

GENERAL PATIENT INFORMATION

Please, complete this entire patient intake form so that the doctor can make his best recommendations for your condition

Name: _____

Address: _____

Birthdate: _____ Age: _____ Sex: M _____ F _____

***If minor list both biological parents' names*

Mother _____

Father _____

Cell phone #: _____

Occupation: _____

Employer: _____

Spouse: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

How did you hear about us? _____

ACCIDENT/INJURY INFORMATION

Is this due to an accident/injury? Yes or No, if yes date _____

Type of accident/injury: Auto Work Home Other

Describe Accident: _____

PAST ACCIDENTS/INJURIES/SURGERIES/MEDICATIONS

List any sport, recreational or home injuries _____

List any automobile accidents and injuries _____

List any hospitalizations and surgeries _____

List all spinal surgeries or other procedures _____

List medications, over the counter drugs and vitamins you take _____

Are you currently under the care of other practitioners?

If yes explain: _____

REASONS FOR SEEKING CARE

1. _____ How long has this been an issue? _____

Is it: Dull ___ Sharp ___ Ache ___ Numb/Tingle ___ Stabbing ___ Constant ___ Occasional ___ Staying the Same ___ Worsening ___

Rate the pain: No pain 0 1 2 3 4 5 6 7 8 9 10 Severe My pain is worse in morning/evening? _____

2. _____ How long has this been an issue? _____

Is it: Dull ___ Sharp ___ Ache ___ Numb/Tingle ___ Stabbing ___ Constant ___ Occasional ___ Staying the Same ___ Worsening ___

Rate the pain: No pain 0 1 2 3 4 5 6 7 8 9 10 Severe My pain is worse in morning/evening? _____

3. _____ How long has this been an issue? _____

Is it: Dull ___ Sharp ___ Ache ___ Numb/Tingle ___ Stabbing ___ Constant ___ Occasional ___ Staying the Same ___ Worsening ___

Rate the pain: No pain 0 1 2 3 4 5 6 7 8 9 10 Severe My pain is worse in morning/evening? _____

Please mark an X on the diagram to the right where you have symptoms.

What makes your conditions better? _____

What makes your conditions worse? _____

What doctors have you seen for these conditions? _____

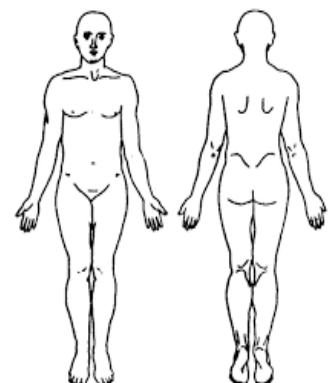
List treatments _____

Results of these treatments _____

I am interested in: Temporary relief YES NO A solution to my problem YES NO

Pt/Guardian Signature _____ Today's Date: _____

John G. Schutz, D.C.



FAMILY HISTORY: (Please circle all who apply)

Diabetes	Mother	Father	Sister	Brother	Kidney problems	Mother	Father	Sister	Brother
Heart disease	Mother	Father	Sister	Brother	Headaches	Mother	Father	Sister	Brother
Heart problems	Mother	Father	Sister	Brother	Back or neck pain	Mother	Father	Sister	Brother
Cancer	Mother	Father	Sister	Brother	Arthritis	Mother	Father	Sister	Brother
					Other:	_____			

Please check all that apply:

Now	Previously	GENERAL
___	___	Anemia
___	___	Cancers or Tumors
___	___	Diabetes
___	___	Epilepsy
___	___	Hepatitis
___	___	Polio
___	___	Rheumatic Fever
___	___	Scarlet Fever
___	___	Thyroid Conditions
___	___	Sexually Transmitted Diseases
___	___	Surgeries (any type)
___	___	AIDS or AIDS related complex
___	___	Tuberculosis

BY SYSTEMS

___	___	Convulsions
___	___	Dizziness
___	___	Mental Illness
___	___	Depression or Nervousness
___	___	Headaches
___	___	Paralysis
___	___	Night Sweats
___	___	Tremors
___	___	Weight Gain or Weight Loss
___	___	Alcoholism
___	___	Childhood Diseases

EYES EARS NOSE THROAT RESPIRATORY

___	___	Chronic Colds
___	___	Chronic Cough
___	___	Sinusitis
___	___	Allergies
___	___	Difficulty Breathing
___	___	Pneumonia
___	___	Chest or Rib Pain

EXERCISE

___	Light
___	Moderate
___	Heavy
___	Daily

WORK ACTIVITY

___	Sitting Mostly
___	Standing Mostly
___	Light Labor
___	Heavy Labor
___	Unemployed

HABITS

___	Smoking
___	Alcohol
___	Caffeine/Soda Pop
___	Drugs

CARDIOVASCULAR

Now	Previously	Chest Pain
___	___	Rapid Heart Beat
___	___	High or Low Blood Pressure
___	___	Pace Maker
___	___	Other _____

MUSCULOSKELETAL

___	___	Arthritis
___	___	Osteoporosis
___	___	Neck Pain
___	___	Pain or Weakness Radiating into Arms
___	___	Mid Back Pain
___	___	Pain Radiating Around Ribs
___	___	Low Back Pain
___	___	Pain or Weakness Radiating into One or Both Legs
___	___	Arm, Elbow or Wrist Pain
___	___	Leg, Knee, or Ankle Pain

GASTROINTESTINAL & GENITOURINARY

___	___	Acid Reflux
___	___	Stomach Pains
___	___	Nausea
___	___	Gallbladder Condition/Problems
___	___	Liver Condition/Problems
___	___	Blood In Stool
___	___	Constipation or Diarrhea
___	___	Colitis/Diverticulitis
___	___	Excessive Urination
___	___	Blood in Urine
___	___	Painful Urination
___	___	Kidney Condition/Problems
___	___	Prostate Condition/Problems

FEMALE REPRODUCTIVE

___	___	Premenstrual Syndrome
___	___	Menstrual Conditions/Problems
___	___	Menopausal Symptoms/Hot Flashes
___	___	Breast Soreness/Lumps/Discharge

ARE YOU PREGNANT? YES NO

EXERCISE

___	Light
___	Moderate
___	Heavy
___	Daily

WORK ACTIVITY

___	Sitting Mostly
___	Standing Mostly
___	Light Labor
___	Heavy Labor
___	Unemployed

HABITS

___	Smoking	Packs Per Day _____
___	Alcohol	Drinks Per Day/Week _____
___	Caffeine/Soda Pop	Cups per Day _____
___	Drugs	Type _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Waverly Chiropractic Specialties. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my scheduled care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this clinic to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning your information, if you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you in our waiting room or at the front desk.

Patient/Parent/Legal Guardian Authorizing Care _____ Today's Date _____

Informed Consent Notification for Chiropractic Care

As is the case with the practice of medicine, chiropractic care is not an exact science and therefore risks and limitations do apply. Below is a non-conclusive list of possible adversities associated with chiropractic adjustments, manual therapies, exercise therapies, physiologic modalities, and spinal decompression.

Sprains/strains and or other injury to muscles, ligaments, spinal discs; bruising to the spine, ribs, and extremities, headache, spinal and rib fractures, extremity pain. Heart related adversities including heart attack with exercise therapy. Burns to the skin with heat therapy, ultrasound, and electric modalities, frost-bite to the skin with the use of ice or cold therapies.

It is inconclusive at this time as to the association of spinal manipulation relative to stroke. A nine year study on over 110 million people, demonstrated no greater likelihood when seeing a chiropractor compared to seeing a medical provider. The proposed risk is approximately 1 in 5 million.

Options for treating your symptoms may include medical intervention, other therapies, over the counter medications, and surgery, if you chose any of these please speak to the treating health care provider to discuss these risks. You also have the choice to refuse care; by doing so there is every possibility that the underlying cause or pathology of your condition will continue to worsen. Over time this process may complicate treatment making it more difficult and less effective.

Rarely, one may feel somewhat worse during the initial phase of chiropractic care. If you ever have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform the doctor. Please make sure you inform our doctor of any adversities to your care or changes in your health.

I have read, or have had read to me the above consent information, I have discussed and understand the risks associated with the use of manual therapies, physiologic modalities, exercise therapy and spinal decompression of which this clinic employs. I also understand there is no guarantee of cure or successful treatment outcome.

By signing below, I hereby give my consent for chiropractic treatment and diagnostic procedures for myself or my child.

Please print patients name _____ DOB: _____

Patient/Parent/Legal Guardian Signature _____ Today's Date: _____

Relationship to The Patient (circle one): SELF FATHER MOTHER LEGAL GUARDIAN

PAIN/CONDITION DISABILITY QUESTIONNAIRE and INSTRUCTIONS: These Questions ask your views on how your pain or condition currently affects your everyday functional activities. Please answer every question and mark the ONE number on EACH scale that best represents the way you feel.

Patients Name _____ **DOB:** _____ **Today's Date:** _____
(PATIENT MUST FILL IN NAME)

Primary reason for your visit (condition) _____

Please rate your symptoms: 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----
NONE SEVERE

Does your condition interfere with your normal work inside or outside the home?

Work Normally Unable to work at all
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----

Does your condition interfere with personal care?

Take care of myself completely Need help with all my personal care
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----

Does your condition interfere with traveling?

Travel anywhere I like Only travel to see doctors
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----

Does your condition affect your ability to sit or stand?

No problems Cannot do at all
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----

Does your condition affect your ability to lift overhead, grasp objects, or reach for things?

No problems Cannot do at all
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----

Does your condition affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems Cannot do at all
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----

Does your condition affect your ability to walk or run?

No problems Cannot walk/run at all
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----

Has your sleep been impaired since your condition began?

No impairment Severe impairment
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----

Do you take pain or other types of medication to control your condition?

No medication needed On pain medication throughout the day
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----

Does your condition interfere with recreational activities and hobbies that are important to you?

No interference Total interference
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10-----