Welcome to our office!

Adult Intake Form

Date: ______________________ PLEASE PRINT – THANK YOU

PERSONAL INFORMATION

First Name: ____________ M.I.: _____ Last Name: ____________

Preferred Name: ____________

Address: ____________

City / Prov / PC : ____________

Home Phone: (   ) ____________ Work Phone: (   ) ____________

Cell Phone: (   ) ____________ Email: ____________

Birth Date: ____________ Age: _____ Sex: M F

Occupation: ____________ Employer's Name: ____________

Marital Status: S M D W Other Spouse's Name: ____________

# of Children: ________ Children's Names & Ages: ____________

____

Who can we thank for referring you or how did you hear about our office? ____________

____

Do you have an extended health insurance plan through your place of work? (Benefits) ❑ Y ❑ N

If yes, Name of Insurance Company ____________

REASON FOR SEEKING CARE

What is your reason for seeking care at Lakeside Family Chiropractic? ____________

____

When did this begin? (If applicable) ____________

Are there any major injuries, (auto accidents, falls, concussions) and/or surgeries we should know about? ____________

____

What is this affecting that is MOST important in your life? (List all that apply)

____

Have you seen any other providers for this condition? (List all that apply)

____

Have you seen a chiropractor before? Yes No If yes, were X-Rays taken? Yes No

How long ago? ________ Clinic/Doctor Name: ____________

What is your reason for the change? (If applicable) ____________

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: ____________

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

Print Patient's Name: ______________________ Date: ____________

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Digestive Troubles
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Hypertension
- ☐ Arthritis
- ☐ Loss of Balance
- ☐ Neck/Back Pain
- ☐ Pain in Arms/Legs
- ☐ Irritabilty
- ☐ Fatigue/Sleep Issues
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Sensitivity to Light
- ☐ Loss of Concentration
- ☐ Memory Problems
- ☐ Headaches
- ☐ Stiffness/Flexibility
- ☐ Sinus Troubles/Allergies
- ☐ Cold Hands/Feet
- ☐ Other ______________________

Explain any boxes checked above or add additional concerns:

____

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____

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____

Is there anything else regarding your current condition you feel the doctor should know? ______________________

____

____

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Blood Pressure
- ☐ Pain Narcotics
- ☐ Muscle Relaxers
- ☐ Migraine/Headache
- ☐ Cholesterol
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Other ______________________
- ☐ Other ______________________
- ☐ Other ______________________

Explain any boxes checked above: ______________________

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EMERGENCY CONTACT

First Name: ______________________ M.I.: __________

Last Name: ______________________

Preferred Name: ______________________

Address: ______________________

City / Prov. / Postal Code ______________________

Phone: (   ) ______________________

DID YOU KNOW...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue / Sleep Problems
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems
Indigestion

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in Legs
Reproductive Problems

C1 C2 C3 C4 C5 C6 C7
T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12
L1 L2 L3 L4 L5
SACRAL

VITAMINS / SUPPLEMENTS

- ☐ Multi-Vitamin
- ☐ Vitamin D3
- ☐ ______________
- ☐ ______________
- ☐ Fish Oil/Omega-3
- ☐ Probiotics
- ☐ ______________
- ☐ ______________

Explain any boxes checked above:

____

____

____

Print Patient's Name: ______________________________ Date: ______________

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

• In the event we can help you, we urge our patients to follow the doctor's recommendations for care. Payment is due upon services rendered. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, your care plan must be followed.

• ***A $25 fee will be charged to your account for any appointments missed without a 24 hour notice of cancellation. We require a credit or debit card on file due to this policy.***

• I authorize Lakeside Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

• If you have any questions about our financial policies, please speak with our staff. If you need to make special payment arrangements, we will do everything possible to meet your financial needs.

Patient Signature: ______________________________ Date: ______________

CONSENT TO/TERMS OF ACCEPTANCE

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) 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 progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic care in general, (including spinal adjustment), the care options are recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic care recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my person and future chiropractic care.

Dated this ______________ day of______________________________, 20____________.

Patient Signature (Legal Guardian) ______________________________

Witness of Signature ______________________________

Name: ______________________________ (please print)

Name: ______________________________ (please print)