New Patient Intake Form

Patient Data **Date**

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ **Middle Initial** ____ **Last 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 **Number of Children:** _____

Employment Status: Employed Unemployed FT Student PT Student Other____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____-_____ **Cell Phone** (____) _____-_____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____			

Surgeries: (Check all that apply to you)

Appendectomy	Cardiovascular Procedure	Cervical Spine	Hysterectomy
Joint Replacement	Prostate	Lumbar Spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Other _____			

Allergies: (Check all that apply to you)

Eggs	Fish and Shellfish	Milk or Lactose	Peanuts
Soy	Sulfites	Wheat/Glutens	Other _____

Social History: (Check all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Chew Tobacco:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling

Other _____

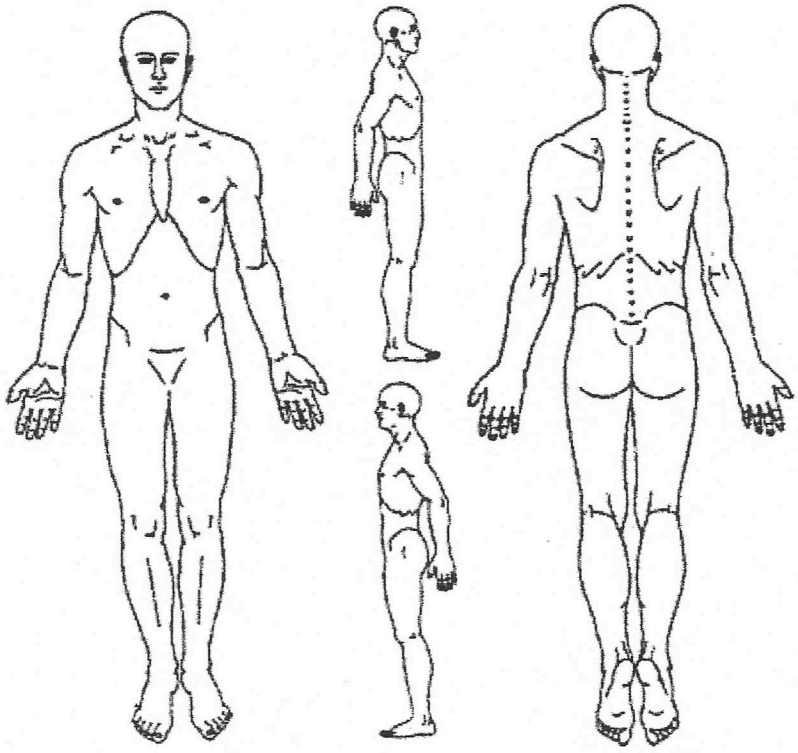
Occupational Activities: (Check one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper
Other _____			

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



List your symptoms in order of severity, with worse symptom being #1: _____

_____

When did your symptoms begin? _____

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	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Dull ache	Numb	Shooting
Burning	Tingling	Stabbing	Other _____

REVIEW OF SYSTEMS: Please check all that apply

GENERAL
☐Weight loss or gain
☐Fatigue
☐Fever or chills
☐Trouble Sleeping

SKIN
☐Rashes
☐Lumps
☐Itching
☐Dryness
☐Color changes
☐Hair and nail changes

HEAD
☐Headache
☐Head injury
☐Neck pain

EARS
☐Decreased hearing
☐Ringing in ears
☐Earache
☐Drainage

EYES
☐Vision loss and/or changes
☐Glass or contacts
☐Pain
☐Blurry or double vision
☐Redness
☐Glaucoma
☐Cataracts

NOSE
☐Stuffiness
☐Discharge
☐Nosebleeds
☐Sinus Pain

THROAT
☐Bleeding
☐Dentures
☐Sore tongue

NECK
☐Lumps
☐Swollen glands
☐Pain
☐Stiffness

BREASTS
☐Lumps
☐Pain
☐Discharge

RESPIRATORY
☐Cough
☐Sputum
☐Coughing up blood
☐Shortness of breath
☐Painful breathing
☐Wheezing

CARDIOVASCULAR
☐Chest pain or discomfort
☐Tightness
☐Palpitations
☐Difficulty breathing lying down
☐Swelling

GASTROINTESTINAL
☐Swallowing difficulties
☐Change in appetite
☐Nausea
☐Change in bowel habits
☐Constipation
☐Diarrhea
☐Yellow eyes or skin

URINARY
☐Frequency
☐Burning or pain
☐Blood in urine
☐Incontinence

VASCULAR
☐Calf pain with walking
☐Leg cramping

MUSCULOSKELETAL
☐Muscle or joint pain
☐Stiffness
☐Back pain
☐Redness of joints
☐Swelling of joints
☐Trauma

NEUROLOGIC
☐Dizziness
☐Fainting
☐Seizures
☐Weakness
☐Numbness
☐Tingling
☐Tremor

ENDOCRINE
☐Heat or cold intolerance
☐Frequent urination
☐Increased/decreased thirst
☐Change in appetite

PSYCHIATRIC
☐Nervousness
☐Depression
☐Memory Loss

Please list all current medications being taken _____

_____

_____

Consent to Examination at Treatment

The Chiropractic Examination: Prior to receiving chiropractic care, a health history and an examination will be completed to assess your specific condition, overall health and spinal health. These procedures will help in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan at your second visit.

The material risks inherent to your treatment: Every type of healthcare is associated with some risk of potential problem. Chiropractic care is a safe and effective approach for many health conditions, however as with any health care procedure, chiropractic treatments present the risks of complications or negative side effects. Below includes a list of various treatments available and the potential risks associated with these treatments

- Chiropractic Manipulation Therapy: The primary treatment used at Art of Health Chiropractic is spinal manipulative therapy. Spinal manipulative therapy includes the use of the doctor's hands or mechanical instruments upon your body in such a way to mobilize your joints. This movement may cause an audible "pop" or "click," such as experienced when you "crack" your knuckles. Risks associated with chiropractic treatments include, but are not limited to, dislocations, sprains, disc injuries, fractures, and strokes. These negative effects are very rare and your doctor has done a careful screening for any contraindications during the consultation and examination. Another more common side effect associated with chiropractic manipulation therapy is some soreness or stiffness following your treatment.

- Deep Tissue Laser Therapy: Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation, therefore, appropriate eye protection is required at all times during treatment. Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment, you may see immediate results after the first treatment or depending on the severity of your condition you may require several treatments before you begin to feel results. Increased soreness may occur after your first laser session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program.

- Kinesio Taping: The application of Kinesio Tape may cause skin irritation. Please inform your doctor if your skin is sensitive to adhesives. Improper removal of Kinesio Tape may cause the pulling of body hair, bruising, or slight abrasion. Please follow directions given by the doctor on proper removal of the tape.

It is not reasonable to expect my doctor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedures which he or she feels at the time to be in my best interest.

I have read and/or the above points have been explained to me to my satisfaction and I have had the opportunity to discuss them with the doctor and/or other clinic personnel.

_____ _____

Patient or Legally Authorized Individual Signature Date

Art of Health Chiropractic
2823 Bransford Avenue
Nashville, TN 37204

CONSENT TO TREATMENT OF A MINOR

Minor's Name: _____

****

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize **Art of Health Chiropractic** to administer treatment as it so deems necessary to the minor. In the event that the minor has received treatment at your practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at **Art of Health Chiropractic** which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent/Legal Guardian (please spell clearly): _____

Relationship to the minor:

☐ Parent ☐ Adoptive parent with custody

☐ Guardian by Law. Date Guardianship Commenced: ___/___/___

☐ Other (please specify): _____

Address of Parent/Guardian: _____

_____

Home Phone #: (____) _____ Work Phone #: (____) _____

Signature: _____ Date: ___/___/___

Witness (if any)

Witness' Name: _____

Witness' signature: _____ Date: ___/___/___

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

For the purposes of this Consent Form, “Office” shall refer to Art of Health Chiropractic.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office’s privacy notice entitled, “Our Privacy Practices.” I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office’s privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: ___/___/___

Only NAET Patients Need to Complete this Form

COMMONLY SEEN ALLERGIC CONDITIONS

Please check all that apply

- ☐Addictions to carbohydrates
- ☐Addictions to coffee, chocolate, caffeine, smoking
- ☐Addiction to drugs
- ☐Addiction to food
- ☐Allergy to chemicals
- ☐Allergy to cold
- ☐Allergy to heat
- ☐Allergy to milk products
- ☐Allergy to mold
- ☐Allergy to peanuts
- ☐Allergy to penicillin
- ☐Allergy to pets, animals or humans
- ☐Allergy to plastics
- ☐Allergy to prescription drugs and immunizations
- ☐Allergy to radiation
- ☐Allergy to shellfish
- ☐Allergy to sunlight
- ☐Allergy to clothing
- ☐Anxiety
- ☐Attention deficit
- ☐Bad breath
- ☐Bronchitis
- ☐Candida/yeast
- ☐Chronic fatigue
- ☐Colitis
- ☐Depression
- ☐Diarrhea
- ☐Distractibility
- ☐Dyslexia
- ☐Ear infections
- ☐Eating disorders
- ☐Eczema
- ☐Excessive appetite
- ☐Fibromyalgia
- ☐Flatulence
- ☐Food craving
- ☐Frequent colds
- ☐Frequent infections
- ☐General itching
- ☐Headaches
- ☐Hives
- ☐Hyperactivity
- ☐Hypoglycemia
- ☐Impulsivity
- ☐Indigestion
- ☐Insomnia
- ☐Irritable bowel syndrome
- ☐Leaky gut syndrome
- ☐Migraines
- ☐Nervous stomach
- ☐Night sweats
- ☐OCD
- ☐Parasitic infestation
- ☐Phobias
- ☐Poor appetite
- ☐Poor memory
- ☐Restless leg syndrome
- ☐Sinusitis
- ☐Toxicity to mercury
- ☐Toxicity to heavy metal