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_______________________________________ Email ______________________________________________

City____________________________ State_______ Zip______________

Home Phone (_____)_____-________ Cell Phone (_____)_____-________ Work Phone (_____)_____-________

In what City were you Born? _______________________________________________________________

Occupation___________________________________ Employer’s Name__________________________________

Emergency Contact___________________________ Phone (_____)_____-________

**INSURANCE INFORMATION**

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

Insurance Company___________________________________

Plan ID #______________________________________Group #______________________________________

Insurance Company Address_____________________________ City__________________ State______ Zip__________

Primary 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 _____/_____/________
History

Patient Name______________________________________ Date_____/_____/________

Height: ____________ Weight: ________________ Blood Pressure: ______________________________

List any past diseases including those from childhood______________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

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 any medical allergies__________________________________________________________________________________________
List any 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 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 on 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 eat healthy? Briefly explain your diet ______________________________________________

HIGH MED LOW What is your level of stress? Explain____________________________________________

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

Physician: ____________________________________ Date: ____/____/_______
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 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:

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<th>IVD syn</th>
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Severity: 1 2 3 Clinical Decision: Straightforward Low Moderate High

Physician: ________________________________ Date: _____/_____/________