NEW PATIENT INTAKE FORM

Date:_____

PATIENT INFORMATION:

Patient Name_____

Address_____

City_____State_____Zip_____

Date of Birth _____Age_____Gender_____

Social Security#_____

Home Phone_____Cell Phone_____

Work
Phone_____Email_____

Occupation_____Employer's Name_____

Work Address_____

Emergency Contact_____Relationship_____

Emergency Phone#_____

How were you referred to our office?_____

Please provide a copy of your driver's license and insurance card. If this is an HMO, please provide a referral form from primary care doctor. Thank you.

CHIEF COMPLAINT

What is the main reason that you are seeking medical/chiropractic/rehabilitation attention?

_____
_____
_____
_____
_____

HISTORY OF PRESENT ILLNESS

Did your problem occur after a work related injury? ( ) no ( ) yes

If yes, please describe_____
_____
_____
_____
_____

Did your problem begin after a specific trauma? ( ) no ( ) yes

If yes, please describe_____
_____
_____
_____
_____

Please briefly describe how your problem started:_____
_____
_____
_____

How long have you had your current pain?_____

Have you had pain like this before?_____
Has your pain been improving, worsening, or staying the same? _____

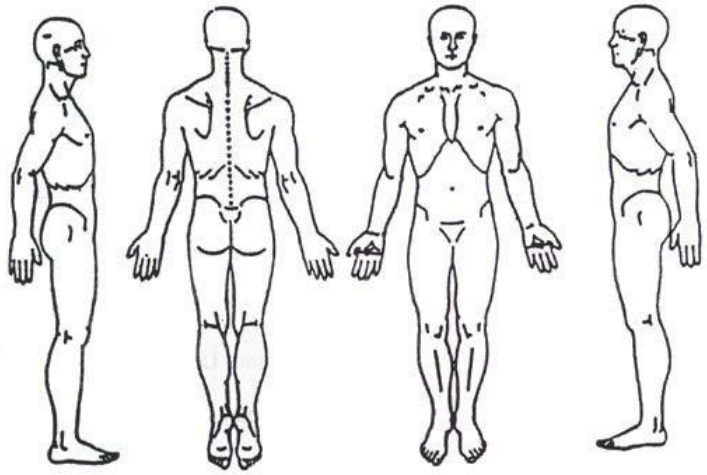
Please describe the nature of the pain (Achy, Dull, Throbbing, Stabbing, Burning,

Numbness, Tingling, Heaviness, Cramping, Other)_____
Have you had weakness in the arms or legs that gets worse each day? ( ) yes ( )no

Have you had new trouble with urination, bowel movements, or sexual function? ( ) yes ( ) no

Is your pain worse in the neck or in the arm?
( ) not applicable ( ) neck ( ) arm/hand ( ) equal

Is your pain worse in the back or in the thigh/leg?
( ) not applicable ( ) back ( ) thigh/leg ( ) equal



Draw on the body diagram **areas of pain with an X** and **areas of numbness with an O**

With 0 being no pain and 10 being the worst imaginable pain,

Please rate your pain when it is at its worst (Bad day!!) with an X

0 _____5_____10

No Pain **Worst Pain**

Please rate your pain when it is at its best (Good day!!) with an X

0 _____5_____10

No Pain **Worst Pain**

Please rate your pain when it is its average with an X

0 _____5_____10

No Pain **Worst Pain**

At what time of day is your pain the worst?

( ) Morning ( ) End of the day ( ) Nighttime ( ) Doesn't matter

Please indicate the **positions** that specifically worsen your discomfort?

( ) Sitting prolonged ( ) Standing prolonged ( ) Walking prolonged

( ) Laying down ( ) Other_____

( ) Nothing increases the pain, it is constant

Please describe any **positions** that relieve your discomfort?

( ) Sitting prolonged ( ) Standing prolonged ( ) Walking prolonged

( ) Lying down ( ) Other_____

( ) Nothing decreases the pain, it is constant

How long can you sit?_____

How long can you stand?_____

How long can you walk?_____

What treatments have been tried for this condition?

( ) Chiropractic ( ) Helpful ( )Not Helpful (

) Acupuncture ( ) Helpful ( )Not Helpful

( ) Other alternative therapy_____ ( ) Helpful ( )Not Helpful (

) Physical Therapy, if so where and when? ( ) Helpful ( )Not Helpful

_____

_____

( ) Injections, if so (***please bring procedure reports***)

Type of injection _____ ( ) Helpful ( )Not Helpful

When? _____ Where?

_____

( ) Surgeries for this problem (***please bring operative reports***)

Type of Surgery _____ ( ) Helpful ( )Not Helpful

MEDICATIONS:

Please list **all** of your **current medications**, including over the counter medications

Name Dosage Number of times daily

_____

_____

_____
_____
_____
_____
_____

Please list your **previously tried medications** for this current problem

Name	Dosage	Number of times daily

_____
_____
_____
_____
_____

What are your ALLERGIES?

_____
_____
_____

PAST MEDICAL HISTORY:

Please list all current or past medical conditions:

_____
_____
_____
_____

PAST SURGICAL HISTORY:

Type of surgery/ side	Date

_____
_____
_____
_____

FAMILY HISTORY. CHECK ALL THAT APPLY:

( )Heart Problems	( )Stroke	( )Kidney Disease
( )Cancer	( )Arthritis	( )Diabetes
( )Thyroid Disease	( )Hypertension	( )Chronic Back Pain

( )Other_____

SOCIAL HISTORY. CHECK ALL THAT APPLY:

( )Alcohol Use How Often_____

( )Alternative Medicine Use ( )Caffeine Use, How Often_____

( )Financial Difficulty ( )Exercise, How Often_____

( )Recreational Drug Use

TOBACCO USE. CHECK ALL THAT APPLY:

( )None ( )Chewing Tobacco ( )Cigar ( )Pipe ( )Cigarette

( )Previous Smoker ( )Never Smoked

Cigarette Packs Per Day?_____ How Old Were You When You Started Smoking____?

REVIEW OF SYSTEMS:

Have you had any weakness, fatigue, or weight loss?_____
Have you had any fever, chills, or sweats?_____
Have you had a loss of appetite or any trouble sleeping?_____
Have you had any rash, dryness or itching of your skin?_____
Have you noticed any bruises?_____
Have you had any headaches, dizziness, or blurry vision?_____
Have you had any redness or discharge in your eyes?_____
Have you noticed any pain, itchiness, or ringing of the ears?_____
Have you had a runny nose or nosebleed?_____
Have you noticed a change in taste, or loss of smell?_____
Have you had any difficulty swallowing, sore throats, or hoarseness?_____
Have you had any neck pain?_____
Have you noticed any breast lumps, pain, or discharge?_____
Have you had any coughing, wheezing, or phlegm?_____
Have you had any chest pain, chest tightness, shortness of breath, or palpitations?_____
Have you had any stomach pain, vomiting, or diarrhea?_____
Have you been able to go to the bathroom lately? _____
Is there ever any blood in your stool?_____
Have you had any trouble peeing, frequent urination, or increased thirst?_____
Have you had any blood in your urine, or dark colored urine?_____
Have you had any sexually transmitted diseases?_____
Do you have any joint pain, muscle pain, or weakness?_____

Have you noticed any numbness or tingling anywhere?_____
Have you had any disturbing or unusual thoughts, or seen anything that wasn't there?_____
Do you have any mood swings, anxiety, or crying spells?_____

PATIENT AGREEMENT:

TO: PATIENTS OF VANGUARD SPINE & SPORT

Vanguard Spine & Sport specialize in the treatment of the spine and associated pain. We perform various treatments consisting of passive modalities, therapeutic interventions and spinal manipulation. The goal of our services is to reduce and/or eliminate your pain, however, as with any chiropractic and/or physical medicine services there are risks associated with the services we provide.

As your healthcare provider, we feel that it is crucial that you understand these risks. By informing you of these risks we are striving to more actively involve you in your care as well as further assist you in making well-informed decisions regarding your treatment options.

PASSIVE MODALITIES

Passive modalities consist of the following treatments: hot packs, cold packs, ultrasound electrical stimulation, massage, kinesio taping and traction.

The primary risk associated with passive modalities is skin irritation due to exposure to heat, cold or agents used in the application of modalities, i.e. lotions, pads and tape. If you have experienced skin sensitivity to heat, cold temperatures, adhesive and/or lotions or similar products in the past or are aware of any skin allergies, please inform our staff prior to treatment so proper precautions can be made prior to initiating treatment.

THERAPEUTIC INTERVENTIONS

Therapeutic interventions consist of the following types of treatments: stretching, flexibility exercises, strengthening exercises, joint mobilizations and myofascial release.

Therapeutic interventions are generally quite safe though there are risks associated with each of these procedures. The primary risk is potential aggravation of your current condition and/or underlying condition. As with any physical activity and/or exercise there is also the risk of injury. Though this risk is minimal as you are under the direct supervision of experienced clinical staff, it may still exist.

Some responses to therapeutic interventions are muscle soreness, muscle fatigue, increased discomfort, bruising, overall tiredness and/or joint stiffness and/or pain. It is important that you inform your treating staff member of any of these responses following

your treatment and more importantly it is crucial that you continue to attend your appointments as scheduled so your condition can be documented and your symptoms effectively managed.

SPINAL MANIPULATION

Spinal Manipulation consists of adjustments that seek to restore normal function to the spine and other joints. Typically, this involves applying a specific, highly controlled treatment directly to a joint or muscle. This treatment often reduces or eliminates both local and referred pain, allows muscle spasms to relax, and may even release the irritation from the nervous system, which may result in other health benefits.

As with any healthcare service there are potential reactions and risks, however as with any healthcare intervention, it is hoped that the expected benefits of spinal manipulation exceed the expected risks. Appropriate measures are taken to lessen the chance of an adverse reaction occurring.

Most common risk is sprain/strain. Rare risk factors potentially include disc herniation, cauda equina syndrome, fracture and vertebrobasilar artery compromise.

PATIENT UNDERSTANDING AND ACCEPTANCE OF RISKS ASSOCIATED WITH TREATMENT

I have reviewed the information provided regarding the benefits and risks of treatment provided at Vanguard Spine and Sport. I have been given the opportunity to discuss my questions and/or concerns and by signing below I acknowledge that I understand and accept the risks associated with my treatment.

Patient Signature _____

Date _____

Guardian's Signature _____

Date _____