

Chiropractic Center of Lakeland

Patient Intake Forms

PATIENT INFORMATION

Full Name: _____ Birthdate: _____ Date: _____

Address: _____ City: _____ State: _____

ZIP: _____ Primary Phone #: _____ Email: _____

Are you considered a minor? Yes No If Yes, who is the responsible payer? _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone #: _____

Do you have insurance we will be using? Yes No Insurance Company: _____

How did you hear about our office? _____

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American
White (Caucasian) / Hawaiian or Pacific Islander / Decline to Answer

MEDICAL HISTORY

Please mark for **CONDITIONS** you have had or currently have.

Headaches	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Neck	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	Frequent	<input type="checkbox"/>
Upper Back	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Urination	<input type="checkbox"/>
Mid Back	<input type="checkbox"/>	High Blood	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>
Low Back	<input type="checkbox"/>	Pressure	<input type="checkbox"/>	Angina	<input type="checkbox"/>		
Shoulder	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>		
Elbow/Arm	<input type="checkbox"/>	Cholesterol	<input type="checkbox"/>	Loss of Bladder	<input type="checkbox"/>		
Wrist/Hand	<input type="checkbox"/>	Liver Disorder	<input type="checkbox"/>	Control	<input type="checkbox"/>		
Hip	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Abnormal Weight	<input type="checkbox"/>		
Leg	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Loss/Gain	<input type="checkbox"/>		
Knee	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Abominal Pain	<input type="checkbox"/>		
Ankle/Foot	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>		
Jaw	<input type="checkbox"/>	Gall Bladder	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>		

List Medication you are currently taking: _____

List past surgeries: _____

Please indicate if you have any immediate family members with the following conditions:

Rheumatoid Arthritis Diabetes Lupus Heart Problems
 Fibromyalgia Cancer Multiple Sclerosis

Women Only: Are you pregnant? Yes No How Long? _____ Nursing? Yes No



Full Name: _____

Date: _____

PRIMARY AREA OF COMPLAINT

What brings you into the office today?

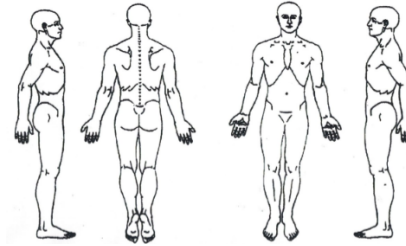
- Regional Pain, Recent Injury, Wellness Care (Skip the rest of this form)

Select ONE (the primary) region below where you feel the complaint (for additional complaints use next page)

- Neck and/or Upper Back, Mid-Back, Low Back/ Pelvis, Extremity: _____

The complaint is (Pick ONE):

- New, Comes and Goes, Chronic with WHEN, INITIAL START, MOST RECENT, WHEN fields



Please indicate where you feel the complaint:

What caused the complaint you are experiencing today?

The symptom is getting:

- Better, Worse, Staying the same

How often do you feel the symptom?

- Occasional, Intermittent, Frequent, Constant

___ / 10 * Please rate the intensity of your symptom TODAY from 0-10, with 10 being the worst possible.

How would you describe the feeling of your symptom? (Check all that apply):

- Ache, Tightness, Burning, Sharp, Tingling, Stabbing, Shooting, Throbbing, Pulling, Dull, Stiffness, Spasm

What makes the complaint worse?

What helps relieve the complaint?

Does the PAIN travel into your arms or legs? Yes No

* If yes, Where: _____

Have you had NEW NUMBNESS or TINGLING in your arms or legs since this started? Yes No

* If yes, Where: _____

What lifestyle activities does this interfere with? (Check all that apply)

- Personal Care, Prolonged Standing, Traveling, Sleeping, Social/Recreational Activities, Prolonged Sitting, Walking, Bending, Lifting, Other: _____

Are you currently or have you previously been treated for this problem? Yes No

* If yes, type of treatment: _____

Have you had any testing for this condition? Yes No

* If yes... X-ray, MRI, CT Scan, Other: _____

Doctor's Notes: _____

Full Name: _____

ADDITIONAL AREA OF COMPLAINT (SKIP IF YOU HAVE NO 2ND COMPLAINT)

Type of issue?

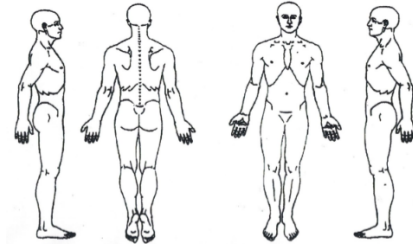
- Regional Pain Recent Injury

Select **ONE ADDITIONAL** region below where you feel a complaint.

- Neck and/or Upper Back Mid-Back Low Back/ Pelvis Extremity: _____

The complaint is (Pick ONE):

- New * WHEN: _____
 Comes and Goes * INITIAL START: _____
 * MOST RECENT: _____
 Chronic * WHEN: _____



Please indicate where you feel the complaint:

What caused the complaint you are experiencing today?

The symptom is getting:

- Better Worse Staying the same

How often do you feel the symptom?

- Occasional Intermittent Frequent Constant

___ / 10 * Please rate the intensity of your symptom TODAY from 0-10, with 10 being the worst possible.

How would you describe the feeling of your symptom? (Check all that apply):

- Ache Tightness Burning Sharp Tingling Stabbing
 Shooting Throbbing Pulling Dull Stiffness Spasm

What makes the complaint worse? _____

What helps relieve the complaint? _____

Does the PAIN travel into your arms or legs? Yes No

* If yes, Where: _____

Have you had NEW NUMBNESS or TINGLING in your arms or legs since this started? Yes No

* If yes, Where: _____

What lifestyle activities does this interfere with? (Check all that apply)

- Personal Care (washing, dressing, etc...) Prolonged Standing Traveling Sleeping
 Social/Recreational Activities Prolonged Sitting Walking Bending
 Lifting Other: _____

Are you currently or have you previously been treated for this problem? Yes No

* If yes, type of treatment: _____

Have you had any testing for this condition? Yes No

* If yes... X - ray MRI CT Scan Other: _____

Doctor's Notes: _____



PLEASE READ AND INITIAL EACH SECTION

Thank you for choosing us as your chiropractic healthcare provider. To help us provide timely care for all patients, we ask that you give at least **24 hours' notice** if you need to cancel or reschedule an appointment. Your appointment time is reserved specifically for you, and advance notice allows us to offer that time to another patient in need of care.

Initial:

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Our office **does not** charge for missed or cancelled chiropractic appointments; however, we appreciate your effort to keep your scheduled time whenever possible.

PLEASE NOTE : massage appointments require at least **24 hours' notice** to cancel or reschedule. A **\$25 cancellation fee** may apply for late cancellations or missed massage appointments.

When you begin care at The Chiropractic Center of Lakeland, our goal is to help improve spinal function and reduce interference caused by spinal joint restrictions or misalignments. Chiropractic care focuses on the evaluation and correction of spinal subluxations, which are areas of the spine that may not be moving or functioning properly.

Initial:

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Corrections are performed through chiropractic adjustments, either by hand or with a mechanical instrument, depending on the patient's needs.

Our office does not diagnose or treat diseases or conditions outside the scope of chiropractic care. If we find anything during your examination that appears unusual or may require care from another type of healthcare provider, we will recommend that you seek the appropriate evaluation.

The claims for treatment for my current condition which the doctor will diagnose with an onset date of _____ , is **NOT** related to an automobile accident, *(Today's Date)* workers compensation claim, or any other accident involving a third party or payor.

Initial:

[]

Patient Signature: _____

Date: _____



**Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and Consent
for Use of Health Information**

Name: _____ Date: _____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Note of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20 _____

By _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By _____
Signature of Parent/Guardian (Circle One)