Bloom Chiropractic Center
New Patient Intake Form

Patient Information

Today's Date: _____ PIN # (to sign in) - _____

First Name: _____ **MI:** _____ **Last Name:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Sex:** ☐ Male ☐ Female **Date of Birth:** _____

Home #: _____ **Cell #:** _____

Email: _____

Marital Status: ☐Single ☐ Married ☐Widow ☐Other

Employment Status: ☐Employed ☐Student ☐Retired ☐Unemployed

Occupation: _____

Emergency Contact Name: _____ **Relationship:** _____

Contact #: _____

Referral Information

Referring Physician: _____ Location:_____

Referred Patient:_____

Are you familiar with the activator (what the doctor uses to adjust)

☐Yes ☐ No

Were you a previous patient of Bloom Chiropractic?

☐Yes ☐ No

History

In the past have you had:

Previous Chiro Care:	☐Yes	☐No	Pregnancy:	☐Yes	☐No
Auto Accident:	☐Yes	☐No	Work Injury:	☐Yes	☐No
Broken Bones:	☐Yes	☐No	Strain/Sprain:	☐Yes	☐No
Surgery:	☐Yes	☐No	Stroke:	☐Yes	☐No

How often do you:

Drink Alcohol	☐Daily	☐Weekly	☐Occasionally	☐Never
Exercise	☐Daily	☐Weekly	☐Occasionally	☐Never
Drink Water	☐Daily	☐Weekly	☐Occasionally	☐Never
Drink Soft Drinks	☐Daily	☐Weekly	☐Occasionally	☐Never
Smoke	☐Daily	☐Weekly	☐Occasionally	☐Never

Health Checklist

☐ Allergies
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma
☐ Breast Lump
☐ Bronchitis
☐ Bruise Easily
☐ Cancer
☐ Chest Pain
☐ Cold hands/feet
☐ Constipation
☐ Depression
☐ Diabetes
☐ Digestion Problems
☐ Dizziness
☐ Fatigue
☐ Headache/ Migraine
☐ High Blood Pressure
☐ Insomnia
☐ Irregular Heart Beat
☐ Kidney Infection
☐ Kidney Stones
☐ Loss of Memory
☐ Loss of Balance
☐ Loss of Smell
☐ Loss of Taste
☐ Pacemaker
☐ Sciatica
☐ Scoliosis
☐ Thyroid Condition
☐ Ulcers
☐ Varicose Veins

Current Complaint

1. When did your symptoms begin _____

2. Describe your symptoms _____

_____

_____

3. Injury Occurred: ☐ Auto ☐Work ☐Other

4. What activities make your symptoms worse: _____

5. What activities make your symptoms better: _____

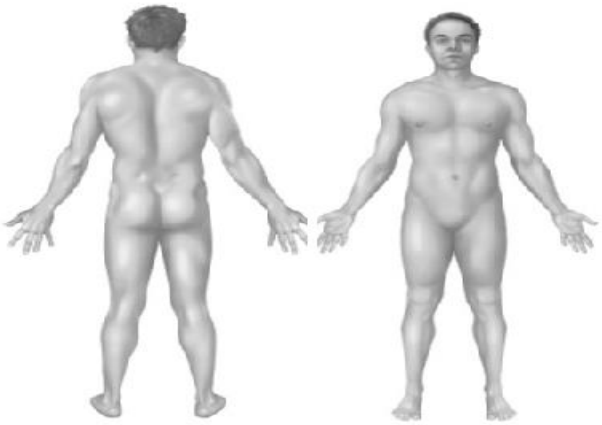
6. Have you received treatment elsewhere for your symptoms: ☐No ☐Yes, if so where_____

_____

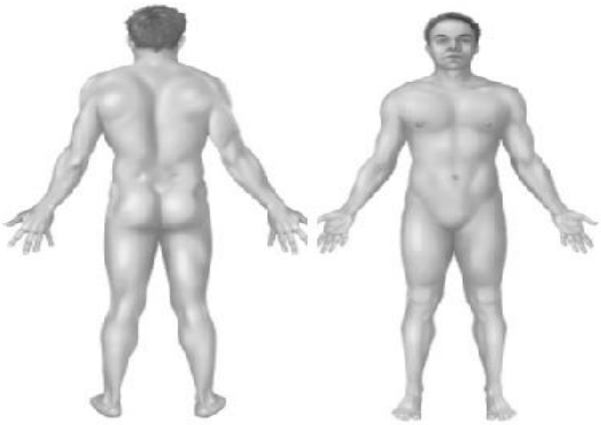
Please fill out the following diagram and questions for each area of pain.

NOTE: Each diagram should only have ONE area selected

Mark the body below for Complaint #1



Mark the body below for Complaint #2



Please answer for 1st Complaint

TYPE OF DISCOMFORT (Circle All That Apply)

Sharp Dull Aching Burning Numbing Shooting

Tightness Throbbing Diffuse Tingling

FREQUENCY (Circle One)

Constant 100-75% Frequent 75-50% Intermittent 50-25% Occasional 25-1%

INTENSITY (Circle One)
1 = no pain, 10 =unbearable

1 2 3 4 5 6 7 8 9 10

Discomfort Increases With: (circle all that apply)

Movement Pressure Prolonged Sitting Coughing/Sneezing

Discomfort Decreases With: (circle all that apply)

Rest Chiropractic Medication Movement Ice Heat

Please answer for 2nd Complaint

TYPE OF DISCOMFORT (Circle All That Apply)

Sharp Dull Aching Burning Numbing Shooting

Tightness Throbbing Diffuse Tingling

FREQUENCY (Circle One)

Constant 100-75% Frequent 75-50% Intermittent 50-25% Occasional 25-1%

INTENSITY (Circle One)
1 = no pain, 10 =unbearable

1 2 3 4 5 6 7 8 9 10

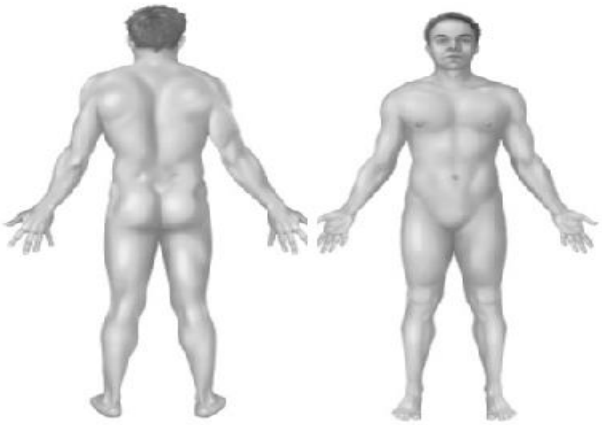
Discomfort Increases With: (circle all that apply)

Movement Pressure Prolonged Sitting Coughing/Sneezing

Discomfort Decreases With: (circle all that apply)

Rest Chiropractic Medication Movement Ice Heat

Mark the body below for Complaint #3



Please answer for 3rd Complaint

TYPE OF DISCOMFORT (Circle All That Apply)

Sharp Dull Aching Burning Numbing Shooting

Tightness Throbbing Diffuse Tingling

FREQUENCY (Circle One)

Constant 100-75% Frequent 75-50% Intermittent 50-25% Occasional 25-1%

INTENSITY (Circle One)
1 = no pain, 10 =unbearable

1 2 3 4 5 6 7 8 9 10

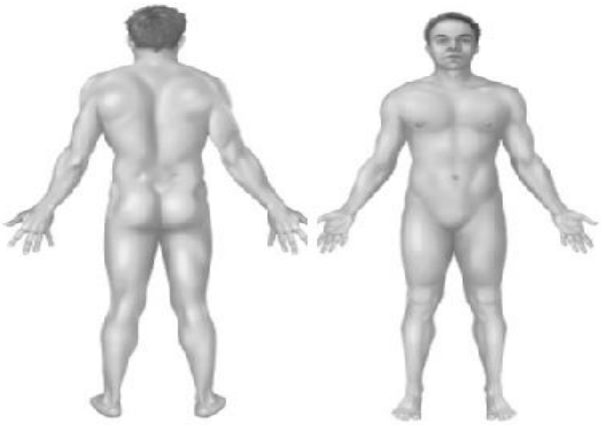
Discomfort Increases With: (circle all that apply)

Movement Pressure Prolonged Sitting
Coughing/Sneezing

Discomfort Decreases With: (circle all that apply)

Rest Chiropractic Medication Movement Ice Heat

Mark the body below for Complaint #4



Please answer for 4th Complaint

TYPE OF DISCOMFORT (Circle All That Apply)

Sharp Dull Aching Burning Numbing Shooting

Tightness Throbbing Diffuse Tingling

FREQUENCY (Circle One)

Constant 100-75% Frequent 75-50% Intermittent 50-25% Occasional 25-1%

INTENSITY (Circle One)
1 = no pain, 10 =unbearable

1 2 3 4 5 6 7 8 9 10

Discomfort Increases With: (circle all that apply)

Movement Pressure Prolonged Sitting
Coughing/Sneezing

Discomfort Decreases With: (circle all that apply)

Rest Chiropractic Medication Movement Ice Heat

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

Name:_____

Email address: _____

After each visit, you will receive an email that allows you to see your medical history. To opt out of that option, please check the box below

☐ **I choose to decline receipt of my clinical summary after every visit**

(These summaries only show what you list above; not visit notes.)

DOB: ___/___/_____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Race (Circle one): White (Caucasian)/ American Indian or Alaska Native / Asian / Black or African American /Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication	Dosage (ex. 75 mg)	Amount (ex. 1 pill)	How Often (ex. once a day)

Do you have any medication allergies? NO or YES- If Yes, Please List Below

Medication:_____ **Reaction:** _____
Medication:_____ **Reaction:** _____
Medication:_____ **Reaction:** _____

Height: _____ Weight: _____ lbs Blood Pressure: _____/_____

INFORMED CONSENT

DOCTOR–PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, VSS and VSC, they are not internal medical specialists. Your doctor of chiropractic may express an opinion as to whether or not you should take the step to get an additional opinion, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or therapy if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

If you have any questions, please discuss any questions or problems with the doctor and/or staff.

I have read, and understand the foregoing.

_____ _____

PATIENT'S PRINTED NAME **DATE**

_____

SIGNATURE of patient, parent, legal guardian or patient's legal representative

ACKNOWLEGEMENT OF PRIVACY POLICY OF BLOOM CHIROPRACTIC

Bloom Chiropractic herein after referred to as the clinic.

I acknowledge that I was provided a copy of the Notice of Privacy Policy and that I have read them OR declined the opportunity to read them and understand the Notice of Privacy Policy. I understand that these privacy practices will be followed by the clinic to ensure the privacy of my personal health information (PHI). I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) **Date**

_____

SIGNATURE of patient, parent, legal guardian or patient's legal representative

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Please list below the names and your relationship of people to whom you authorized the clinic to release your private health information to: (example: spouse, child, friend)

Examples of information that may be released:

- Financials (balances or payments)
- Medical Records
- Appointment Date/Time

Print Name	Relationship

☐ I wish to decline and not list anyone

I hereby consent to have my physician and staff members at Bloom Chiropractic to communicate with me by email and/or phone, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that emails are not sent via a secure portal and are not a confidential method of communication. I further understand that, because of this, there is a risk that emails regarding my medical care might be intercepted and read by a third party.

I give my permission to leave both appointment reminders AND my private health information at the following (please fill-in the ones you agree to): Please list at least 1 phone number

Cell Phone number_____ OK to leave message? YES or NO

Home Phone number _____ OK to leave message? YES or NO

Email_____

You may revoke or terminate this authorization at any time by submitting a written revocation to this office