Confidential New Patient Intake

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name *gender* *today's date*

____

date of birth *age* *marital status* *# of children*

____

address *street* *city* *state* *zip*

____

home phone *cell phone*

____

occupation *company name* *city* *work phone*

____

spouse or guardian's name *occupation* *company name* *city*

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How did you hear about us? *Email address (never shared – used for clinic news)*

____

Describe your major problems. *When did it/they start?*

____

What would you like to do but can't because of this problem? *List other professionals you've seen for this problem.*

PERSONAL HEALTH HISTORY Read through the list and check the box next to each condition that applies to you.

GENERAL CURRENT CONDITIONS

- ☐ **Recent accident** such as a fall, whiplash, or blow to the head
- ☐ Spinal/back/neck problems
- ☐ Muscle spasms
- ☐ Restricted movement
- ☐ Numbness or tingling of hands or feet or radiating pain
- ☐ Headaches or Migraines
- ☐ Sinus problems
- ☐ Nausea
- ☐ Depression
- ☐ Anxiety or difficulty with stress
- ☐ Dizziness or vertigo
- ☐ Vision problem
- ☐ Hearing problem
- ☐ Sleeping trouble
- ☐ Asthma or breathing problem
- ☐ Digestive trouble
- ☐ Heartburn/Acid Reflux
- ☐ Menstrual problems
- ☐ Jaw or mouth problem
- ☐ Arm, shoulder, elbow or hand problem
- ☐ Leg, hip, knee or foot problem

DIAGNOSED CONDTIONS

- ☐ Born with bone or joint disorder
- ☐ Degenerative arthritis
- ☐ Rheumatoid arthritis
- ☐ Compression fracture
- ☐ Heart attack or heart disorder
- ☐ History of stroke or aneurysm
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Lupus
- ☐ Ankylosing spondylitis
- ☐ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
- ☐ 3 or more months of steroid medications or intravenous drugs (past or present)
- ☐ Tuberculosis
- ☐ Hepatitis B or HIV infection
- ☐ Multiple sclerosis
- ☐ Thyroid or hormone disorder
- ☐ High blood pressure
- ☐ Convulsions/epilepsy
- ☐ OTHER:

SPECIFIC PAIN IN THE BODY

- ☐ Difficulty swallowing because of neck pain
- ☐ Pain or electric shocks in arms or legs when moving neck
- ☐ Leg pain worse with exercise
- ☐ Numbness of inner thighs
- ☐ Back pain with urinary problems
- ☐ Severe pain that interrupts sleep
- ☐ Constant pain that doesn't improve by changing positions or by lying down

SPECIFIC CURRENT CONDITIONS

- ☐ Poor balance
- ☐ Loss of bowel or bladder control
- ☐ Blurred or double vision, dizziness, nausea or faintness <u>when neck is in certain positions</u>
- ☐ Memory loss after injury
- ☐ Recent, unexplained weight loss
- ☐ Recent progressive muscle weakness or shaking

List any surgeries or hospitalizations you've had, include dates.

List your current prescription medications, over the counter medications, and supplements that you are taking.

Are you pregnant? *Date of last period?* *Last known height and weight.*

What do you do for exercise? *How often do you exercise?* *How do you de-stress?*

Any tobacco use? *How much per day and for how long.* *Any recent fevers or serious illnesses?*

Family history (circle any that apply) spine problems, auto-immune disorders, arthritis, cancer, diabetes, heart disease, kidney disease, mental illness, bleeding disorders, seizures.

personal physician (name) *phone#*

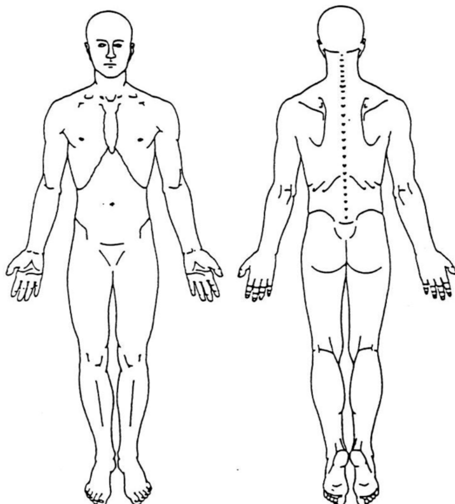
Have you been under chiropractic care before? *Name and location of chiropractor.* *When was your last visit?*

***Please shade in the area of your main complaint on the diagram below. Use x's for numbness or tingling**.*

Score your pain level at its best, its current, and your pain at its worst on a scale of 0-10.

What does your pain feel like (achy, deep, dull, throbbing, electrical, radiatin, stabbing, pinching,etc.)?

What makes your pain worse? *What makes your pain better?* *What % of the day does it bother you?*



Have you had x-rays/mri's of your main complaint?

Have you had prior episodes of this pain? When?

Did your pain start from an injury, or gradual onset?

Is your pain getting worse, better, or staying the same?

Dr. Trent Artichoker MS, DC | www.DenverChiropracticLLC.com | 303-455-2225
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Denver Chiropractic, LLC

Health Insurance Information (please present your health insurance card)

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health Insurance company *insured's name* *policy #*

Consent to Examination and Treatment

I hereby request and consent to the performance of chiropractic examination, adjustments and other chiropractic procedures, and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Trent Artichoker, DC and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Dr. Trent Artichoker, DC I understand and I am informed that, in the practice of chiropractic that there are some risks to examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

Our Privacy Policy

The office of Dr. Trent Artichoker, DC is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Dr. Trent Artichoker, DC may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

By signing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that my confidential medical information above is correct to the best of my knowledge.

Office Policies (please initial by each sentence)

_____ 1. An average case of acute neck or back pain typically takes between 6-12 office visits for it to resolve. Chronic pain may take more visits. Neck or back pain usually fluctuates, meaning that you might have flare ups along the course of your healing.

______2. If you make an appointment and do not show up, we will charge you $25. Please give us notice if you are unable to make the appointment that you scheduled.

______3. If you have never been adjusted, you may be sore after your treatment. This soreness is similar to a long hike or a good workout type of soreness. Soreness can be a good response, as is the soreness you get after a good workout.

Signature____ **Date** ________________

Please print your name____

Denver Chiropractic, LLC