



## INTAKE FORM

(Please Print)

Today's Date:				Medical Physician's Name:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status:	
				Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>			
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):			Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Website	<input type="checkbox"/> Ad
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

REASON FOR VISIT															
Have you had previous chiropractic care? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Is this condition getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Constant <input type="checkbox"/> Comes and Goes															
How would you describe your discomfort? <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing															
What percent of the time does this condition bother you? <input type="checkbox"/> 0% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%															
Would you consider this problem (check one)...															
<input type="checkbox"/> MINIMAL (Annoying but causing NO limitations)						<input type="checkbox"/> MODERATE (Sometimes tolerable but definitely causing limitations)									
<input type="checkbox"/> SLIGHT (Tolerable but causing a little limitation)						<input type="checkbox"/> SEVERE (Causing significant limitations)									
						<input type="checkbox"/> 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)

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> Nerve Pills | <input type="checkbox"/> Pain Killers (including aspirin) | <input type="checkbox"/> Muscle Relaxers |
| <input type="checkbox"/> Stimulants  | <input type="checkbox"/> Blood Thinners                   | <input type="checkbox"/> Tranquilizers   |
|                                      |   | <input type="checkbox"/> 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

- |                                      |  |  |
|--------------------------------------|--|--|
| <input type="checkbox"/> Chills      | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Nervousness                     |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Headache                | <input type="checkbox"/> Wheezing                        |
| <input type="checkbox"/> Dizziness   | <input type="checkbox"/> Loss of Sleep           | <input type="checkbox"/> Bronchitis                      |
| <input type="checkbox"/> Fainting    | <input type="checkbox"/> Allergy (to what _____) | <input type="checkbox"/> Numbness in BOTH hands AND feet |
| <input type="checkbox"/> Fatigue     | <input type="checkbox"/> Loss of Weight          |  |

#### CARDIOVASCULAR

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Previous Heart Problem | <input type="checkbox"/> Swollen Ankles  |
| <input type="checkbox"/> Low Blood Pressure  | (Describe: _____)                               | <input type="checkbox"/> Varicose Veins  |
| <input type="checkbox"/> Pain over heart     | <input type="checkbox"/> Slow Heartbeat         | <input type="checkbox"/> Aortic Aneurysm |
| <input type="checkbox"/> Poor Circulation    | <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Bruise Easily   |
| <input type="checkbox"/> Rapid Heartbeat     | <input type="checkbox"/> TIA                    |  |

#### 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 ACKNOWLEDGMENT

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](http://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 of 18, a parent or guardian must sign below:

\_\_\_\_\_  
*Parent/Guardian signature*

\_\_\_\_\_  
*Date*