AMBERWOOD TERRACE
CHIROPRACTIC

663 County Road 17, Suite 3
Elkhart, IN 46516

NEW PATIENT INTAKE FORM

Please fill out the following pages completely and leave no questions unanswered. All of the information will give us the best representation of different stressors that you have accumulated through your life, whether it be physical, chemical or emotional. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.) _____ DOB:_____ Today's Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

SS#_____ Email Address: _____ Sex: ☐ M ☐ F

How did you hear about us? _____

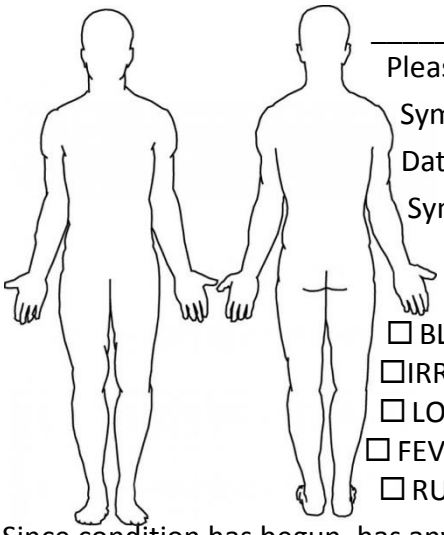
Marital Status: ☐ M ☐ S ☐ W ☐ D Spouse's Name: _____

Emergency Contact: _____ Phone: _____

Current Health Condition:

Chief Complaint (Why are you here today and how did you injure yourself?): _____

_____



_____

Please mark on the image the areas affected.

Symptoms: ☐ PAIN ☐ STIFFNESS ☐ NUMBNESS ☐ WEAKNESS

Date of Onset:_____ Date Symptoms Worsened:_____

Symptoms worse in the: ☐ MORNING ☐ AFTERNOON ☐ NIGHT ☐ W/ ACTIVIY

☐ CONSTANT ☐ INTERMITTENT

Associated signs & symptoms:

☐ BLURRED VISION ☐ HEADACHES ☐ STIFFNESS ☐DEPRESSION ☐ ACHES
☐IRRITABILIT/MOOD SWINGS ☐NAUSEA ☐DIZZINESS ☐ NUMBNESS
☐ LOCALIZED TINGLILNG ☐ RINGING IN EARS ☐ COLD LIMB ☐ FATIGUE
☐ FEVER ☐ HEARTBURN ☐ MUSCLE SPASM ☐ PALE BLUISH SKIN ☐ ANXIETY
☐ RUNNY NOSE ☐ SWEATING ☐ SWELLING ☐ VOMITING ☐ WEAKNESS

Since condition has begun, has anything helped you? If yes, what? _____

On a scale of 0-10 (10 being the worst), what is the level of impairment due to symptoms (resting)? _____

On a scale of 0-10 (10 being the worst), what is the level of impairment due to symptoms (w/activity)? _____

Previous Treatment:

Previous Chiropractic Care? ☐ YES ☐ NO If yes, who?_____

Have you seen other doctors for this condition? ☐ YES ☐ NO If yes, who? _____

Are you currently taking any prescriptions medications? ☐ YES ☐ NO If yes, please list.

_____

_____

Complete Health History:

EYE/VISION:	☐ I DENY ANY EYE/ VISION ISSUE(S)	☐ **BLINDNESS** ☐ **TEARING** ☐ **CATARACTS** ☐ **ITCHING** ☐ **WEAR GLASSES/CONTACTS** ☐ **GLAUCOMA**
NERVOUS SYSTEM:	☐ I DENY ANY NERVOUS SYSTEM ISSUE(S)	☐ **DIZZINESS** ☐ **LOSS OF MEMORY** ☐ **LOSS OF CONSCIOUSNESS** ☐ **NUMBNESS** ☐ **SLEEP DISTURBANCE** ☐ **STROKES** ☐ **FACIAL WEAKNESS** ☐ **LIMB WEAKNESS** ☐ **HEADACHES** ☐ **SEIZURES** ☐ **UNSTEADINESS OF GAIT** ☐ **TREMORS**
EARS, NOSE AND THROAT :	☐ I DENY ANY E/N/T ISSUE(S)	☐ **BLEEDING** ☐ **DISCHARGE** ☐ **SNORING** ☐ **LOSS OF SMELL** ☐ **FREQUENT SORE THROATS** ☐ **SINUS INFECTIONS** ☐ **CONGESTION** ☐ **EAR INFECTIONS** ☐ **TINNITUS** ☐ **DIFFICULTY SWALLOWING** ☐ **TMJ PROBLEMS**
CARDIOVASCULAR:	☐ I DENY ANY CARDIOVASCULAR ISSUE(S)	☐**CHEST PAIN** ☐ **LEG PAIN OR ACHINESS** ☐ **HEART MURMUR** ☐ **ORTHOPNEA (DIFFICULTY BREATHING LYING DOWN)** ☐ **SWELLING OF LEGS** ☐ **ULCERS** ☐ **VARICOSE VEINS** ☐ **WAKING AT NIGHT SHORT OF BREATH** ☐**PALPITATIONS**
RESPIRATION:	☐ I DENY ANY RESPIRATORY ISSUE(S)	☐ **ASTHMA** ☐ **COUGHING UP BLOOD** ☐ **COUGH** ☐ **WHEEZING** ☐ **SPUTUM PRODUCTION** ☐ **SHORTNESS OF BREATH**
GASTOINTESTINAL:	☐ I DENY ANY GASTROINTESTINAL ISSUE(S)	☐ **ABDOMINAL PAIN** ☐ **DIARRHEA** ☐ **HEARTBURN** ☐ **JAUNDICE** ☐ **INDIGESTION** ☐ **CONSTIPATION** ☐ **RECTAL BLEEDING** ☐ **ABNORMAL STOOL** ☐ **VOMITING** ☐ **HEMORRHOIDS**
FEMALE:	☐ **I** DENY ANY FEMALE ISSUE(S)	☐ **BIRTH CONTROL** ☐ **BREAST LUMP** ☐ **CRAMPS** ☐ **HORMONE THERAPY** ☐ **IRREGULAR MENSTRUATION** ☐ **BURNING URINATION** ☐ **VAGINAL DISCHARGE**
MALE:	☐ I DENY ANY MALE ISSUE(S)	☐ **BURNING URINATION** ☐ **ERECTILE DYSFUNCTION** ☐ **IRREGULAR URINATION** ☐ **HESITANCY/DRIBBLING** ☐ **PROSTATE PROBLEMS**
ENDOCRINE:	☐ I DENY ANY ENDOCRINE ISSUE(S)	☐ **COLD INTOLERANCE** ☐ **EXCESSIVE APPETITE** ☐ **DIABETES** ☐ **EXCESSIVE THIRST** ☐ **HAIR LOSS** ☐ **HEAT INTOLERANCE** ☐ **VOICE CHANGES** ☐ **UNUSUAL HAIR GROWTH** ☐ **GOITER** ☐ **EXCESSIVE HUNGER**
SKIN:	☐ I DENY ANY SKIN ISSUE(S)	☐ **CHANGES IN NAIL TEXTURE** ☐ **CHANGES IN SKIN COLOR** ☐ **HAIR LOSS** ☐ **HAIR GROWTH** ☐ **HIVES** ☐ **ITCHINIG** ☐ **RASH** ☐ **SKIN LESIONS/ULCERS** ☐ **VARICOSITIES** ☐ **NUMBNESS, TINGLING, OR PRICKLING**
PSYCHOLOGIC:	☐ I DENY ANY PSYCHOLOGICAL ISSUE(S)	☐ **ANHEDONIA (INABILITY TO EXPERIENCE JOY OR ENJOY LIFE)** ☐ **ANXIETY** ☐ **BIPOLAR DISORDER** ☐ **CONVULSIONS** ☐ **CONFUSION** ☐ **DEPRESSION** ☐ **INSOMNIA** ☐ **MOOD CHANGE(S)** ☐ **MEMORY LOSS**
ALLERGY	☐ I DENY ANY ALLERGY ISSUE(S)	☐ **ANAPHYLAXIS** ☐ **ITCHING** ☐ **FOOD INTOLERANCE** ☐ **SNEEZING** ☐**NASAL CONGESTION**
HEMATOLOGY:	☐ I DENY ANY HEMATOLOGY ISSUE(S)	☐ **ANEMIA** ☐ **BLOOD CLOTTING** ☐ **BRUISES EASILY** ☐ **BLEEDING** ☐ **BLOOD TRANSFUSION(S)** ☐ **FATIGUE** ☐ **LYMPH NODE SWELLING**

Past Health History:

Childhood Illness: ☐ I deny any childhood illness(es) ☐ Other _____

☐ Spina Bifida ☐ Headaches ☐ Hepatitis ☐ HIV ☐ Measles ☐ Mumps ☐ Chicken Pox ☐ ADD ☐ Anemia
☐ Diabetes ☐ Ear Infections ☐ Eczema ☐ Allergies ☐ Asthma ☐ Bed Wetting ☐ Cerebral Palsy

Adult Illness: ☐ I deny any adult illness(es) ☐ Other _____

☐ Alzheimer's ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Measles ☐ Cancer ☐ Crohns ☐ CRPS ☐ Cystic Kidney Disease
☐ Depression ☐ Diabetes ☐ Emphysema ☐ HIV ☐ Hypertension ☐ Liver Disease ☐ Lung Disease ☐ Lupus ☐ MS
☐ Parkinson's ☐ Pleurisy ☐ Pneumonia ☐ Scoliosis ☐ Shingles ☐ STD's ☐ Thyroid Problems ☐ Vertigo

Immunizations: ☐ I deny any immunizations ☐ Diphtheria, Tetanus & Pertussis ☐ TB ☐ Chicken Pox
☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Influenza ☐ Polio ☐ Measles, Mumps & Rubella
☐ Pneumococcal ☐ Small Pox ☐ Whooping Cough

HAVE YOU HAD ANY SURGERIES? ____ IF YES, PLEASE LIST. _____
PLEASE LIST ANY PREVIOUS INJURIES: _____
PLEASE LIST ANY NON-DRUG ALLERGIES: _____
HAVE YOU EVER BEEN PREGNANT? _____

FAMILY HISTORY ☐NONE	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER	CHILD
CANCER							
HEART							
DIABETES							
KIDNEY							
AUTOIMMUNE							
HEREDITARY							
PSYCHIATRIC							
OTHER							

Social Health:

WHAT IS YOUR OCCUPATION?_____
PLEASE DESCRIBE YOUR WORK ACTIVITIES:_____
HOW OFTEN DO YOU USE TOBACCO? ☐NEVER ☐QUIT ☐DAILY ☐WEEKLY ☐MONTHLY
HOW OFTEN DO YOU DRINK ALCOHOL? ☐NEVER ☐QUIT ☐DAILY ☐WEEKLY ☐MONTHLY
HOW OFTEN DO YOU USE ILLICIT DRUGS? ☐NEVER ☐QUIT ☐DAILY ☐WEEKLY ☐MONTHLY
HOW OFTEN DO YOU EXERCISE? ☐NEVER ☐1-2 DAYS/WEEK ☐3-4 DAYS/WEEK ☐5-7 DAYS/WEEK
HOW WOULD YOU DESCIRBE YOUR DIET? ☐POOR ☐ADEQUATE ☐GOOD ☐EXCELLENT
HOW WOULD YOU DESCRIBE YOUR SLEEP QUALITY? ☐POOR ☐ADEQUATE ☐GOOD ☐EXCELLENT
WHAT POSITION DO YOU NORMALLY SLEEP IN? ☐BACK ☐STOMACH ☐LEFT SIDE ☐RIGHT SIDE
HOW WOULD YOU DESCRIBE YOUR DAILY STRESS LEVELS? ☐NONE ☐MILD ☐MODERATE ☐EXCESSIVE
PLEASE LIST ANY ATHLETIC PARTICIPATION OR HOBBIES:_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

ATC
AMBERWOOD TERRACE
CHIROPRACTIC

Informed Consent for Chiropractic Treatment

TO THE PATIENT: You have the right to be informed about your condition, the recommended treatment and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make your better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss my diagnosis, the nature and purpose of my treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment and the risks and benefits of alternative treatment, including no treatment at all.

I understand that there are some risks to chiropractic treatment including, but not limited to: broken bones, dislocations, sprains and strains, increased symptoms and pain, no improvement of symptoms or pain or a worsening/aggravation of the spinal conditions.

Chiropractic care, like all forms of healthcare while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. Specifically, there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome, and death.

The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications and vessel abnormalities may cause and artery to be more susceptible to dissection.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from treatment.

I have read, or have had read to me, the above consent. I have had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment. I intend this consent form to cover the entire course of my treatment for my current condition and for future conditions for which I may seek treatment.

Patient Name:_____ Signature:_____ Date:_____

Parent or Guardian:_____ Signature:_____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ATC
AMBERWOOD TERRACE
CHIROPRACTIC

I **do / do not (please circle one)** give consent to ATC to use my/my families pictures/testimony for the purpose of advertising.

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow- up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I may request your NOTICE OF PRIVATE PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose and carry out treatment, payment or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Patient Name:_____ Signature:_____ Date:_____

Parent or Guardian:_____ Signature:_____ Date: _____

Written Consent for a Child

Name of patient who is a minor/child _____

I authorize Dr. Derrick Hendricks and any and all Amberwood Terrace Chiropractic staff to perform diagnostic procedures, radiographic evaluations, renders chiropractic care and perform chiropractic adjustments to my minor/child.

As of this date, I have the legal right to select and authorize healthcare services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Amberwood Terrace Chiropractic.

Guardian Signature _____ Date:_____

Witness Signature:_____Date: _____

ATC
AMBERWOOD TERRACE
CHIROPRACTIC