ADIRONDACK WELLNESS GROUP

ADULT INTAKE FORM

Name____ Today's Date: ____________
Home Address:____
City______________________________ State_____________________ Zip______________
Date of Birth _______________________ **Age** _________ Sex- Male / Female
MARRIED WIDOWED SINGLE MINOR SEPARATED DIVORCED
Home or Cell Phone __________________________________ May we leave a message? **Yes / No**
Cell Phone____ May we leave a message? **Yes / No**
Occupation ____
Email Address____
May we add you to our email newsletter and calendar of events? **YES / NO**
Who may we thank for your referral? ____

PARENTAL CONSENT TO EVALUATE AND TREAT A MINOR

I, ____, being the parent/legal guardian of ____________________________ hereby grant permission for my child to receive chiropractic care.
Name(s) of authorized other individual(s)____
Witness ____

CONSENT TO INITIATE CARE

At our office, we have one simple goal - we want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered some of our business procedures to keep our fees reduced. Please read over these procedures below to understand how our office functions, and decide if you wish to participate. If you have any questions, please direct them to the receptionist.

- For out of network or services, you may choose to submit receipts to your insurance company, or third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office. We take *no responsibility* for non-payment by insurance companies for non-covered services rendered at our office.
- Patients are responsible for payment of non covered services. Such services will be described by the physician and agreed to by both patient and doctor before services are rendered.
- Patients may have a copy of their records, and the original x-rays (if applicable) at any time they request.
- No balances can be kept or run by patients at any time, and all treatment visits are to be paid immediately at time of service.
- All initial visits and exams are paid upon *completion* of these services.
- Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient’s health is not being best served.

I wish to initiate care at this office. I have read and understand the CONSENT TO INITIATE CARE and agree to all terms. I understand that I am under no obligation to receive or continue care.

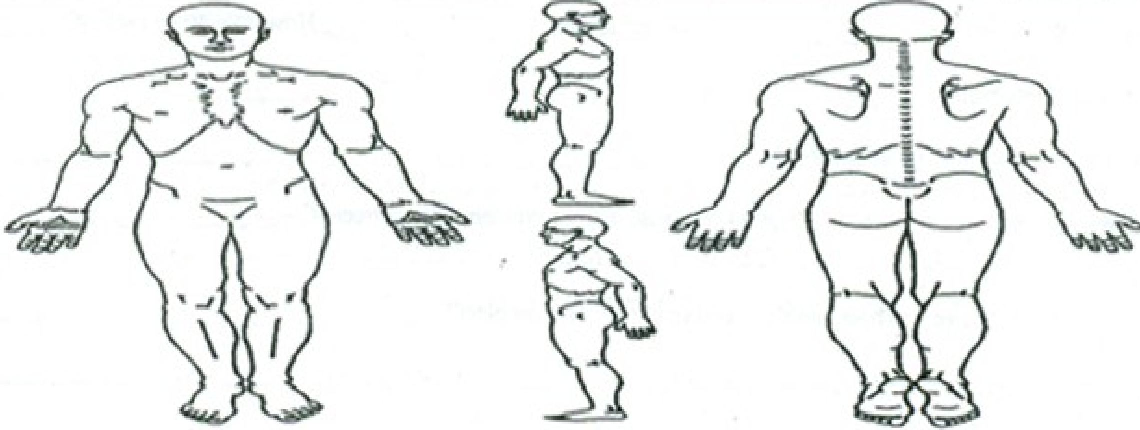
Print your name: ____ Today’s Date: _______

Sign your name: ____

SOME QUESTIONS TO HELP US HELP YOU

where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol (s) listed below.

Ache	>>>>>>	Numbness	======	Pins and Needles	↓↓↓↓↓↓	Burning	××××××
Stabbing	∇∇∇∇∇	Throbbing	~~~~~~	Tingling	+++++	Sharp	↔↔↔↔
Dull	0 0 0 0 0	Soreness	∩∩∩∩∩	Shooting	⊕ ⊕⊕ ⊕	Other	



On a pain analog scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which numbe would describe your pain/discomfort severity, please circle.

What is your pain/discomfort like today?	No Pain	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10	Severe Pain
What is your least pain/discomfort?	No Pain	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10	Severe Pain
What is your worst pain/discomfort?	No Pain	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10	Severe Pain

Chief complaint? ____

____

Other complaints? ____

____

How long have you had this problem for? ______________________________

How did this problem start? ______________________________________

____

Is your problem getting (circle <u>one</u>): Better Worse About The Same

Is pain worse in the morning or at night? □ **Morning** □ **Night**

Have you seen your primary care physician for this complaint? Yes No

What makes it better? ____

____

What makes it worse? ____

____

What does your symptoms feel like? ___________________________________

____

Do you have numbness, tingling or pain in the arms/legs? __________________

If yes, describe where: ____

MEDICAL HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS OR CONDITIONS? (CHECK ALL THAT APPLY)

- ☐ ACID REFLUX
- ☐ AIDS / HIV
- ☐ ALCOHOLISM
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ANXIETY/PANIC ATTACKS
- ☐ APPENDICITIS
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ANEURYSM
- ☐ BLOOD CLOTS
- ☐ BREAST LUMPS
- ☐ BREAST IMPLANTS
- ☐ BRONCHITIS
- ☐ BULGING / HERNIATED DISC
- ☐ CANCER / MALIGNANCY
- ☐ CHICKEN POX
- ☐ CHRON'S DISEASE
- ☐ DIABETES
- ☐ DIZZINESS / VERTIGO
- ☐ DRUG USE
- ☐ DEPRESSION
- ☐ EATING DISORDER
- ☐ EMPHYSEMA
- ☐ EPILEPSY / SEIZURE S
- ☐ FIBROMYALGIA
- ☐ FRACTURES/DISLOCATIONS
- ☐ GOITER
- ☐ GOUT
- ☐ HEART DISEASE
- ☐ HEPATITIS
- ☐ HERNIA
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LUPUS
- ☐ LYME'S DISEASE
- ☐ MEASLES / MUMPS
- ☐ MENINGITIS
- ☐ MIGRAINES
- ☐ MISCARRIAGE
- ☐ MONONUCLEOSIS
- ☐ MULTIPLE SCLEROSIS
- ☐ OSTEOPOROSIS
- ☐ PACEMAKER/DEFIBRILATOR
- ☐ PARKINSON'S DISEASE
- ☐ PINCHED NERVE
- ☐ PNEUMONIA
- ☐ POLIO
- ☐ PROSTATE DISEASE
- ☐ PROSTHESIS
- ☐ PSORIASIS
- ☐ PSYCHIATRIC CARE
- ☐ RHEUMATOID ARTHRITIS
- ☐ RHEUMATIC FEVER
- ☐ SCIATICA
- ☐ SCOLIOSIS
- ☐ STROKE / CVA / TIA
- ☐ THYROID PROBLEMS
- ☐ TUBERCULOSIS
- ☐ TUMORS / GROWTHS
- ☐ TYPHOID FEVER
- ☐ OTHER__________________
- ☐ OTHER__________________

IS IT POSSIBLE THAT YOU MIGHT BE PREGNANT? ☐ NO ☐ YES.........DUE DATE __________ LAST MENSTRUAL PERIOD__________

Please list any medications you are currently taking: ____
____

Please list any surgeries you have had: ____

Please list any auto accidents you have had: ____

Please circle any in your family history: **Heart disease – Diabetes – Arthritis – Cancer – Back Problems**

Do you get any dizziness? ☐ **Yes** ☐ **No** Do you have any heart, lung, or stomach problems ☐ **Yes** ☐ **No**

Height: _______________ Weight:________________ Shoe Size________________ Shoe Width _________________

Name of previous Chiropractor? ________________________ Were X-rays taken in the past 6 months? **Yes** / **No**

Are you looking for temporary relief or do you want to have the cause of your problems fully corrected?
____

What other health problems would you like help with? ____
____

Optional: What do you think chiropractic can help with? ____
____
____
____

WORK INJURY
AND
AUTOMOBILE INJURY NOTICE
(Worker's Compensation, Personal Injury and No Fault)

By signing below, I acknowledge that I am aware that Adirondack Wellness Group and Dr. Bryan Schuerlein do not provide care for work related injuries, automobile accident injuries, or personal injuries. I also acknowledge that I must inform this office if I am in an automobile or work related injury and must seek care at my medical doctor’s office or another health care provider for injuries or conditions sustained. I also am completely aware that Adirondack Wellness Group and Dr. Bryan Schuerlein will not bill, submit claims, nor prepare or submit reports for any automobile, personal or work related injury.

Signed: ____

Name (Please Print): ____________________________________

Date: ____