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New Patient Intake Form

Please complete this form. If you have any questions, the receptionist is here to assist you.

Today's Date _____ SSN: _____ Driver's License # _____
Last Name _____ First Name _____ MI _____
Prefer to be called _____ Age _____ Birth date _____ M F

Whom may we thank for referring you? _____

Mailing Address _____
(street) (City) (State) (Zip)

Phones: Home _____ Work _____ Cell _____

e-mail address _____

Marital Status Single Married Divorced Widowed

Occupation _____ Employer _____

Work address _____
(street) (City) (State) (Zip)

Spouse's Name _____

Emergency Contact Person _____ Phone Number _____

Have you received Chiropractic care in the past? Yes No When _____

If yes, please give the name of the Chiropractor _____

Please describe the reason for previous care _____

Name of you Medical Doctor _____

Name of your health insurance company _____ Policy # _____

Reason(s) for seeking chiropractic care starting with the most important to you:

	Area of concern/interest	Approximate Date Started
1.	_____	_____
2.	_____	_____
3.	_____	_____

What is one thing about your health/life that you would love to change?

File _____



Patient General History Questionnaire

Name: _____

Date: _____

Chiropractors are interested in helping your body function optimally. Frequently, there are events, injuries, or traumas that occur throughout life that affect the development and structure of your spine. Such altered function can influence the nervous system and may affect your general health.

Please answer the following to the best of your ability:

In general, would you say your health is (check one):

- Excellent Very Good Good Fair Poor

Compared to one year ago, how would you rate your general health now?

- Much better now Somewhat worse now About the same
 Somewhat better now Much worse now

Health is affected by your nervous system, but is also affected by your environment, the foods you eat, and your lifestyle activates and habits.

Health Risk Factors

Comments:

- | | | |
|--------------------------------------|--|---------------------|
| Do you smoke? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Packs/day _____ |
| Do you drink alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drinks/week _____ |
| Do you drink coffee/caffeine drinks? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cups/day _____ |
| Do you have a healthy diet? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Do you exercise regularly? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Do you sleep well? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Is your job stressful? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| How much water do you drink per day? | | ___ Glasses per day |

Can you think of any other habit or activity that has a positive or negative effect on your health? Yes No If yes, please explain _____

Please indicate any medications you are currently taking:

- | | | |
|---|---|--|
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Steroids | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Anti-Anxiety/Anti-Depression | <input type="checkbox"/> Stimulants | <input type="checkbox"/> Sleeping Aids |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Pain Killers (including Aspirin / Ibuprofen) | |

File _____



High Cholesterol

Others/nutritional supplements/dietary aids, etc: _____

Review of Systems

Please check any conditions you have had in the past or have now:

Now	Past	Now	Past	Now	Past			
<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder/arm pain	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat
<input type="checkbox"/>	<input type="checkbox"/>	Hip/leg pain	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble	<input type="checkbox"/>	<input type="checkbox"/>	Frequent infections
<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problem
<input type="checkbox"/>	<input type="checkbox"/>	GERD	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Women: Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble	<input type="checkbox"/>	<input type="checkbox"/>	Pins & needles
<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Balance
<input type="checkbox"/>	<input type="checkbox"/>	Cold Hands	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in toes	<input type="checkbox"/>	<input type="checkbox"/>	Cold Feet
<input type="checkbox"/>	<input type="checkbox"/>	Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>	Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Finger Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/constipation	<input type="checkbox"/>	<input type="checkbox"/>	TJM
<input type="checkbox"/>	<input type="checkbox"/>	Ears Ringing/buzzing/Tinnitus				<input type="checkbox"/>	<input type="checkbox"/>	Stroke

Have you ever:

Had any accidents, falls, traumas, or injuries?

Comments:

Yes No _____

Been hospitalized?

Yes No _____

Had a broken bone?

Yes No _____

Had surgery?

Yes No _____

Family History

Did/do you, your mother or father had/have any of the following: Put a **M** for Mother, **F** for Father, **S** for Self.

_____ High Blood Pressure	_____ Diabetes	_____ Mental Illness
_____ Thyroid Disease	_____ Kidney Disease	_____ Heart Attack
_____ Circulation Problems	_____ Pacemaker	_____ Emphysema
_____ Seizures/Convulsions	_____ Stomach Problems	_____ Ulcer
_____ Cancer	_____ HIV Positive	_____ Stroke
_____ Asthma	_____ Arthritis	_____ Rheumatoid

I certify that I have read and understand the above information to the best of knowledge. The above questions have been accurately answered.

Patient Signature _____

Date _____

File _____

Terms of Acceptance and Consent for Care

When a client seeks chiropractic health care and we accept a client for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each client understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom.** Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at Chino Valley Family Chiropractic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signed _____ (Patient's Signature) _____ (Date)

I, _____ (Print name) have read and fully understand the above statement.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

(Patient's Signature) _____ (Date) Witnessed: _____ (Witness's Signature) _____ (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle. _____

(Signature) _____ (Date)



Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to [Chino Valley Family Chiropractic].

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 98 North Highway 89 Chino Valley, AZ 86323. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative's Authority

File _____



QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

Date _____

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain and pain at its best and worst.

What is your **PAIN LEVEL RIGHT NOW?**

No Pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

What is your **TYPICAL or AVERAGE PAIN LEVEL?**

No Pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

What is your PAIN LEVEL **AT ITS BEST?**

No Pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

What is your PAIN LEVEL **AT ITS WORST?**

No Pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

File _____