Arctic Chiropractic Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ **Date:** _____

SSN: _____ **D.O.B.:** _____ (dd/mm/yr)

□ **male** □ **female**

Address: _____

_____

Marital Status

S	M	W	D	SEP

Phone: home/cell: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

How did you hear about us: _____

Check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow

☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ___ Length of cycle: _____

Date - 1st day last period: _____

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? _____

How many children do you have?

Birth control method: _____

Date of last PAP test: _____

☐ normal, ☐ abnormal

Date of last mammogram: _____

☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

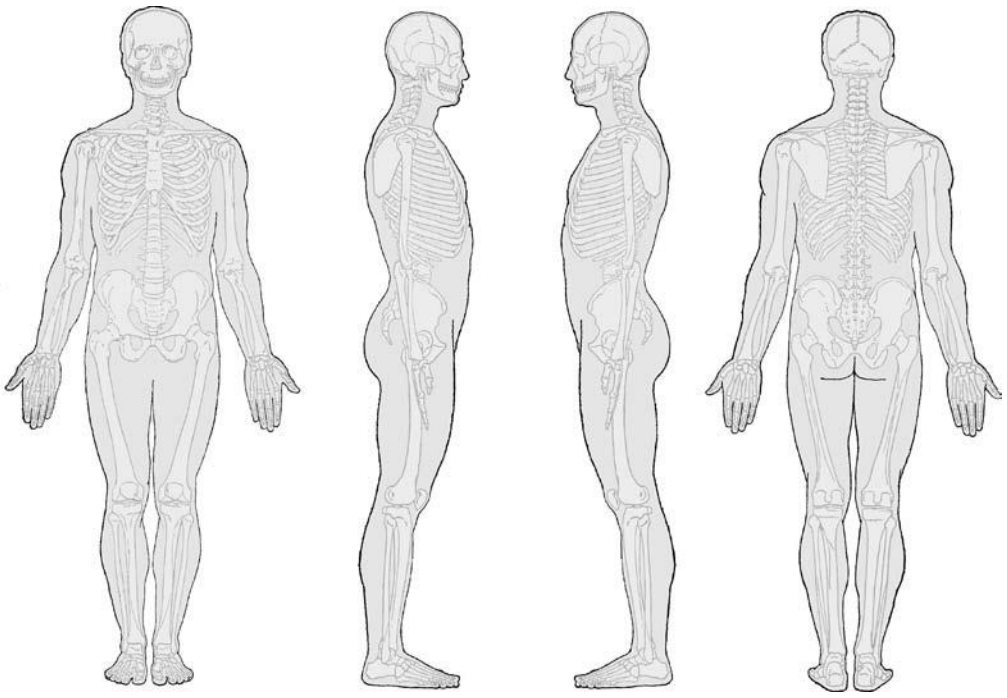
What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:

Worst Possible Pain

No Pain



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of?

_____

Arctic Chiropractic Fairbanks

Informed Consent to Chiropractic Treatment

The State of Alaska requires every patient to be informed of the risks of treatment and the alternatives to treatments prior to the beginning of care. The following is Arctic Chiropractic Fairbanks, LLC's informed consent for treatment. We intend this consent form to cover the entire course of treatment for your present condition and for any conditions for which you seek treatment at this clinic.

The nature of chiropractic treatment. The doctor will use his/her hands or a mechanical device in order to adjust/manipulate your joints. You may hear a "click" or "pop", similar to when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as a hot or cold packs, electric muscle stimulation, therapeutic ultrasound, myofascial therapy, massage, traction as well as exercise instruction may also be used.

Possible risks and probability. There are inherent risks in all treatments derived by any health care provider ranging from taking a single aspirin to a complicated brain surgery. Chiropractic care is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustments/manipulations. The risk is very minor to non-existent in any treatment of the extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to the most serious would include muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to the intervertebral discs, nerves, or spinal cord (very rare). The risk involved in the treatment of the neck would include any of the preceding list but also include the remote possibility of cerebrovascular injury, or stroke (very rare: incident rate is one in ten million). A minority of patients may notice a stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritations, burns or other minor complications (rare).

Other treatment options, not provided by this clinic, which could be considered, may include the following:

Over-the-counter analgesics. The risks of these medications include irritations to the stomach, liver and kidneys and other side effects in a significant number of cases.

Medical care, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above and patient dependence in a significant number of cases.

Surgery in conjunction with medical care adds the risks of adverse reactions to anesthesia (which include death), as well as extended convalescent period in a significant number of cases.

Risks of remaining untreated. Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is quite probable the delay of treatment will complicate the condition, and make further rehabilitation more difficult.

Concerns or questions. Please ask your Doctor. The doctors and the staff at Arctic Chiropractic Fairbanks have gone to great lengths to make your health and safety a top priority. We will be glad to explain any concerns about treatment you may have. Suffice to say we will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of chiropractic care. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____	_____	_____
Print Patients Name	Signature	Date
_____	_____	_____
Guardian (if patient is a minor)	Signature	Date

Arctic Chiropractic Fairbanks

Consent for Massage Therapy

- The unclothed body will be properly draped at all times for your warmth, sense of security, and a mark of massage professionalism.
- Forced attention and manual therapy will be given as agreed upon by the therapist and client for the predetermined goals of stress reduction, relief of muscular discomfort, and/or health therapy. I have been given an opportunity to ask questions.
- I as a client to provide complete and accurate health information and notice of health changes at successive appointments as appropriate.
- I understand that massage therapy is designed to be an ancillary health aid and is not primary health care treatment.
- Written referral is requested from your primary care provider if:
    - You are currently receiving care.
    - You have a specific medical condition or symptoms for which you take medication or receive periodic evaluation or treatment.
- I will immediately inform my therapist of any unusual sensation or discomfort, so that the application of pressure or strokes may be adjusted to my level of my comfort.
- I understand that this is a professional massage, is therapeutic in nature and is performed by a trained state-licensed therapist.
- I understand that by signing this form, I give consent to receive the treatment discussed in all future sessions and agree that my presence at subsequent session shall be constructed to validation of this written consent.
- I have read this form and hereby freely give my permission to receive massage therapy.
- **I understand that the massage is not sexually oriented in any way and that any illicit or suggested remarks or behavior on my part will result in immediate termination of the session.**

Date:_____

Printed Name:_____

Signature: _____