

# Holland Family Chiropractic New Patient Intake Form

**Patient Data** \_\_\_\_\_ **Date** \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Preferred name \_\_\_\_\_

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Marital Status:  Single  Married  Other

Employment Status:  Employed  Unemployed  FT Student  PT Student  Other \_\_\_\_\_

**Employer Data** \_\_\_\_\_

Name \_\_\_\_\_

Your Occupation \_\_\_\_\_ Your Job Description \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Spouse Data** \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_

Contact Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Contact Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

**Have you been to a chiropractor before?** \_\_\_\_\_ **If so, who did you see?** \_\_\_\_\_

**Medical Conditions:** (Check all that apply to you)

- |                                       |  |  |  |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Other _____  |  |  |  |

**Surgeries:** (Check all that apply to you)

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy      | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical spine | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate                 | <input type="checkbox"/> Lumbar spine   | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Brain             | <input type="checkbox"/> Shoulder                 | <input type="checkbox"/> Thoracic spine | <input type="checkbox"/> Knee         |
| <input type="checkbox"/> Carpal Tunnel     | <input type="checkbox"/> Gastro-intestinal        | <input type="checkbox"/> Uro-genital    | <input type="checkbox"/> Hernia       |
| <input type="checkbox"/> Other _____       |   |   |                                       |

**Allergies:** (Check all that apply to you)

- |                               |   |  |                                      |
|-------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanuts     |
| <input type="checkbox"/> Soy  | <input type="checkbox"/> Sulfites           | <input type="checkbox"/> Wheat/Glutens   | <input type="checkbox"/> Other _____ |

**Social History:** (Check all that apply to you)

- |                  |                                      |                                      |                                |
|------------------|--------------------------------------|--------------------------------------|--------------------------------|
| Caffeine use:    | <input type="checkbox"/> occasional  | <input type="checkbox"/> often       | <input type="checkbox"/> never |
| Drink Alcohol:   | <input type="checkbox"/> occasional  | <input type="checkbox"/> often       | <input type="checkbox"/> never |
| Exercise:        | <input type="checkbox"/> occasional  | <input type="checkbox"/> often       | <input type="checkbox"/> never |
| Chew Tobacco:    | <input type="checkbox"/> occasional  | <input type="checkbox"/> often       | <input type="checkbox"/> never |
| Cigarettes:      | <input type="checkbox"/> <1 pack/day | <input type="checkbox"/> >1 pack/day | <input type="checkbox"/> never |
| Wear Seat Belts: | <input type="checkbox"/> occasional  | <input type="checkbox"/> always      | <input type="checkbox"/> never |
| Other _____      |                                      |                                      |                                |

**Family History:** (Check all that apply)

- |               |                                 |                                  |
|---------------|---------------------------------|----------------------------------|
| Arthritis:    | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Cancer:       | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Diabetes:     | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Heart Disease | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Hypertension  | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Stroke        | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Thyroid       | <input type="checkbox"/> Parent | <input type="checkbox"/> Sibling |
| Other _____   |                                 |                                  |

**Occupational Activities:** (Check one that best describes your job description)

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Administration           | <input type="checkbox"/> Business Owner      | <input type="checkbox"/> Clerical/Secretary | <input type="checkbox"/> Computer User |
| <input type="checkbox"/> Heavy Equipment operator | <input type="checkbox"/> Daycare/Childcare   | <input type="checkbox"/> Construction       | <input type="checkbox"/> Health Care   |
| <input type="checkbox"/> Food Service Industry    | <input type="checkbox"/> Medium Manual Labor | <input type="checkbox"/> Manufacturing      | <input type="checkbox"/> Home Services |
| <input type="checkbox"/> Heavy Manual Labor       | <input type="checkbox"/> Light Manual Labor  | <input type="checkbox"/> Executive/Legal    | <input type="checkbox"/> Housekeeper   |
| <input type="checkbox"/> Other _____              |  |   |  |

Doctor's Signature \_\_\_\_\_

**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**Review of Systems** – (Check box if you have had trouble with any of the following, circle NO if none)

<b>Cardiovascular</b>			No	<b>Respiratory</b>			No	<b>Allergic/Immunologic</b>			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								<b>Ear, Nose and Throat</b>			No
Jaw Pain				<b>Eyes</b>			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
<b>Genitourinary</b>			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				<b>Psychiatric</b>			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				<b>Gastrointestinal</b>			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				<b>Endocrine</b>			No	Bowel Problems			
<b>Neurologic</b>			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				<b>Hematologic</b>			No				
Pinched Nerves					Past	Present		<b>Musculoskeletal</b>			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
<b>Constitutional</b>			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Signature \_\_\_\_\_

**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

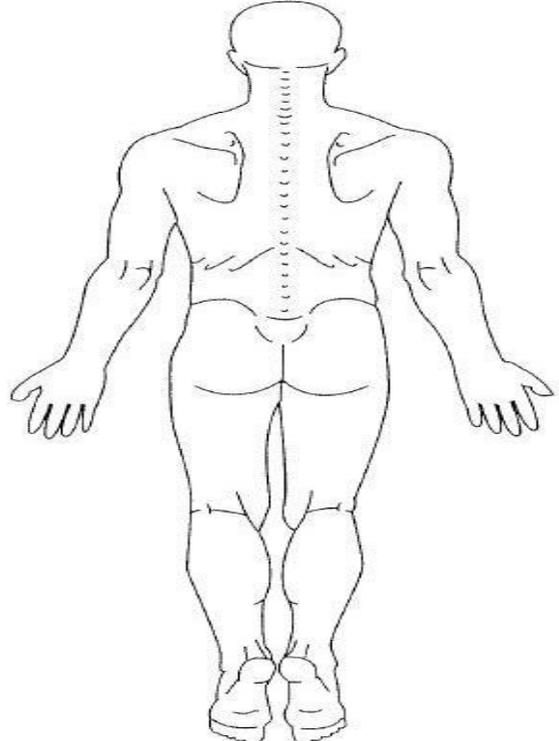
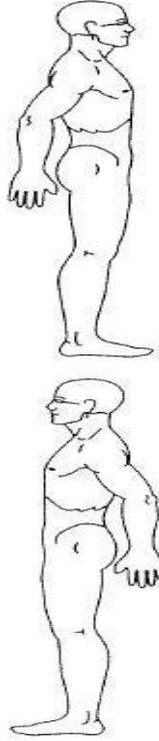
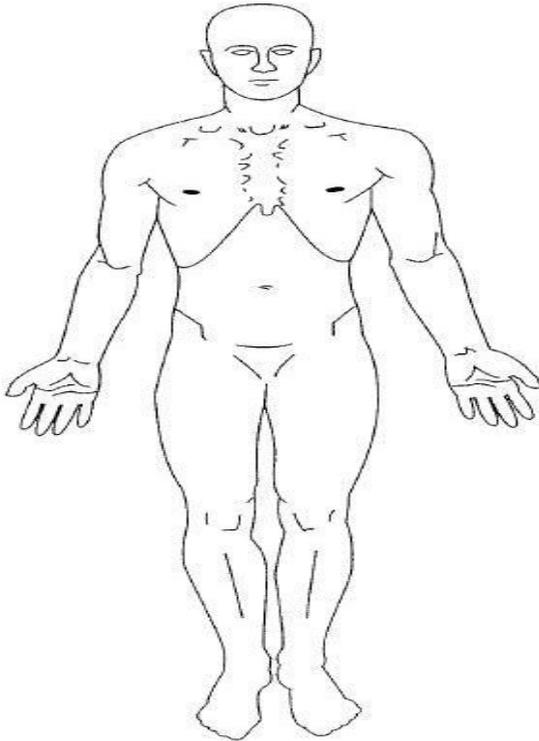
**N=Numbness**

**B=Burning**

**S=Stabbing**

**T=Tingling**

**A=Dull Ache**



Describe your symptoms in order of severity, with worse symptom being #1: \_\_\_\_\_

When did your symptoms begin? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Are your symptoms a result of:  Motor Vehicle Accident  Work related Accident  Other \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

How often do you experience your symptoms?

Constantly  
(76-100% of the day)

Frequently  
(51-75% of the day)

Occasionally  
(26-50% of the day)

Intermittently  
(0-25% of the day)

What describes the nature of your symptoms?

Sharp

Dull ache

Numb

Shooting

Burning

Tingling

Stabbing

Other \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

**Patient Name**

**Date**

**How are your symptoms changing?**

- Getting better
- Not changing
- Getting worse

**Daily Activities: Effects of Current Condition on Performance**

- Bending:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Care –Infirm Family:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Carrying Groceries:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Change Posn–Sit-Stand:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Climb Stairs:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Driving:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Extended Computer Use:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Feeding:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Household Chores:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Kneeling:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Lift Children:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Lifting:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Pet Care:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Reading (Concentration):  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Self Care–Bathing:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Self Care–Dressing:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Self Care–Shaving:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Sexual Activities:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Sleep:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Static Sitting:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Static Standing:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Walking:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform
- Yard Work:  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (Limited)  **Sev** Unable to Perform

**Recreational Activity: Effects of Current Condition on Performance**

- \_\_\_\_\_  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (limited)  **Sev** Unable to Perform
- \_\_\_\_\_  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (limited)  **Sev** Unable to Perform
- \_\_\_\_\_  **No Effect**  **Mild** Painful (Can do)  **Mod** Painful (limited)  **Sev** Unable to Perform

**For office use only**

**Employment, ADL, and Recreation Information**

Outcomes Assessment Tool Used \_\_\_\_\_ Score \_\_\_\_\_

Description of Work: \_\_\_\_\_

Condition’s Effect On Job Performance:  **No Effect**  **Mild** (painful can do)  **Mod** (painful limited ability)  
 **Mod/Sev** (limited duty)  **Sev** (no limited duty)  **Sev** (can’t do limited duty)

Doctor’s Sign ature \_\_\_\_\_

**Patient Name**

**Date**

**Payment/Insurance Information:**

Who is responsible for your bill?    Self    Health Insurance    Spouse    Worker's Comp  
 Auto Insur.    Medicare    Medicaid    Other \_\_\_\_\_

Personal Health Insurance Carrier: \_\_\_\_\_ Insur. Card ID # \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_   Primary Care Physician \_\_\_\_\_

**Worker's Compensation Injury / Auto / Personal Injury:**

Have you filed an injury report with your employer?    Yes    No   Date: \_\_\_\_/\_\_\_\_/\_\_\_\_   Time: \_\_\_\_\_ am / pm

**HIPAA Privacy Practices**

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

Consent to Treat a Minor: (Minor's Printed Name) \_\_\_\_\_

Guardian / Spouse's Signature Authorizing Care \_\_\_\_\_

Date \_\_\_\_\_

**SIGNATURE OF PHYSICIAN:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# INFORMED CONSENT FORM

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

## The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

## Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> spinal manipulative therapy | <input type="checkbox"/> palpation           | <input type="checkbox"/> vital signs                |
| <input type="checkbox"/> range of motion testing     | <input type="checkbox"/> orthopedic testing  | <input type="checkbox"/> basic neurological testing |
| <input type="checkbox"/> muscle strength testing     | <input type="checkbox"/> postural analysis   | <input type="checkbox"/> Electrical Stim            |
| <input type="checkbox"/> ultrasound                  | <input type="checkbox"/> hot/cold therapy    |   |
| <input type="checkbox"/> radiographic studies        | <input type="checkbox"/> mechanical traction |   |
| <input type="checkbox"/> Other (please explain)      |  |   |
- 
- 
- 

## The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

## The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

**The availability and nature of other treatment options**

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**The risks and dangers attendant to remaining untreated**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.  
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with (*insert doctor’s name*) and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

\_\_\_\_\_  
Patient’s Name

TYLER HOLLAND, D.C.  
Doctor’s Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Parent or Guardian  
(if a minor)