



Chiropractic Intake

8791 Wolff Ct. Suite 140
Westminster, CO 80031
PH: 303-427-2414
FX: 303-427-5719

Name: _____	DOB: _____	Age: _____	Sex: M / F
Address: _____	City: _____	ST: _____	ZIP: _____
Home Phone: _____	Mobile Phone: _____	Preference: <input type="checkbox"/> H <input type="checkbox"/> C	
Email Address: _____ (By providing your email you consent to being added to our mailing list)			
Employer: _____	Occupation: _____		
Emergency Contact: _____			
Relationship: _____	Contact Phone: _____		
Do you have Medicare? _____ (If yes, please provide your card)			
How did you hear about our office? (Who referred you) _____			

What type of treatment are you looking for? (Check all that apply)

- Quick Fix. I want the minimal amount of care to "patch up the symptoms" of my problem.
- Problem Fix. I want to resolve the symptoms and go on to "fix the cause" of my problem.
- Optimal. I want to take care of my current problems then go on to "achieve optimal health".

Please describe the current condition that brings you to our office: _____

When did the condition start: _____

Onset of the condition was (circle one): Sudden Gradual Associated w/ an event

The event: _____

Is the condition getting worse? Yes No

Is this condition interfering with your: Sleep Work Daily Routine Other: _____

Have you received treatment for this problem? Yes If Yes, please describe: _____

Any other health concerns: _____

Have you ever been in an auto accident: Never Past Year Past 5 years Over 5 years

Please describe: _____

Check all that apply: PAST (P) OR CURRENT (C)

Musculoskeletal System	P	C	G/I Tract	P	C	Nervous System	P	C
Low Back Pain			Excessive Hunger			Muscle Jerking		
Mid Back Pain			Difficulty Swallowing			Confusion		
Pain b/w Shoulders			Excessive Thirst			Forgetful		
Neck Pain			Nausea			Cardio-Vascular		
Arm Problems			Abdominal Pain			Chest Pains		
Shoulder Pain			Blood			Pain over Heart		
Leg Problems			Black Stool			Difficulty Breathing		
Ankle/Foot Pain			Hemorrhoids			Persistent Cough		
Wrist/ Hand Pain			Liver Problems			Rapid Heart Rate		
Swollen Joints			Gall Stones			Slow Heart Rate		
Painful Joints			Weight Fluctuation			Varicose Veins		
Stiff Joints			Acid Reflux/ Heart Burn			Known Heart Problems		
Sore Muscles			Genito- Urinary System			Known Lung Problems		
Weak Muscles			Fullness of Bladder			Eye/Ear/Nose		
Walking Problems			Urinary Difficulty			Vision Problems		
Spasms			Frequent Urination			Ear Pain		
Broken Bones			Painful Urination			Ear Tubes		
TMJ (Jaw Pain)			Stones			Tinnitus/ Ringing		
Teeth Grinding			Nervous System			Sinus Pain		
Female System			Convulsions			Seasonal Allergies		
Irregular Menstruation			Irritability			Nose Bleeds		
Hot Flashes/ Night Sweats			Impatience			Sore Throat		
Breast Pain/ Lumps			Depression			Hoarseness		
Pain During Cycle			Insomnia			Dry Mouth		
Miscarriage			Fainting			Bad Breath		
Pregnancy			Paralysis			Bad Taste		
G/I Tract			Numbness			Infections (Write In)		
Constipation			Tingling					
Diarrhea			Dizziness					
Poor Appetite			Headaches					

Medications: Please list your current medications including “over the counter” medications and nutritional supplements.

Name of Medication:	Dose:	Reason for taking:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Allergies:

Food: _____

Seasonal: _____

Environmental: _____

Medications: _____

Have you had any surgeries or extended hospitalizations?:

Family History: Identify any conditions that a family member has now or has had in the past
(G=Grandparent, M=Mother, F=Father, S=Sibling)

Alcoholism/ Drug Abuse	Goiter	Seizures/ Fainting	
Anemia	Gout	Stroke	
Cancer:	Heart Disease	Tumors	
Cold Sores	Pneumonia	Ulcers	
Deep Vein Thrombosis	Rheumatic Fever	Vaccination Reaction	
Diabetes	Miscarriage	Eczema	
Diverticulitis/ IBS		Genetic Disorders:	

Social Habits:

	Heavy	Moderate	Light
Alcohol			
Coffee			
Soda			
Tobacco			
Drugs (Rec.)			
Stress			
Electronics			
TV			
Artificial Sweeteners			

Exercise: 5-7x/wk 3-5x/wk 1-3x/wk

Type _____ Duration _____

Sleep: 8+ hrs 7-8 hrs 6-7 hrs 5-6 hrs <5 hrs

Meals: 5+ 4 3 2 1

Water: 64+oz 32-64oz 16-32oz <8oz

Water Type: _____

Work Activity: Heavy duty Light labor Mostly sitting

Mostly standing Walking/moving Driving

Dietary Restrictions:

Vegetarian		Soy	
Vegan		Gluten	
Other:			

Permission to Communicate Protected Health Information:

I, _____ DOB: _____, grant permission for Natural Family Health Care, Inc. to disclose my health information to those specified below:

Name Relationship Phone

Name Relationship Phone

Name Relationship Phone

***I understand this may include detailed personal medical information including, but not limited to: medical services to be provided, notification of supplements to be picked up, or appointments to be scheduled.**

Date: _____

Signature of Patient or Authorized Representative

This consent form will expire when revoked in writing by the patient/representative or, in the case of a minor, on the date the minor becomes an adult under state law.

Privacy Policy:

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree how your records are used.

1. The patient understands and agrees to allow NFHC to use their PHI for treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office will not release any of your records without your written consent.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by NFHC to assure that your records are not readily available to those who do not need them.
6. If a patient has a complaint about the privacy of records, please contact Michael, our office manager.
7. If the patient refuses to sign this consent, our office has the right to refuse care.

I have read and understand how my PHI will be used and I agree to these policies and procedures. Please let us know if you would like a full copy of the office "Notice of Patient Privacy Policy".

Signature: _____ Date: _____

Printed Name: _____

Consent for Professional Services:

I authorize and release Natural Family Health Care, Inc to administer treatment, physical examinations, chiropractic care or any other clinic service deemed necessary by a provider of Natural Family Health Care, Inc.

Signature of Patient or Authorized Representative

Financial Policy

I understand that Natural Family Health Care is not a provider for any insurance companies, other than Medicare.

I clearly understand that all services and products rendered to me are my personal responsibility. If this financial agreement is not paid when due, I agree to pay all reasonable costs of collections including but not limited to court costs, and attorney's fees.

****Any missed appointments without 24 hour prior cancellation notice will be charged the full amount of the visit.****

_____ Date: _____
Signature of Patient or Authorized Representative

Heart Sound Recorder Consent Form

I give NFHC permission to record the sound of my heart and to create a graph of that sound on the Heart Sound Recorder (a general wellness cardiac stress monitor). I have been informed and understand that the Heart Sound Recorder (HSR) is not capable of diagnosing heart conditions and is not in any way a substitute for such a device. I further understand that the HSR has not been reviewed or cleared by the FDA. I understand that if I have or believe I have a heart condition, that I should see a physician, qualified to evaluate and treat that condition.

Any suggested nutritional or dietary advice is not intended as treatment or therapy for any disease or symptom of disease.

I understand that any techniques, treatments, or lifestyle changes suggested after the use of this device should be undertaken only with the guidance of a licensed physician.

I am giving NFHC permission to share my graph with other practitioners for educational purposes only so long as my name and other personal information are removed.

By signing below, I agree to the above.

Signature: _____ Date: _____

Printed Name: _____