Date: _____

Name: _____ **Date of Birth:** _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Work: _____

E-mail:_____

Social Security # _____ Gender: Male Female

Relationship: Married Widowed Single Separated Divorced Minor

Occupation: _____ Employer: _____

Spouse's Name: _____ Date of Birth: _____

Referred by: _____

Primary Care Physician: _____ Phone #_____

Insurance Co. _____ ID # _____ Group #_____

Name of Insured: _____ DOB:_____ Relationship to Patient: _____

Secondary Insurance Co. _____ ID # _____ Phone # _____

Is condition due to an automobile/work accident? Y N Has auto insurance been contacted? Y N

Date of accident _____ Claim #_____ Party Responsible for Payment _____

Adjuster's Name _____ Phone # _____

IN CASE OF EMERGENCY, CONTACT:

Emergency Contact Name_____ Relationship_____ Phone _____

Primary Compliant (be specific): _____

When did it start: _____ Is the pain: Better Worse Same

Severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____ Is the pain: Constant Come and Go

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Stiffness Other

Other Complaints: _____

_____

Does the pain affect your daily activities?

Bending:	□ No Effect	□ Mild Pain	□ Moderate Pain	□ Severe Pain
Change Position:	□ No Effect	□ Mild	□ Moderate	□ Severe
Climb Stairs:	□ No Effect	□ Mild	□ Moderate	□ Severe
Driving:	□ No Effect	□ Mild	□ Moderate	□ Severe
House Chores:	□ No Effect	□ Mild	□ Moderate	□ Severe
Kneeling:	□ No Effect	□ Mild	□ Moderate	□ Severe
Lifting:	□ No Effect	□ Mild	□ Moderate	□ Severe
Dressing:	□ No Effect	□ Mild	□ Moderate	□ Severe
Sleeping:	□ No Effect	□ Mild	□ Moderate	□ Severe
Sitting:	□ No Effect	□ Mild	□ Moderate	□ Severe
Walking:	□ No Effect	□ Mild	□ Moderate	□ Severe
Yard Work:	□ No Effect	□ Mild	□ Moderate	□ Severe
Other_____	□ No Effect	□ Mild	□ Moderate	□ Severe

Review of Systems (Please fill out all sections)

Constitutional: ☐ Does not apply to me
☐ Fatigue ☐ Fever ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss

Eyes/Vision: ☐ Does not apply to me
☐ Blurred Vision ☐ Cataracts ☐ Change in Vision ☐ Double Vision ☐ Eye Pain ☐ Glaucoma

Ears, Nose, Throat: ☐ Does not apply to me
☐ Bleeding ☐ Difficulty Swallowing ☐ Discharge ☐ Dizziness ☐ Ear Drainage ☐ Ear Infection
☐ Ear Pain ☐ Fainting ☐ Headaches ☐ Head Injury ☐ Hearing Loss ☐ Hoarseness
☐ Sinus Infections ☐ Sore Throats (frequent) ☐ Tinnitus (Ringing in Ears) ☐ TMJ Problems ☐ Loss of Smell

Respiration: ☐ Does not apply to me
☐Asthma ☐ Cough ☐ Coughing Up Blood ☐Shortness of Breath ☐ Sputum Production ☐ Wheezing

Cardiovascular: ☐ Does not apply to me
☐ Angina (chest pain or discomfort) ☐ Chest Pain ☐ Claudication (leg pain or achiness) ☐ Heart Murmur
☐ Heart Problems ☐ Difficulty breathing while lying down ☐ Palpitations ☐ Swelling of Legs ☐ Ulcers
☐Waking at night with shortness of breath ☐ Shortness of breath with Exertion or Exercise ☐ Varicose Veins

Gastrointestinal: ☐ Does not apply to me
☐ Abdominal Pain ☐ Belching ☐ Black, Tarry Stools ☐ Constipation ☐ Diarrhea
☐ Difficulty Swallowing ☐ Heartburn ☐ Hemorrhoids ☐ Indigestion ☐ Nausea
☐ Jaundice (yellowing of the skin) ☐ Rectal Bleeding ☐ Abnormal Stool Color ☐ Vomiting

Female: ☐ Does not apply to me
☐ Birth Control Therapy ☐ Breast Lumps/Pain ☐ Burning Urination ☐ Cramps ☐ Frequent Urination
☐ Hormone Therapy ☐ Irregular Menstruation ☐Urine Retention ☐ Vaginal Bleeding ☐ Vaginal Discharge

Male: ☐ Does not apply to me
☐ Burning Urination ☐ Frequent Urination ☐ Hesitancy/Dribbling ☐ Prostate Problems ☐ Urine Retention

Endocrine: ☐ Does not apply to me
☐ Cold Intolerance ☐ Diabetes ☐ Excessive Appetite ☐ Excessive Hunger ☐ Excessive Thirst
☐ Frequent Urination ☐Goiter ☐ Hair Loss ☐ Heat Intolerance ☐ Unusual Hair Growth

Nervous System: ☐ Does not apply to me
☐ Dizziness ☐ Facial Weakness ☐ Headaches ☐ Limb Weakness ☐ Loss of Consciousness
☐ Loss of Memory ☐ Numbness ☐ Seizures ☐ Sleep Disturbance ☐ Slurred Speech
☐ Stress ☐ Strokes ☐ Tremors

Past Health History- Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: ☐ Does not apply to me

☐ ADD ☐ Allergies/Hay Fever ☐ Asthma ☐ Atopic Dermatitis (Eczema) ☐ Cerebral Palsy
☐ Chicken Pox ☐ Diabetes ☐ Ear Infections ☐ Fetal Drug Exposure ☐ Food Allergies
☐ Headaches ☐ Hepatitis ☐ Measles ☐ Mumps ☐ Rash
☐ Scoliosis ☐ Seizure Disorder ☐ Sickle Cell Anemia ☐ Other_____

Adult Illness: ☐ Does not apply to me

☐ Alzheimer's ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Chicken Pox ☐Crohn's/Colitis
☐CRPS (RSD) ☐ CVA (stroke) ☐ Cystic Kidney Disease ☐ Depression ☐ Diabetes (Non-insulin) ☐ Ear Infection
☐ Emphysema ☐ Eye Problems ☐ Fibromyalgia ☐ Heart Disease ☐ Hepatitis ☐ HIV ☐ Hypertension
☐ Influenza Pneumonia ☐ Liver Disease ☐ Lung Disease ☐ Lupus Erythema (Discoid) ☐ Lupus Erythema
☐ Multiple Sclerosis ☐ Parkinson's Disease ☐ Pleurisy ☐ Pneumonia ☐ Scoliosis ☐ Seizure Disorder
☐ Shingles ☐ STD's ☐ Thyroid Problems Other:_____

Surgeries: ☐ Does not apply to me

Please be specific:_____

Injuries: ☐ Does not apply to me

☐ Back Injury ☐ Fracture ☐ Head Injury ☐ Work Accident ☐ Car Accident ☐ Soft Tissue Injury ☐ Other_____

Family History: _____

_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Ila Foster all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The doctor's office may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I also understand that if I suspend or terminate the insurance policy, any fees for professional services to me will be immediately due and payable. This consent will end when my current treatment plan is completed or one year from this date signed below. I hereby authorize the Doctor to treat my condition as she deems appropriate.

INFORMED CONSENT

The primary treatment we use as a Doctor of Chiropractic is the spinal adjustment. We will use that procedure to treat you. We may use our hands or a mechanical device upon your body in such a way as to move your joints and this may cause an audible sound. You may also feel or sense movement. As a part of the analysis, examination, and treatment, you are consenting to spinal adjustments, palpation, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis, radiological studies, therapeutic procedures, nutritional and exercise advice, and treatment the doctor deems necessary. As with any healthcare procedure, there are certain complications which may arise during a chiropractic adjustment and therapy. Those complications include but are not limited to: fractures, disc injuries, dislocations, and muscle strain, cervical myelopathy and costovertebral strains and separations, and burns. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million to one in five million cervical adjustments. Some patients will feel some stiffness and soreness following the first few days of treatment. We 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 our attention, it is your responsibility to inform us. Other treatment options for your condition may include: Over-the-counter analgesics, rest, medical care with prescription drugs, hospitalization, and surgery. If you chose to use one of these options, there are risks and benefits also and you may wish to discuss these with your primary medical physician. Remaining untreated allows the formation of adhesions and reduces mobility which sets 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. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN: I have read [ ] or **have had read to me [ ]** the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Ila Foster 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 myself 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.

Patient's Signature: _____ Date: _____

Consent to Treat a Minor: _____ Relationship: _____
(Print Name of Parent, Guardian or Personal Representative)

Signature Authorizing Care: _____ Date: _____

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ___/___/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / African American / Caucasian/ Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

□ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient's Signature: _____ Date: _____

For office use only
Height: _____ Weight:_____ Blood Pressure:_____ /_____