Intake Form—Sunrise Chiropractic

Name

Street City Zip

SS# DL# Birth Date Sex M / F

Phone Cell Pager Fax

E-mail Marital Status S M D W Spouse's Name

Exam For? Self Family Other Family Members

Seen Other Chiropractor? Y / N Who? When? Bringing X-Rays? Y/N

Primary Reason For Consulting Office?

How Long Has This Been Going On? Days Months Years

Is this the result of a work or auto injury? Y / N When

Occupation FT/PT Employer #

How did you find out about our office?

Emergency Contact #

INFORMED CONSENT / TERMS OF ACCEPTANCE FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures and if necessary diagnostic X-rays on me by the doctor of chiropractic named above and/or anyone authorized by the same doctor. I further understand and am informed that Sunrise Chiropractic does not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, the doctor encounters a non-chiropractic or unusual findings, he/she will inform me and offer referral. Regardless of what the disease is called, the doctor will not offer to treat it, nor will he/she offer advice regarding treatment prescribed by others.

Sunrise Chiropractic's only objective is to eliminate interference to the expression of the body's innate wisdom. As in all health care, there are some slight risks to treatment and do not expect the doctor to be able to anticipate or explain all risks and combinations; and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read this consent and intend this consent form to cover the entire course of my care for this condition and any care in the future:

Signature: Date:

INFORMED CONSENT FOR MASSAGE CARE

I understand that: therapeutic massage services are designed to be a health aid and are in no way meant to take the place of a physician's care when it is indicated, information exchanged during any massage session(s) is educational in nature and is intended to help me become more familiar with and conscious of my own health status, this information is to be used at my own discretion, Furthermore, I agree to hold the massage therapist and Sunrise Chiropractic free of liability for any injury I might suffer as a consequence of undergoing massage therapy.

I understand a $25 fee will be charged on missed appointments or cancellations with less than a 24 hour advance notice. This fee is not billable to insurance. Therefore my credit card number is required to hold appointment times and will only be charged if I fail to comply with this policy.

Credit Card #: Exp. Date:

Signature: Date:

YOUR LIFE REVIEW — Lifestyle / Chiropractic Experience

Primary Health Concern:_____

Circle the severity of this concern today: (slight) 1 2 3 4 5 6 7 8 9 10 (severe)

Circle the severity of this concern at it's worst: (slight) 1 2 3 4 5 6 7 8 9 10 (severe)

Circle the severity of this concern on average: (slight) 1 2 3 4 5 6 7 8 9 10 (severe)

Describe this concern: Sharp Dull Travels Constant On/Off Other_____

Since it's onset this concern is: Better Worse No Change

Other facts about current concern or others: _____

Have you tried other health care providers for concern? _____Who?_____

List your current medications: _____

PLEASE CHECK ALL THAT APPLY (Even if not seemingly related to your concern)

____Headaches	____Menstrual irregularity	____Fainting
____Numbness in fingers	____Buzzing in ears	____Nervousness
____Numbness in toes	____Ringing in ears	____Cold feet
____Problems urinating	____Loss of smell	____Neck pain
____Mood swings	____Loss of taste	____Tension
____Sleeping problems	____Back pain	____Hot flashes
____Stomach upsets	____Dizziness	____Cold hands
____Loss of balance	____Irritability	____Fatigue
____Pins & needles in legs	____Diarrhea	____Depression
____Pins & needles in arms	____Heartburn	____Ulcers
____Light bothers eyes	____Fevers	____Scoliosis

INJURY HISTORY

Were you born in a hospital? Yes _____No_____Did you ever fall as a child? Yes _____No_____

Did you ever play any sports? Yes _____No_____What Sports?_____

Ever broken a bone?_____

List any motor vehicle accidents (please note type and year, even if not apparently injured)_____

_____

List any surgeries_____

FAMILY HISTORY

Is there a family history of: (Please check all that apply)

____High Blood Pressure	____Tuberculosis	____Arthritis
____Recurrent Infections	____High Stress	____Allergies
____Nervous Disorders	____Headaches	____Asthma
____Heart Disease	____Fatigue	____Stroke
____Vaccine Reaction	____Diabetes	____Cancer
____Mental Illness	____Scoliosis	____Other _____

AGREEMENTS

The statements made on this form are accurate, to the best of my recollection, and I agree to allow this office to do an examination of me for further evaluation.

Signature_____ Date_____

QUALITY OF LIFE ISSUES-(Doctor will fill out)

_____

_____

Current Quality Of Life: (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Short Term Goal:_____ Long Term Goal:_____