Legacy Chiropractic Patient Intake Form

PERSONAL INFORMATION

PLEASE PRINT

First Name:_____**M.I**._____**Last Name**:_____**Preferred Name**:_____

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

Birthdate:_____/_____/_____ **Gender**: □ Male □ Female □ Unspecified

Primary Phone:_____ **Cell Phone**:_____ **Work Phone**:_____

Would you like text appointment reminder: □ No □ Yes If "Yes", cell phone carrier_____

Email Address:_____

Emergency Contact: (Name, Relationship, Phone#)_____

REASON FOR VISIT

What is the reason for your visit today? □ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other_____

What caused this complaint(s)?_____

_____

When did this complaint begin? _____/_____/_____ **Is it getting worse?** □ Yes □ No □ Constant □ Comes and goes

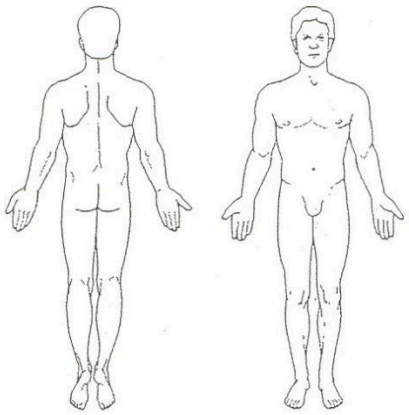
Have you had this or similar complaint in the past? □ Yes □ No If "Yes", when?_____

What does your complaint (s) feel like? **Circle all** that apply: *Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*_____

On the scale below, please circle the severity of your main complaint right now:

No Pain					***Moderate Pain***					***Worst Possible Pain***
0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***

Please check **ALL** of the health conditions below that apply to **you** currently or in the past.			
□	Osteoarthritis/Degenerative Joint Disease	□	Whiplash Injury *Date of injury:*
□	Asthma	□	Headaches
□	Diabetes □ Type I □ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? □ Yes □ No □ Not Sure	□	Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____
□	Anemia	□	Migraines
□	Cancer/Tumor	□	Osteoporosis /Osteopenia
□	Rheumatoid Arthritis	□	Epilepsy / Seizures
□	Depression/ Anxiety	□	Fibromyalgia / Chronic Fatigue
□	Disc Herniation	□	Genetic Disorders
□	High Blood Pressure /Hypertension	□	Falls/Accidents:
□	Heart Disease / Stroke		



←Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

What area(s) does the pain radiate, shoot, or travel to?
(If applicable)?_____

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____
_____
_____
_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____
_____
_____
_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? □ Yes □ No

List current prescription medications. If there are NO current medications, check here □

Name of prescription medication	***Start date***	4.	Date:
1.	Date:	5.	Date:
2.	Date:	6.	Date:
3.	Date:	7.	Date:

Dated: _____

_____
Patient's Name (Please print)

X_____
Signature of Patient, Parent or Legal Guardian (if a minor)

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.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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.

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 impulses, resulting in a lessening of 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 spinal 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 PRACTICE 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 above statements.

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 care on this basis.

_____ _____

(signature) (date)