



New Patient Intake Form

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician **Marathon Chiropractic Clinic** and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with **Dr. Ryan Woods** 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 and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

Print Patient's Name

Print Name of Representative

Signature of Patient

Signature of Representative

_____/_____/_____
Date

_____/_____/_____
Date

Physician Signature _____ Date ____/____/_____



New Patient Intake Form

PATIENT INFORMATION

First Name _____ Middle _____ Last _____

Date of Birth ____/____/____ Sex M F Married Single Other

Address _____

City _____ State _____ Zip _____

Home Phone (____) ____ - ____ Cell Phone (____) ____ - ____ Work Phone (____) ____ - ____

Occupation _____ Employer's Name _____

Employer's Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone (____) ____ - ____

INSURANCE INFORMATION

Do you have insurance which covers chiropractic treatment? YES NO (If NO skip this section)

Do you have health insurance where you work? YES NO FECA/Group # _____

Insurance Company _____ Plan ID # _____

Insurance Company Address _____ City _____ State _____ Zip _____

Insured same as patient YES NO (If yes then skip next 3 lines)

Patient Relationship to Insured Self Spouse Child Other

Insured Name _____ Insured Address _____

Insured D.O.B. ____/____/____ Insured Gender M F Insured Phone (____) ____ - ____

ACCIDENT/ILLNESS INFORMATION

Is this condition related to: Employment YES NO

Auto Accident YES NO

Other Accident YES NO

Date of Accident ____/____/____ Dates missed from work _____

How did you hear about Marathon Chiropractic? _____

Physician Signature _____ Date ____/____/____



Marathon Chiropractic

Ryan Woods, D.C.



History

Patient Name _____ Date ____/____/____

List any past diseases including those from childhood _____

List any previous conditions you have been diagnosed with such as diabetes, cancer, heart disease, etc _____

List any **surgeries**, major **traumas** (including concussions and broken bones), illnesses, recent immunizations, or other hospitalizations _____

Have you ever been diagnosed with a spondylolisthesis, compression fracture, or other spinal fracture? _____

List all **medications** you are currently on or have recently taken _____

List all **vitamins** or other supplements you currently take _____

Have you **family** members suffered from any diseases such as heart disease, diabetes, cancer, or any other inherited disease? If so, please list _____

What is your occupation? _____

What are your hobbies/recreational interests? _____

YES NO Are you currently taking NSAIDS (Ibuprofen, Acetaminophen, etc) How often? _____

YES NO Do you drink alcohol? If yes how many drinks and how often? _____

YES NO Do you smoke? How many packs a day? _____ How many years? _____

YES NO Do you use recreational drugs? What/How often? _____

YES NO Are you practicing risky sexual behavior? _____

YES NO Do you exercise on a regular basis? How? _____

YES NO Do you eat fast food more than 3 times a week? How often? _____

YES NO Do you drink water of a regular basis? How many glasses a day? _____

YES NO Do you have difficulties sleeping soundly through the night? _____

YES NO Do you feel fatigued on a regular basis? _____

YES NO Do you have allergies? _____

YES NO Do you eat healthy? Briefly explain your diet _____

YES NO Have you been to a chiropractor before? If so, why and when? _____

HIGH MED LOW What is your level of stress? Explain _____

Physician: _____ Date: ____/____/____



Review of Systems

Patient Name _____ Date ____/____/____

- Yes No Do you ever have skin, hair, or nail problems? _____
- Yes No Have you recently had any rashes/blistering? _____
- Yes No Do you ever have mouth or throat problems? _____
- Yes No Do you ever have nose or sinus problems? _____
- Yes No Do you have hearing or other ear problems? _____
- Yes No Do you have visual problems? _____
- Yes No Do you have recurring headaches/migraines? _____
- Yes No Do you ever have chest, lung, or breathing problems? _____
- Yes No Do you suffer from airborne allergies? _____
- Yes No Do you have any food allergies? _____
- Yes No Do you ever have recurring infections? _____
- Yes No Do you smoke? Cigarettes per day? _____ How long? _____
- Yes No Do you ever have heart or blood vessel problems? _____
- Yes No Do you have high cholesterol or blood pressure? _____
- Yes No Have you ever suffered a stroke or heart attack? _____
- Yes No Do you ever have blood or lymph node problems? _____
- Yes No Do you ever have digestive problems? _____
- Yes No Does your stomach get upset easily? _____
- Yes No Do you ever have genital problems? _____
- Yes No Do you ever have urinary or bowel problems/infections? _____
- Yes No Do you have frequent bouts of diarrhea or constipation? _____
- Yes No Do you have any nervous system diseases or mental health problems? _____
- Yes No Have you ever suffered from depression? _____
- Yes No Do you have any ticks or twitches? _____
- Yes No Do you ever have gland or hormone problems? _____
- Yes No Are you Diabetic? _____
- Yes No Do you ever have numbness or tingling? _____
- Yes No Do you ever have immunity problems? _____
- Yes No Do you recently feel weakness or fatigue more than in the past? _____
- Yes No Do you ever have muscle, tendon, or ligament problems? _____
- Yes No Do you have any bone or joint diseases like osteoporosis or arthritis? _____
- Yes No Have you ever been diagnosed with cancer? _____
- Yes No Does your pain wake you up at night? _____
- Yes No Have you had any recent weight gain or loss? _____
- Yes No Do you ever have sores that are slow to heal? _____
- Yes No **FEMALES** Do you ever have menstrual problems? _____
- Yes No Do you take birth control? How long? _____
- Yes No Is there a chance you are currently pregnant? _____
- Yes No Do you have any breast problems or lumps in tissue? _____

Physician: _____ Date: ____/____/____



Marathon Chiropractic



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Ryan Woods, D.C.

(828) 264-6474

Presenting Problem

Patient Name _____ Date ____/____/____

What is the presenting problem/chief complaint? _____

When did the problem begin? _____

What was the mechanism/cause of injury? _____

Where is the pain located? _____

Describe the pain (ie burning, sharp, shooting, aching, boring, etc) _____

Rate the pain as it is right now, 0-10 with 0 being no pain and 10 being most excruciating pain. _____

Rate the pain when it's at its worst, 0-10 _____

Does anything alleviate the pain? _____

Does anything exacerbate the pain? _____

Does the pain radiate into the extremities? _____

Is the pain worse or better at any time of the day? If so, when? _____

Are there any other associated symptoms? _____

Does the pain affect any of your normal daily activities? What/How? _____

Have you sought any medical attention for this complaint yet? If so, who did you see and what was the therapy? _____

What kind of other treatment have you sought for this problem? _____

Have you had any imaging for this problem (Xray, MRI, CT, etc.)? _____

Describe below any other problems you have been experiencing related or unrelated to the chief complaint

Office use only:

ICD9:

C	str/spr 847.0	seg dys 739.1	IVD syn 722.0	Cervico-cranial syn 723.2	cerv/brachial syn 723.3	brach rad/neur 723.4
T	str/spr 847.1	seg dys 739.2	IVD syn 722.11	Intcost nuer 729.2/353.8	costovert dys 739.8	TOS 353.0
L	str/spr 847.2	seg dys 739.3	IVD syn 722.10	Facet syn 724.8	Sciatica 724.3	
SI	SI str/spr 846.1/846.9	SI seg dys 739.4		Lumbosacral str/spr 846.0		Other:

Severity: 1 2 3 Clinical Decision: Straightforward Low Moderate High

Physician: _____ Date: ____/____/____