INTAKE FORM

(Please Print)

Today's Date:	Medical Physician's Name:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone number: ( )
City:	State:	Zip:

Mobile Phone Number:	E-mail Address:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Website	☐ Ad

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here:

REASON FOR VISIT

Have you had previous chiropractic care? ☐ Yes ☐ No

What is your major complaint?	Other complaints:

How did the condition develop?	Date of Onset:

What aggravates this condition?	Does anything offer relief?

On a scale from 0 to 10, 10 being the worst pain you can imagine and 0 being no pain, where would you rate your pain? (circle one)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Have you had the same or similar problems in the past? ☐ Yes ☐ No

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

How would you describe your discomfort? ☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing

What percent of the time does this condition bother you? ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Would you consider this problem (check one)…

☐ MINIMAL (Annoying but causing NO limitations)
☐ SLIGHT (Tolerable but causing a little limitation)
☐ MODERATE (Sometimes tolerable but definitely causing limitations)
☐ SEVERE (Causing significant limitations)
☐ EXTREME (Causing near constant >80% of the time limitations)

If you cannot find a solution to this problem what do you think will happen to you?

If there is an effective and affordable procedure to treat your condition, are you ready to start treatment? ☐ Yes ☐ No

Do you have any questions we can answer for you?

List in order of importance all OTHER Health Challenges / Concerns NOT including Your Main Health Challenge:

1.
2.
3.
4.

MEDICATIONS

Are you currently taking any of the following medications? (Please check all that apply)

☐ Nerve Pills
☐ Stimulants
☐ Pain Killers (including aspirin)
☐ Blood Thinners
☐ Muscle Relaxers
☐ Tranquilizers
☐ Insulin

Please list all medications you are taking:

Please list all Nutritional Supplements you are taking:

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to:

List all previous surgeries/treatments with dates:

List any and all accidents with dates:

Do you exercise regularly? ☐ Yes ☐ No	Describe what exercise:
Do you smoke? ☐ Yes ☐ No	If so, how much?
Do you drink? ☐ Yes ☐ No	If so, how much?
Is your mattress comfortable? ☐ Yes ☐ No	What is the age of your mattress?

Do you wear: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

HEALTH HISTORY

Have you had ANY of the following in the last 12 months or currently?
Please mark P for Past and C for Current. P = Past C = Current

GENERAL

__ Chills
__ Convulsions
__ Dizziness
__ Fainting
__ Fatigue
__ Fever
__ Headache
__ Loss of Sleep
__ Allergy (to what_________________)
__ Loss of Weight
__ Nervousness
__ Wheezing
__ Bronchitis
__ Numbness in BOTH hands AND feet

CARDIOVASCULAR

__ High Blood Pressure
__ Low Blood Pressure
__ Pain over heart
__ Poor Circulation
__ Rapid Heartbeat
__ Previous Heart Problem
(Describe:____________________)
__ Slow Heartbeat
__ Stroke
__ TIA
__ Swollen Ankles
__ Varicose Veins
__ Aortic Aneurysm
__ Bruise Easily

DISEASES / CONDITIONS

__ Appendicitis
__ Anemia
__ Arthritis
__ Alcoholism
__ Abdominal Surgery
__ Bleeding Disorder
__ Blood Clot(s)
__ Breathing Difficulty
__ Cancer
__ Cholesterol – High
__ Colon Problems
__ Diabetes
__ Depression
__ Epilepsy
__ Eczema
__ Eating Disorder
__ Glaucoma
__ HIV+
__ Heart Disease
__ Hernia
__ Headaches
__ Influenza
__ Kidney Disease
__ Liver Disease
__ Low Back Pain
__ Mental Illness
__ Measles
__ Mumps
__ Pleurisy
__ Pneumonia
__ Polio
__ Prostate Problems
__ Hyper Thyroid
__ Hypo Thyroid
__ Rectal Surgery

EARS / EYES / NOSE / THROAT

__ Asthma
__ Crossed Eyes
__ Double Vision
__ Blurred Vision
__ Difficulty Swallowing
__ Deafness
__ Hearing Loss
__ Ear Pain
__ Thyroid Problem
__ Nose Bleeds
__ Sinus Problem
__ Sore Throat

GASTRO-INTESTINAL

__ Gas
__ Colon Trouble
__ Diarrhea
__ Gallbladder Trouble
__ Hemorrhoids
__ Liver Trouble
__ Nausea
__ Stomach Ache
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Constipation
__ Rectal Bleeding
__ Bloating

GENITO-URINARY

__ Blood in Urine
__ Frequent Urination
__ Inability to Control Urine
__ Kidney Infection
__ Painful Urination
__ Prostate Trouble

FOR MEN ONLY

__ Lump in Testicle
__ Penis Discharge

FOR WOMEN ONLY

__ Menstrual Cramps
__ Excessive Menstrual Flow
__ Hot Flashes
__ Irregular Cycle
__ Painful Periods
__ Birth Control Pills
__ Abnormal Pap Smear

MUSCLE / JOINT / BONE

__ Backache
__ Foot Trouble
__ Pain Between Shoulders
__ Painful Tailbone
__ Stiff Neck
__ Spinal Curvature
__ Swollen Joints

NEUROLOGIC

__ Seizures
__ Dizziness
__ Hand Trembling
__ Weakness
__ Difficulty with Speech
__ Loss of Memory
__ Loss of Coordination

RESPIRATORY

__ Chest Pain
__ Chronic Cough
__ Difficulty Breathing
__ Coughing/Spitting Blood

FOR WOMEN

Are you taking birth control? ☐ Yes ☐ No	Are you nursing? ☐ Yes ☐ No
Are you Pregnant? ☐ Yes ☐ No	If so, how long have you been pregnant?

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

POLICIES AND PRACTICES

PRIVACY PRACTICES ACKNOWLEDEGMENT

I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I clearly understand that I am ultimately responsible for payment to Goddard Wellness, for any and all services rendered to me at the time of my visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable.

I accept full responsibility for treatment and I release The Diamond Disc Institute and its doctors/employees from any and all liability in the unlikely event that a problem occurs from my treatment.

I, the undersigned, affirm and certify that the above information is complete and accurate to the best of my knowledge and is true and correct, and consent to chiropractic care in this office.

NOTICE OF PRIVACY PRACTICE

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. Protecting our patients' privacy has always been important to this practice. A new state and federal law, the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. At The Diamond Disc Center, we are very careful to keep your health information secure and confidential. This new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W, Room 509F Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact The Diamond Disc Institute.

VERIFICATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the Practice has provided me a copy of the Notice Of Privacy Practices, via the website www.diamonddiscinstitute.com or hard copy on the file at the offices at 12670 Lake Blvd., Lindstrom MN 55045 which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information.

I understand and acknowledge the above statements with my signature below.

Patient *Date*

If under the age of18, a parent or guardian must sign below:

Parent/Guardian signature *Date*