good / Insufficient / Erratic
Sleep: Trouble falling asleep / Trouble staying asleep / Restful / Good sleep
Stress: None / Low / Moderate / Severe
Have you had any unexpected weight loss/gain in the last 6 months? Yes / No If yes, how much?_____

Do you smoke? __Never smoked __Current every day smoker __Current some day smoker __Former
Daily caffeine intake (cups): __None __1-3 __4-6 __7-10 __11-15 __16-20
Weekly alcoholic drinks (cups): __None __1-3 __4-6 __7-10 __11-15 __16-20
Do you exercise regularly? No / Light / Moderate / Heavy

Primary Complaint: _____

Mild **1 2 3 4 5 6 7 8 9 10** **Severe**

What caused this problem?_____

Frequency: Constant(76%-100%) / Frequent(51%-75%) / Intermittently(26%-50%) / Occasionally(0%-25%)

Onset: How long ago did the symptoms start? _____

Quality: Describe your pain: __aching __burning __cramping __deep __dull __numb __radiating __sharp __shooting __sore __stabbing __stiff __swelling __tight __tingling __throbbing

Is the pain worse a specific time of day? Morning / Afternoon / Evening / Night

Aggravating Factors: What makes the problems worse?

__Activities of daily living	__Jogging	__Stairs
__Bending	__Lifting	__Standing
__Caring for children	__Lying down	__Standing for a while
__Cooking/Cleaning	__Massage	__Stretching
__Carrying things	__Pulling	__Stress
__Coughing/Sneezing	__Pushing	__Taking a deep breath
__Daily hygiene activites	__Running	__Turning
__Driving	__Sex	__Twisting
__Eating	__Shopping	__Transitioning from sitting to standing
__Exercise	__Sitting	__Using phone/computer
__Lying to sitting	__Sleeping	__Walking
__Heat/Ice	__Social activities	__Working
__Housework	__Squatting	__Yardwork

Relieving Factors: What makes the problem better? _____

What treatment(s) have you tried for your complaint? __None __Medication __Surgery __Physical Therapy __Chiropractic __Massage __Heat/Ice __Injections __Other_____

Secondary Complaint: _____

Mild **1 2 3 4 5 6 7 8 9 10** **Severe**

What caused this problem?_____

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Relieving Factors: What makes the problem better? _____

What treatment(s) have you tried for your complaint? __None __Medication __Surgery __Physical Therapy __Chiropractic __Massage __Heat/Ice __Injections __Other_____

Ilnesses you have or have had:

__AIDS
__Anemia
__Arthritis
__Asthma
__Bleeding Disorders
__Breast Lump/Mass
__Bronchitis
__Cancer _____
__Chemical Addiction
__Chicken Pox
__Diabetes
__Emphysema
__Fibromyalgia
__Fractures
__Gallstones
__Glaucoma
__Gout
__Heart Problems
__Hepatitis
__Hernia
__Herniated Disc
__High Blood Pressure
__High Cholesterol
__Immune Deficiency
__Kidney Disease
__Liver Disease
__Multiple Sclerosis
__Neuropathy
__Osteoporosis/Osteopenia
__Pacemaker
__Parkinson's Disease
__Pinched Nerve
__Prostate Problems
__Prosthesis
__Psychiatric Disorder
__Rheumatoid Arthritis
__Stroke
__Thyroid Problems
__Tuberculosis
__Tumors/Growths
__Ulcers
__Venereal Disease
__Whooping Cough

Review of systems: Check all that apply

Musculoskeletal:
__None
__Arm/Hand pain
__Back pain
__Feet/Leg pain
__Hip pain
__Knee pain
__Lower back pain
__Mid/upper back pain
__Muscle/joint pain
__Neck pain
__Redness of joints
__Shoulder pain
__Stiffness
__Swelling of joints

Cardiovascular/Respiratory:
__None
__Chest pain
__Coughing up blood
__Coughing up phelgm
__Difficulty breathing
__Fainting
__Irregular heartbeat
__Palpitations
__Persistant coughing
__Shortness of breath
__Tightness in chest
__Wheezing

Head/Neck:
__None
__Dizziness
__Facial pain
__Grinding teeth
__Headache/Migraines
__Head injury
__Jaw clicks
__Lumps/swollen glands

Eyes:
__None
__Blurred vision
__Burning
__Cataracts
__Double vision
__Dryness
__Flashing lights
__Glasses/Contacts
__Glaucoma
__Itching
__Redness
__Specks

Ears:
__None
__Ear infections
__Buzzing in ears
__Poor balance
__Decreased hearing
__Poor hearing
__Drainage
__Ringing in ears
__Earache

Nose:
__None
__Allergies
__Blocked sinuses
__Discharge
__Excessive mucus
__Hay fever
__Itching
__Nose bleeds
__Sinus pressure

Endocrine:
__None
__Heat/Cold Intolerance
__Sweating

Throat/Mouth
__None
__Bleeding
__Braces
__Dentures
__Difficulty swallowing
__Dry mouth
__Hoarseness
__Non healing sores
__Sore throat
__Thrush
__Tooth pain

Urinary:
__None
__Blood in urine
__Burning or pain
__Difficulty/frequent urinating
__Frequent UTI's
__Incontinence
__Kidney stones
__Urgency
__Water retention

Gastrointestinal:
__None
__Change in appetite
__Constipation
__Diarrhea
__Heartburn
__Nausea
__Rectal bleeding
__Change in bowels

Vascular/Hematologic:
__None
__Calf pain with walking
__Cold hands/feet
__Ease of bleeding/bruising
__Leg cramping

Neurologic:
__None
__Seizures
__Easily angered
__Fainting
__Frequent crying
__Memory confusion
__Neuropathy
__Numbness
__Poor concentration
__Tingling
__Tremors
__Weakness

Psychiatric:
__None
__Anxiety
__Depression
__Memory loss
__Nervousness
__Stress
__Suicidal thoughts

Female:
Pregnant Yes / No
Number of pregnancies_____
Number of deliveries_____
Number of cesareans_____
Operations: __Cervix __Uterus __Ovaries
__Clotting
__Dark color
__Discharge
__Heavy/light bleeding
__Hot flashes
__Irregular periods
__Itching/rash
__Leg cramps
__Little/no sex drive
__Menstrual cramps
__Miscarriage
__Missed periods
__Mood swings
__Pain with sex
__Painful breasts
__STD's/infections
__Vaginal sores/dryness
__Water retention

Male:
__Discharge
__Erectile dysfunction
__Hernia
__Impotence
__Low sex drive
__Masses/pain
__Painful urination
__Pain with sex
__Prostate problems
__Sores
__STD's

Family History: Has anyone in your family had any of the following conditions?

(Check if yes, and indicate relationship to you)

__Cancer/Polyps_____
Type_____
__Anemia_____
__Diabetes_____
__Blood Clots_____
__Scoliosis_____
__Other_____

__Heart Disease_____
__Stroke_____
__High/Low Blood Pressure_____
__Bleeding Problems_____
__Spina Bifida_____
__Osteoporosis_____

Informed Consent for Chiropractic\Physiotherapy\Needle Acupuncture Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used. Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare". Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Please take time to read this form, which will provide you with some basic knowledge about needle acupuncture treatment. While receiving needle acupuncture treatment, please feel free to communicate with your practitioner what you experience during the needling process, as this will enable the practitioner to adjust needles and the points selected to maximize your comfort during the treatment. If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please let the practitioner know immediately. This is known as needle shock, and while its occurrence is extremely rare, it helps to let the practitioner know if you experience any of these symptoms so that the needles can be removed. These symptoms go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of needle acupuncture treatment may include local bruising, mild pain in the area treated, brief generalized fatigue, tingling or numbness. Everyone responds to treatment differently therefore; we cannot guarantee the outcome of treatment. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until after several days go by. Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let us know how you responded to the previous treatment at the time of your follow-up visits, so that your treatment plan can be adjusted accordingly. By signing this informed consent, you (the patient) acknowledged that you have read the information above carefully and are giving consent for treatment. Single-use, sterile, disposable needles are used in this clinic

HIPPA Notice of Privacy Practices

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

No Call/No Show Notice

We schedule our appointments so that each patient receives the right amount of time to be seen by Dr. Brooks and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time. As a courtesy, and to help patients remember their scheduled appointments, Progressive Chiropractic sends text message and email reminders the day before your appointment time. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. If you do not cancel or reschedule your appointment, you will be charged a $25 "no-show" fee. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

Patient/Guardian Signature_____ Date_____