New Patient Intake Form

THE DRIVE CHIROPRACTIC

PERSONAL INFORMATION

Today's Date: _____

Legal Name: _____ What do you prefer to be called? _____

Date of Birth: ___/___/_____ Age: _____ Sex Assigned at Birth: M / F

Preferred Pronouns: He / She / They Marital Status: M / S / D / W

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

Cell/ Home Phone: _____ Email: _____

Occupation: _____ Employer/ School: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Are you currently pregnant? Yes / No Due Date: _____

Whom may we thank for referring you to our office? _____

HOW CAN WE HELP YOU?

What brings you in today? _____
When did your symptoms first appear? _____
How did this happen? _____
Is the condition getting progressively worse? Yes / No

Circle the severity of your pain on a scale from:

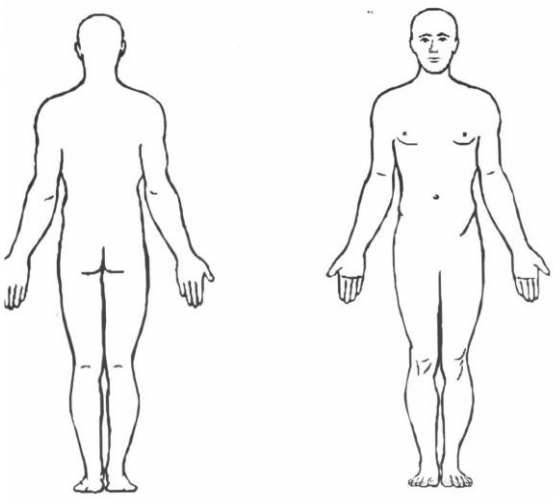
0 (No symptoms) to 10 (Severe pain)

0 1 2 3 4 5 6 7 8 9 10

Type of pain (circle): Numbness Sharp Tingling Dull

Shooting Stiffness Burning Throbbing Aching

Mark on the picture where you have symptoms



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Cramping Swelling Nagging Other: _____

Does the pain radiate, shoot, or travel to any other part of the body? Where? _____

My symptoms are present: 25% of the day 50% of the day 75% of the day 100% of the day

What is the worst time of the day? Morning Afternoon Evening

Is this due to a(n): Auto Accident Work Injury Lawsuit N/A

To whom have you made a report of the accident? Auto Insurance Employer Work Comp

What treatment have you received for your condition? _____

Have you had chiropractic care before? _____ If so, when? _____

What aggravates your symptoms? _____

What relieves your symptoms? _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

Allergies	*Medications*	*Supplements*
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY

List all surgical operations and years: _____

Broken Bones: Yes / No Date: _____ Briefly Explain: _____

Been Hospitalized: Yes / No Date: _____ Briefly Explain: _____

Had a Stroke: Yes / No Date: _____ Briefly Explain: _____

Have you ever broken ribs or had any serious spinal injuries? Briefly Explain: _____

Do you have any vomiting, nausea, fever, chills, or any unexplained weight loss or gain? _____

HEALTH & ILLNESS HISTORY (circle all that apply)

Abdominal Pain	Erectile Dysfunction	Night Sweats	Allergies	Excessive Thirst
Prostate Trouble	Anxiety/Nervousness	Fainting	Ringing/Buzzing Ears	Arthritis
Fatigue or Weakness	Seizures	Asthma	Fertility Problems	Fibromyalgia

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HEALTH & ILLNESS HISTORY CONTINUED (circle all that apply)

Shortness of Breath	Autoimmune Disease	Sinus Trouble	Bedwetting	Headaches
Skin Problems	Upset Stomach	Heartburn	Sleeping Problem	Bone Fracture
Hearing Trouble	Thyroid Trouble	Heart Trouble	Cancer	Tuberculosis
Blood in Urine/Stool	Chest Pain or Pressure	High/Low Blood Pressure		Urinary Pain/Frequent
Cold Hands/Feet	Kidney/Bladder Trouble	Constipation/Diarrhea		Loss of Balance
Vertigo	Depression	Loss of Memory		Vision Trouble
Diabetes	Mood Swings/Irritability	Weight Loss/Gain		
Dizziness	Multiple Sclerosis			

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me by Dr. Dayna Drewes or any other chiropractor who in the future treats me while employed by, working or associated with serving as back-up for Dr. Dayna Drewes D.C. I have had the opportunity to discuss with the treating provider the nature and purpose of treatment and other procedures. I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains, these risks are rare and unlikely. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts known, is my best interest. I have read, and or have read to me, the above consent. I have also had the opportunity to ask questions about its content. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature: _____ Date: _____

CONSENT TO TREAT A MINOR CHILD

I hereby authorize this office to administer chiropractic as deemed necessary for my child.

Signature: _____ (Parent/Legal Guardian) Date:_____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. To that end, we ask that you acknowledge the following regarding chiropractic care and the services that are offered through the clinic.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social wellbeing not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function and interference to the transmission of mental pulses, resulting in lessening the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only purpose and objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I _____ have read and fully understand the statements above.

(Full Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. **I therefore accept Chiropractic on this basis**.

Signature: _____ Date: _____

FINANCIAL/ INSURANCE POLICY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will process any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

Signature: _____ Date: _____

Policy Holder's Name: _____ DOB: _____

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, & HEALTHCARE OPERATIONS

I acknowledge that The Drive Chiropractic's "Notices of Privacy Practices" has been provided to me. I understand I have the right to review The Drive Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of The Drive Chiropractic. The Notice of Privacy Practices for The Drive Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and The Drive Chiropractic's duties with respect to protected health information. I give permission to The Drive Chiropractic to use my name, address, phone number, date of birth and social security number to contact my insurance company to verify my coverage and benefits and to check the status of my insurance claims. The Drive Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Policy by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

AUTHORIZATION TO RELEASE INFORMATION

To: Dayna Drewes D.C.

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequences thereof.

By signing below, I am stating that all of the above information is correct to the best of my knowledge.

Signature: _____ Date: _____