

Ewer Specific Chiropractic Patient Intake Form

PATIENT INFORMATION

Circle One: Initial / Return Visit	Today's Date:	Date of onset / injury:	Circle if Applicable: Auto Accident / Work. Comp	
Date of Birth:	SS#:		Circle One: Right Handed / Left Handed	
Name:			Nickname:	
Street:		City:	State:	Zip:
Email:		Head of House:	Marital: Circle One S M W D	
Employment Status: Circle One Employed Part-time Student Full-time Student Other			Sex: M F	
Employer:		Occupation:	Phone (Cell): Phone Provider: Verizon Alltel AT&T Nextel Quest Sprint T-Mobile Verizon Virgin Mobile	
Phone (Home):		Phone (Work):		
Please allow our office to photocopy the following items: <input type="checkbox"/> All medical cards <input type="checkbox"/> Who is the primary card holder(s)?			Referred By:	
Have you been to another chiropractor this calendar year? If yes, how many times?		Y / N	Have you received Physical Therapy services this calendar year? If yes, how many times?	

SPOUSE INFORMATION

Name:	Date of Birth:
SS#:	Occupation:
Employer:	Employer Phone Number:

RELATIVE TO CONTACT in Case of Emergency (Not Living in Home of Patient)

Name:	Relationship:
Phone:	Address:

INSURANCE INFORMATION

Name of Insured:	Date of Birth:
Insurance Company:	ID:
Group Number:	

HOW WERE YOU REFERRED TO OUR OFFICE?

Name:	Circle One: Attorney Doctor Patient Other _____
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PATIENT NAME: _____

IS YOUR ILLNESS OR INJURY RELATED TO ANY OF THE FOLLOWING?

Circle One: Employment Emergency Accident Auto Accident	If Auto Accident, please print the state where the accident occurred:
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PERSONAL ASSESSMENT

Has this problem been getting:	Better	Worse	Staying the Same	
Have you ever been treated by a chiropractor?			Yes	No
If yes, how many times this year?				
Have you ever been treated for physical therapy?			Yes	No
If yes, how many times this year:				
Have you ever had the same of similar problem before?			Yes	No
Have you ever had medical treatment for this condition before?			Yes	No
Have you ever had any significant accidents or falls?			Yes	No
Have you every been diagnosed as having a particular health condition?			Yes	No
Have you ever had surgery? Types / How much?			Yes	No
Females Only: Are you pregnant? Date of last menstrual cycle?	MAYBE		Yes	No

PERSONAL MEDICAL HISTORY: (Circle Relevant Conditions)

Allergies: Yes No Please List:	Asthma	Alchol / Drug fProblems
Cancer	Diabetes	Digestinve Disorders
Epilepsy	Heart Problems / High Blood Pressure	Sinus Trouble
Smoker (if yes, amount)	Urinary Tract / Kidney Disease	Venereal Disease / Aids
Other:	Pediatric Immunizations up to Date: Yes No	
Do you have an Advanced Healthcare Directive / Living Will? Yes No If yes, please provide ESC with a copy		

Acknowledgement of Receipt of Notice of Privacy Practices for Protected Health Information

I acknowledge that I have received and/or was shown the posted copy displayed in the patient waiting area of Ewer Specific Chiropractic's Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient: _____
Print Name

Signature of Patient/Personal Representative

PATIENT NAME: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of spinal nerve interference. Our chiropractic method of correction is by specific adjustments to the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: Also known as spinal nerve interference. A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature Date

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____.

Signature Date

Consent to Treatment - I hereby give permission to the Doctor to release any information requested by my insurance company acquired in the course of my examination and/or treatment.

Doctor Permission - I hereby give permission to the Doctor (and whomever he may designate as his assistants) to administer treatment of my condition. I also certify that no guarantee has been made as to the results that may be obtained.

Information Review - I hereby verify that I have read and reviewed the above information and represent that same is true, correct, and complete. I understand that the Doctor will be relying on the above information in his treatment of me.

Financial Responsibility and Assignment of Benefits – I agree to pay all charges for medical and health care services not covered by my insurance company.

I certify that I have read this form and understand its contents.

(Patient or other legally authorized person) (Date)

Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

CHIEF COMPLAINT

2ND COMPLAINT

3RD COMPLAINT

I. First Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section.)																																						
<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p> <input type="checkbox"/> Front of Head</p> <p> <input type="checkbox"/> Top of Head</p> <p> <input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. Types of pain</p> <p><input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting</p> <p><input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping</p> <p><input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting</p> <p>Other types of pain: _____</p>	<p>3. Pain Frequency</p> <p><input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time</p> <p><input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time</p>																																				
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III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom).																																						
<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p> <input type="checkbox"/> Front of Head</p> <p> <input type="checkbox"/> Top of Head</p> <p> <input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. Types of pain</p> <p><input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting</p> <p><input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping</p> <p><input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting</p> <p>Other types of pain: _____</p>	<p>3. Pain Frequency</p> <p><input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time</p> <p><input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time</p>																																				
<p>4. Pain Intensity (How it affects your daily activities)</p> <p><input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects</p> <p><input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities</p>	<p>6. Actions affecting this pain</p> <p style="text-align: center;">Brings On Aggravates Relieves</p> <p><input type="checkbox"/> In the A.M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> In the P.M. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Bending forward <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Bending back <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Bending left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Bending right <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Twisting left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Twisting right <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Coughing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Sneezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Straining <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Lifting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other Actions: _____</p>																																					
<p>5. Does this pain radiate into other body parts?</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Left</th> <th style="text-align: center;">Right</th> <th style="text-align: center;">Both</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Neck</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Shoulder</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Arm</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hand</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Hip</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Leg</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Foot</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table> <p>Other locations of radiation: _____</p>				Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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IF PATIENT HAS MORE THAN 3 COMPLAINTS
PLEASE ASK FOR ADDITIONAL FORMS

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty.

1 = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it all, because of the pain". **Only fill in areas affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing ___ Drying hair ___ Brushing teeth ___ Putting on shoes ___ Preparing meals ___ Taking out trash .. ___
 Showering ___ Combing hair ___ Making bed ___ Tying shoes ___ Eating ___ Doing laundry ___
 Washing hair .. ___ Washing face ___ Putting on shirt ___ Putting on pants ___ Cleaning dishes ___ Going to toilet ___

Difficulties with Physical Activities

Standing ___ Walking ___ Kneeling ___ Bending back ___ Twisting left ___ Leaning back ___
 Sitting ___ Stooping ___ Reaching ___ Bending left ___ Twisting right ___ Leaning left ___
 Reclining ___ Squatting ___ Bending forward .. ___ Bending right ___ Leaning forward ___ Leaning right ___
 Standing for long periods ___ Sitting for long periods..... ___ Walking for long periods..... ___ Kneeling for long periods ___

Difficulties with Functional Activities

Carrying small objects ___ Lifting weights off floor ___ Pushing things while seated ___ Exercising upper body ___
 Carrying large objects ___ Lifting weights off table ___ Pushing things while standing .. ___ Exercising lower body ___
 Carrying brief case ___ Climbing stairs ___ Pulling things while seated ___ Exercising arms ___
 Carrying large purse ___ Climbing inclines ___ Pulling things while standing ___ Exercising legs ___

Difficulties with Social and Recreational Activities

Bowling ___ Jogging ___ Swimming ___ Ice Skating ___ Competitive Sports .. ___ Dating ___
 Golfing ___ Dancing ___ Skiing ___ Roller Skating ___ Hobbies ___ Dining out ___

Difficulties with Travelling

Driving a motor vehicle ___ Riding as a passenger in a motor vehicle ___ Riding as a passenger on a train ___
 Driving for long periods of time ___ Riding as a passenger on an airplane ___ Riding as a passenger for long periods ___

Use the following 1 to 5 scale to describe the difficulties below:

1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating..... ___ Hearing..... ___ Listening..... ___ Speaking..... ___ Reading..... ___ Writing..... ___ Using a keyboard..... ___

Difficulties with the Senses

Seeing..... ___ Hearing..... ___ Sense of touch..... ___ Sense of taste..... ___ Sense of smell..... ___

Difficulties with Hand Functions

Grasping..... ___ Holding..... ___ Pinching..... ___ Percussive movements..... ___ Sensory discrimination..... ___

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep..... ___ Being able to participate in desired sexual activity..... ___

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- I have NOT had prior symptoms similar to my current complaints.
 My current complaints DID exist before, but have not been bothering me.
 My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- My history HAS contributed to my current symptoms.
 My history HAS NOT contributed to my current symptoms.
 I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (if applicable) occurred..... ___ months ago / years ago Or on Date: ___/___/___

Write in below any other Prior Symptom History, not covered above: