CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
LAST NAME

_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ State_____ Zip _____

Cell Phone _____ Home Phone_____

Email _____

Sex ☐M ☐F Age _____ Date of Birth _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

SS # _____

Employer/School _____

Occupation _____

Primary Physician _____

Phone Number _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____Contact #_____

Who may we thank for referring you? _____

Have you ever received chiropractic care? ☐No ☐Yes Doctor's Name _____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

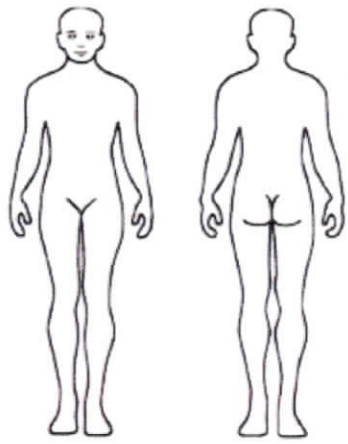
_____

If you are already experiencing a symptom, what is it? _____

How Intense are your symptoms? (circle)

0 (NO SYMPTOMS) 1 2 3 4 5 6 7 8 9 10 (INTENSE SYMPTOMS)

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check all that apply)

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swelling
- ☐ Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom/condition interfering with your life? (check all that apply)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Creativity	☐	☐	☐	☐
Other_____	☐	☐	☐	☐

How committed are you to correcting this issue?

0 (NO COMMITMENT) 1 2 3 4 5 6 7 8 9 10 (VERY COMMITTED)

PATIENT WELLNESS ASSESSMENT

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
I have serious concerns about my overall health	I feel worried about my health	I have constant concerns that affect my health	I have health challenges that affect me on a daily basis	I have some minor complaints about my health	I feel okay about my health with no complaints	I feel good most days	I feel well on a daily basis	I feel energetic and healthy	I feel active, energetic and fit	I feel great and am proactive about my health

What number best describes how you feel about your health today? _____ In what direction is your health currently headed? - +

What goals do you want to achieve? IMMEDIATE _____ SHORT TERM _____ LONG TERM _____

HEALTH & ILLNESS HISTORY

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues Constipation/IBS Diarrhea/GERD
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____

Allergies: _____ _____ _____

CHILDREN & PREGNANCY

of Children _____ Children's Ages _____ Currently Pregnant: ☐N ☐Y Due: _____ # Pregnancies _____

Children's Health Concerns: _____ Current Pregnancy Concerns: _____

MEDICATIONS & SUPPLEMENTS

Please list all medications and supplements and their dosages. Additionally, please bring them in so we can check for healthfulness and any contraindications they may have.

Medications	Dose	Supplements	Dose

DIETARY INTAKE SUMMARY

How many servings of fruit do you consume per day?_____

How many servings of vegetables do you consume per day?_____

How many servings of protein do you consume per day? _____

How many servings of bread/crackers/pasta do you consume per day? _____

Do you consume artificial sweeteners? ☐No ☐Yes Brands? _____

Do you consume fast food? ☐No ☐Yes If so, what do you typically eat? _____

Do you eat breakfast? ☐No ☐Yes If no, what is your first meal of the day? _____

Do you consume alcoholic beverages? ☐No ☐Yes If yes, how many per week? _____

Do you consume coffee? ☐No ☐Yes If yes, how many cups per day? _____

Please indicate the areas of health that you want to improve:

- ☐ Lose Weight
- ☐ Improve blood work
- ☐ More Energy
- ☐ Prevent problems
- ☐ Sleep better
- ☐ Anti-aging support
- ☐ Improve digestion
- ☐ Improve general health

PRIVACY PRACTICES ACKNOWLEDGEMENT

Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____ Birthdate_____

Signature_____

Date_____

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WELCOME

We want to thank you for choosing Get Well Family Health & Chiropractic and for giving us the chance to help you. With your cooperation, we are sure that you will obtain the results you seek. We will do whatever it takes to help you get well as soon as possible.

The purpose of our office is to serve you and we will be happy to answer any questions concerning your health care. We pride ourselves on serving happy, healthy and enthusiastic practice members. Also, please let us know if there is ever an issue or problem you need to discuss (e.g. concern about your care, finances, long waits, etc.). Your comments help us to identify areas of concern and thus help our office improve our service to our practice members.

As you begin to improve, share your joy and health with your friends and loved ones. We always appreciate referrals! Once again, thank you for choosing our office and we look forward to working with you to help you regain optimum health.

Sincerely,

Dr. Robyn Lawrence

Appointments and Office Procedures

Arrival. When you arrive at our office, please sign in and then have a seat or head to your assigned therapy area. The Chiropractic Assistant (CA) is available to handle all front desk business. The CA will make your next appointment, handle any other business you may have and, of course, collect the fee for that day.

Appointments. You will need a 30 minute appointment for your Report of Findings visit (second visit). Your third and subsequent visits to our office will take only 5-15 minutes total with the doctor. If an appointment must be changed, please notify our office immediately so that someone else can be scheduled in your appointment time. Try to reschedule for the same day if possible. If you cannot make it the same day, we ask that you make up that scheduled appointment as soon as possible, preferably the next day. Missed appointments cause patients to lose ground and not get the results that are expected. If you miss your appointment and fail to call us, we will call you to reschedule.

Your schedule. We will recommend a specific schedule of chiropractic care for you which will be outlined in a three to twelve month care plan during your Report of Findings visit. A certain number of adjustments within a certain amount of time is necessary for us to get the results that we both desire.

Fast service. You may be surprised at how quickly we can get you in and out of your chiropractic appointment. Most patients appreciate the fact that we respect their time. We know that your time is just as valuable as ours, so we promise that we won't waste it if at all possible. If ever you need to spend extra time with the doctor for any reason, we will be happy to schedule an appointment at a time when we can give you the attention and the care you need.

No doors. A unique feature of our office is the fact that there are no doors on the adjusting room. You would be surprised at how the simple act of opening and closing doors all day can add precious minutes to the time it takes to care for all of our patients. Obviously, if you ever have a highly personal or sensitive situation to discuss with the doctor, we will be happy to take you to a private room to discuss it.

Bring your children in for checkups. Children are always welcome in the office. Consider having them receive chiropractic care as well. Children are just as susceptible to spinal injury and trauma as you are, perhaps even more so! Don't wait until they have health problems of their own to get them checked out. Newborn children are not too young to get their first spinal examination. The birth process is often the first spinal trauma. We have a lot of experience with taking care of children and the procedures we use on children are very gentle and safe.

Report of Findings

The Report of Findings (ROF) appointment is perhaps the most important visit you will ever make to our office. We will address the issues that brought you into our office and explain how you can save money by not being dependent on us, get well faster, and improve the quality of your health for life. We will discuss how the body functions, how chiropractic care works to bring back your health and how the best results are produced.

Once you have the opportunity to understand WHY we do your exam, we will then review your exam findings and your personalized health report. This will be done in private and it is typically the only time that you will view your x-rays, if they were taken. We will review our recommendations and establish an initial three month care plan that helps you reach your health goals in the most cost-effective manner. You will also receive your first treatment in the office. Ideally, this appointment needs to be scheduled in the same week as your initial appointment, so check your schedule and let us know which time works best for you.

Please let us know if there is a scheduling conflict with your work or school. If necessary, we will provide you with a written excuse to allow you to attend these very important functions.

We ask that you bring your spouse, if married, or significant other. We want them to see and to hear the ROF so he or she can better understand chiropractic care and the reasons for the recommendations we make. We will also answer any questions regarding fees and insurance issues that you might have.

Once we have decided which type of chiropractic care you wish to receive, it is very important that you follow your schedule. It took time for you to lose your health and it will take time to regain it. With your full cooperation, we will do our very best to ensure that you get the results that chiropractic care is capable of delivering and that you deserve. For us to do that, we need you to seriously take responsibility for your health.

We thank you for entrusting us with the care of your heath. We know that you'll be very happy with your experience in our office.

Our Mission

To educate as many families as possible of the devastating effects of vertebral subluxation and move them toward optimal health with the tools and technology available to correct the 3 causes of vertebral subluxation - toxins, traumas and thoughts.