Opdahl Chiropractic Intake Form

PATIENT INFORMATION

Today's Date _____

Last Name: _____ **First Name**: _____ **MI**: ___ **Previous Name**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Cell Phone: (____)_____ **Home Phone**: (____)_____ **Work Phone**: (____)_____

Email Address: _____ Your Email address will be used to send exercises and Information.

Date of Birth: _____ **Age**: _____ **Sex**: O Male O Female O _____ **Social Security Number**: _____

Occupation: _____ **Employer**: _____ **Work Address**: _____

Marital Status: O Single O Married O Divorced O Widowed O Other **Spouse's Name**: _____ **# of Children**: ____

Emergency Contact: _____**Relation**:_____ **Phone Number**: _____

How did you hear about this Office? _____

_____

Smoking Status: Daily / Occasional / Former / Never Smoked **Alcohol**: Daily / Social / Occasionally / Rarely / Former
Race: American Indian or Alaskan Native **/** Asian **/** Black or African American **/** White (Caucasian) **/** Native Hawaiian or Pacific Islander **/** Other **/** I Decline to Answer
Ethnicity: Hispanic or Latino/ Non-Hispanic or Non-Latino / I Decline to Answer

INSURANCE INFORMATION – PLEASE SHOW YOUR INSURANCE CARD TO FRONT DESK

Insurance Carrier: _____ O **Health Insurance** O **Auto** O **Work Comp** O **Other_____**

Policy Holder: _____ **Policy Holder Birth Date:**_____ **Policy Holder Employer**: _____

Policy Number: _____ Insurance Contact:_____

*******Please let us know if you are not the policy holder of this insurance plan*******

FAMILY HISTORY

Father: Serious Health Conditions: _____

Mother: Serious Health Conditions: _____

Siblings: Serious Health Conditions: _____

Children: Serious Health Conditions: _____

Any Other Serious Family Health Conditions? _____

_____

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CURRENT MEDICATIONS and the CORRESPONDING CONDITION (or provide a list)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICATION ALLERGIES or ADVERSE REACTIONS:

_____
_____
_____
_____
_____
_____

SURGERIES you have had:

_____
_____
_____
_____

SIGNIFICANT ACCIDENTS, or INJURIES:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any other health topics that you would like to discuss with Dr. Opdahl: i.e.: Nutrition/Supplements, Exercises, Stretches, etc.

_____
_____
_____
_____
_____
_____

Please check any HEALTH ISSUES/ILLNESSES YOU CURRENTLY HAVE or HAD

O Cancer
O Diabetes
O Heart Disease
O Stroke
O High Blood Pressure
O High Cholesterol
O Hypothyroidism
O Hyperthyroidism
O Osteoporosis
O Seizures
O Rheumatoid Arthritis
O Osteo Arthritis
O Fibromyalgia
O Anemia
O AIDS/HIV
O Asthma
O Bleeding Disorders
O Breast Lump
O Bronchitis
O Chemical Dependency
O Chicken Pox
O Chronic Fatigue
O Emphysema
O Epilepsy
O Gallstones
O Immune Deficiency
O Kidney Disease
O Hepatitis
O Hernia
O Gout
O Liver Disease
O Multiple Sclerosis
O Pacemaker
O Parkinson's
O Prosthesis
O Psychiatric Disorders
O Seizures
O Suicide Attempt
O Tuberculosis
O Tumors/Growths
O Ulcers
O Whooping Cough
O Other_____

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REVIEW OF SYSTEMS

*****Please check only CHRONIC or SIGNIFICANT health issues*****

Musculoskeletal: O Arm/hand pain O Back pain O Feet/leg pain O Herniated Disc O Hip pain
O Knee pain O Lower back pain O Mid back pain O Muscle or joint pain O Neck pain O Pinched nerve
O Shoulder pain O Stiffness O Swelling of joints O Upper back pain O Other_____

Cardiovascular/Respiratory: O Chest pain, pressure or discomfort O Persistent Coughing or blood
O Difficulty breathing O Dizziness/lightheaded O Fainting O Irregular heartbeat O Shortness of breath
O Swelling of Limbs O Wheezing O Other _____

Head/Neck: O Dizziness O Facial pain O Headache O Head injury O Jaw clicks O Migraines O Pain O Stiffness
O Swollen glands O Trouble swallowing O Other _____

Eyes: O Blurred vision O Burning O Cataracts O Dryness O Glasses/contacts O Glaucoma O Pain
O Vision problems O Other_____

Ears: O Decreased hearing O Earache O Ear infections O Poor balance O Poor hearing O Ringing in ears
O Other _____

Nose: O Allergies O Discharge O Nose bleeds O Sinus pressure/pain O Other _____

Throat/Mouth: O Bleeding O Dentures O Difficulty Swallowing O Hoarseness O Mouth pain O Non healing sores
O Sore throat O Tooth pain O Other _____

Urinary: O Blood O Burning/pain O Difficulty urinating O Frequent UTI O Frequent urination O Incontinence
O Kidney infections O Kidney stones O Urgency O Up at night O Other_____

Gastrointestinal: O Change in appetite O Change in bowel habits O Constipation O Diarrhea O Heartburn O Nausea
O Rectal bleeding O Swallowing difficulties O Jaundice O Other _____

Endocrine: O Cold/Heat intolerance O Constipation O Diarrhea O Dry skin O Excessive thirst O Sweating
O Other _____

Vascular/Hematologic: O Calf pain with walking O Cold hands and/or feet O Ease of bleeding O Bruising
O Leg cramping O Other _____

Neurologic: O Dizziness O Fainting O Frequent crying O Memory confusion O Nervousness O Numbness
O Poor concentration O Tingling O Tremors O Weakness O Other _____

Psychiatric: O Anxiety O Depression O Memory loss O Nervousness O Stress O Other _____

Female: O **Are you pregnant**? **O Yes O No** O Heavy bleeding O Hot flashes O Infections O Irregular periods O Leg cramps O Menstrual Issues O Mood swings O Frequent Vaginal Infections O Other_____

Male: O Discharge O Erectile dysfunction O Hernia O Impotence O Low sex drive O Masses or pain
O Painful urination O Prostate problems O Other _____

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES – HIPAA

I, _____, have been informed, and understand and agree to the Notice of Privacy Practices of Opdahl Chiropractic P.A. which describes the practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received or maintained by the practice. I have been offered the full policy pamphlet.

**PATIENT SIGNATURE: _____ DATE: _____

AUTHORIZATION AND ASSIGNMENT

I authorize Opdahl Chiropractic P.A. to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Opdahl Chiropractic P.A. authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

**PATIENT SIGNATURE: _____ DATE: _____

INFORMED CONSENT

I hereby authorize physicians and staff at Opdahl Chiropractic P.A. to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Opdahl Chiropractic P.A. responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is preformed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

**PATIENT SIGNATURE: _____ DATE: _____

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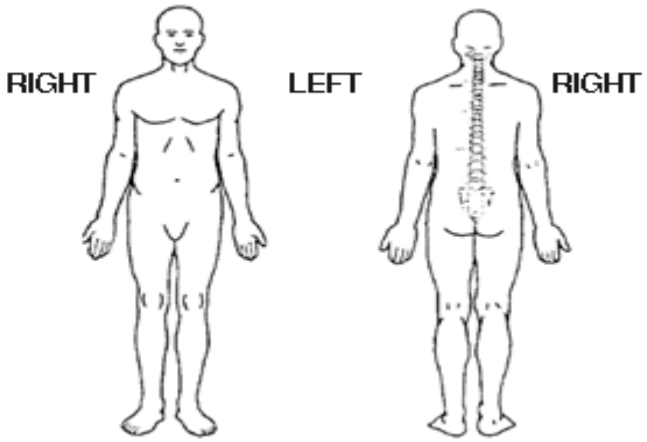
INFORMATION ABOUT TODAY'S CASE

Where are your symptoms? O Headache O Neck O Upper Back O Mid Back O Low Back/Pelvis/Buttocks O Radiating Arm/Leg Pain O Upper Extremity (Arm) O Lower Extremity (Leg) O Other: _____

_____

***Using the symbols in the "Pain Index Box", mark your areas of pain on the body Illustration below:

PAIN INDEX BOX
D = Dull Ache
B = Burning Pain
S = Sharp Pain
N = Numbness
T = Tingling
R = Radiating Pain



DATE YOUR SYMPTOMS BEGAN OR WORSENED : _____

WHAT CAUSED YOUR SYMPTOMS: _____

_____

_____

Describe your symptoms: Dull Ache / Sharp - with Movement / Burning / Numbness or Tingling **Other**: _____

Radiating to an arm or leg? O No O Yes **If "yes", where does the pain stop?** _____

How often is your pain? O **Occasional** (0-25%) O **Intermittent** (26-50%) O **Frequent** (51-75%) O **Constant** (76-100%)

Rate Your Pain										
	NO PAIN		MILD		MILD - MODERATE			SEVERE	VERY SEVERE	EMERGENCY ROOM
Worst Pain Felt:	0	1	2	3	4	5		6	7	8 9 10

Are your symptoms? O Staying the Same O Improving O Worsening

What relieves the discomfort? O Nothing O Ice O Heat O Rest O Medications O Other: _____

Please check *up to 5 activities* that make your pain worse? O Bending O Changing Positions O Child Care O Cleaning O Computer/Technology Use O Concentration O Deep Breaths O Driving O Dressing/Self Care O Exercise/Sports O Household Chores O Lifting O Lying Down O Reading O Sitting O Sleeping O Stairs O Standing O Turning Head O Walking O Working O Yard Work O Other: _____

When is your discomfort the worst? O Morning O Afternoon O Evening O All Day O Intermittent

Have you had these symptoms in the past? O No O Yes **When?**_____

Have you seen another provider for these current symptoms? O No O Yes **Who did you see?** _____