



New Patient Intake Forms

Patient First/Last Name: _____ Email: _____

DOB: _____ Phone: _____

Address: _____

Emergency Contact Name/Phone #: _____

Occupation: _____ Have you seen a chiropractor before? _____

Area of Pain or Discomfort

- | | | |
|-------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Chest | <input type="checkbox"/> Wrist |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Ribs | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Jaw | <input type="checkbox"/> Lower back | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Upper back | <input type="checkbox"/> Tailbone | <input type="checkbox"/> Lower leg |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hip | <input type="checkbox"/> Ankle/ Foot |
| <input type="checkbox"/> Mid back | <input type="checkbox"/> Elbow | |

Location

- | | | |
|------------------------------------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Bilateral | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
|------------------------------------|-------------------------------|--------------------------------|

Describe the pain: check all that apply

- | | | |
|----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Radiating |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numbness | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Tight |

How long have you had this issue?

- | | | |
|------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> <1 week | <input type="checkbox"/> 4-12 weeks | <input type="checkbox"/> 6-12 months |
| <input type="checkbox"/> 1-4 weeks | <input type="checkbox"/> 3-6 months | <input type="checkbox"/> >1 year |

Rate your pain on a scale of 1-10 (circle one)

0	1	2	3	4	5	6	7	8	9	10
No pain	Mild, annoying pain	Nagging, uncomfortable, troublesome pain	Distressing, miserable pain	Intense, dreadful, horrible pain	Worst possible, unbearable, excruciating pain					

Pain Timing:

- | | | |
|------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Morning | <input type="checkbox"/> Evening | <input type="checkbox"/> Activity / movement based |
| <input type="checkbox"/> Afternoon | <input type="checkbox"/> All Day | |

What reduces the pain?

- | | | |
|--------------------------------------|----------------------------------|-------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Moving | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Resting | |
| <input type="checkbox"/> Stretching | <input type="checkbox"/> Ice | |

Is this condition:

- | | | |
|--|------------------------------------|------------------------------------|
| <input type="checkbox"/> Getting Worse | <input type="checkbox"/> Improving | <input type="checkbox"/> No Change |
|--|------------------------------------|------------------------------------|

Are you currently pregnant?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

If yes, when is your due date?: _____

Exercise Frequency and type of exercise

- | | |
|------------------------------------|--------------------------------|
| <input type="checkbox"/> 1-2x/week | <input type="checkbox"/> Daily |
| <input type="checkbox"/> 3-5x/week | <input type="checkbox"/> Never |

Please check and describe any history of trauma or injury (include year/month if known)

- Car accidents _____
- Surgeries _____
- Hospitalization _____
- None

Health History

- | | | |
|--|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Degenerative Disc Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Autoimmune |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Respiratory disorders |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Osteoporosis / Osteopenia | <input type="checkbox"/> None |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Joint Replacement | |

Neurological

- | | | |
|---|---|-------------------------------|
| <input type="checkbox"/> Dizziness/Nausea | <input type="checkbox"/> Problem Speaking | <input type="checkbox"/> None |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Blurred Vision | |

Eyes / Ears / Nose / Throat

- | | | |
|--|--|-------------------------------|
| <input type="checkbox"/> Failing Vision | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> None |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Other Hearing problems not otherwise listed | |
| <input type="checkbox"/> Eye Pain | | |
| <input type="checkbox"/> Ringing / Buzzing in ears | <input type="checkbox"/> Difficulty Swallowing | |

Respiratory Symptoms

- | | | |
|---|--|-------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> None |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Bronchitis | |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Emphysema | |

Cardiovascular Symptoms

- | | | |
|--|---|--|
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hardening of Arteries | <input type="checkbox"/> Phlebitis / Varicose veins |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Pacemaker or similar device |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Angina | <input type="checkbox"/> None |
| <input type="checkbox"/> Previous incident of Stroke | <input type="checkbox"/> Chronic Congestive Heart Failure | |
| <input type="checkbox"/> Cerebral Vascular Aneurism | <input type="checkbox"/> Previous Heart Attacks | |

Gastrointestinal Symptoms

- | | | |
|--|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Irregular / Absent bowel movement | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Indigestion |
| | <input type="checkbox"/> Diabetes | <input type="checkbox"/> None |

Please list your current over the counter and prescription medications/supplements.

McAlister Chiropractic Informed Consent:

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebrae in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing. The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life. In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment. I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment. I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Signature: _____ Print Name: _____

Parental Consent for Minor Patient (If applicable)

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Patient Name: _____ Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____ Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.