Initials _____

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summitfamilychiropractictn.com

ADULT INTAKE FORM

Discover Your True Health Potential.

Welcome to the Summit Family Chiropractic community!

- **First, please initial the top corner of each page.**
- **For any question that does not apply to you, simply respond "N/A" for Not Applicable.**

Today's Date: _____

Have you ever received chiropractic care? ☐ No ☐ Yes, (Please list the City, State, & Doctor):

_____

Has anyone in your family ever received chiropractic care? ☐ No ☐ Yes, (Please list the City, State, & Doctor):

_____

Who can we thank for referring you to our office? _____

PERSONAL INFORMATION

Full Name: _____
Preferred Name: _____
Date of Birth: _____ Age: _____
Address: _____
City: _____ State: _____
Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Cell Phone Provider: _____
Email: _____
Occupation: _____
Employer: _____

☐ Male ☐ Female
Marital Status: ☐ M ☐ S ☐ W ☐ D
Full Name of Spouse: _____
List The Name(s) & Age(s) of Your Children:
_____
_____

Name of Emergency Contact: _____
His or Her Relationship To You: _____
His or Her Phone #: _____

Select Who Is Responsible For Your Finances:
☐ Myself ☐ My Spouse ☐ Both Myself & My Spouse
☐ My Parent(s)/Guardian(s) ☐ Other: _____
Other's Phone #: _____

INSURANCE INFORMATION

Select which is true for you: ☐ Self Pay ☐ Insured, **(Please record the following information)**

Primary Insurance: _____
Member ID #: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Policy Holder's Employer: _____

Secondary Insurance: _____
Member ID #: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Policy Holder's Employer: _____

HEALTH GOALS

Select all of your current health and lifestyle goals:

☐ Relieve Pain/Discomfort
☐ Relieve Muscle Tension
☐ Restore Proper Function
☐ Increase Energy
☐ Improve Posture
☐ Improve Mobility
☐ Improve Flexibility
☐ Drink More Water
☐ Get Adequate Sleep
☐ Pregnancy Care
☐ Fertility Support
☐ Spiritual Renewal
☐ Reduce Medication(s)
☐ Improve Diet/Nutrition
☐ Improve Work & Life Balance
☐ Improve Focus/Concentration
☐ Increase Self Confidence
☐ Restore Emotional Health
☐ Strengthen Immune System
☐ Maintain Healthy Body Weight
☐ Improve Athletic Performance
☐ Increase Time With Family/Friends
☐ Financial Stability
☐ Attend Free Health Classes
☐ Participate in Volunteer Work
☐ Treat Injury: _____
_____
☐ Treat Illness: _____
_____
☐ Quit Unhealthy Habit: _____
_____
☐ Other: _____
_____

Initials _____

CASE HISTORY

Do you have any genetic disorders or disabilities? ☐No ☐Yes, (Explain): _____

_____

Have you ever had a serious illness or health emergency? ☐ No ☐ Yes, (List condition(s) including the year):

_____

Have you ever had an operation? ☐ No ☐ Yes, (List all operation(s) including the year):

_____

_____

Have you ever been in an auto accident? ☐ No ☐ Yes, (Include the year): _____

Have you ever been unconscious? ☐No ☐Yes, (Explain): _____

Have you ever fractured a bone? ☐ No ☐ Yes, (Explain): _____

Do you have any allergies? ☐No ☐Yes, (Explain): _____

How often do you smoke? ☐ Never ☐ In The Past ☐ Occasionally ☐ Daily ☐ Other: _____

How often do you drink alcohol? ☐ Never ☐ In The Past ☐ Occasionally ☐ Daily ☐ Other: _____

How often do you exercise? ☐ Never ☐ In The Past ☐ Occasionally ☐ Daily ☐ Other: _____

What is your typical work activity? (Check all that apply): ☐ Light Lifting ☐ Heavy Lifting ☐ Physical Repetition ☐ Excessive Sitting ☐ Excessive Standing ☐ Low Stress ☐ High Stress ☐ Other: _____

Have you ever taken an antibiotic drug? ☐No ☐Yes, (Include times per lifetime): _____

Are you currently taking any over-the-counter or prescription drug, vitamin/supplement, or natural remedy?
☐ No ☐ Yes, (Please list the name & reason for taking): _____

_____

_____

_____

CURRENT SYMPTOMS

Select which is true for you:

☐ I **DO NOT** have symptoms. I am seeking chiropractic care to maintain wellness.
(If above is selected, move ahead to the "INITIAL ASSESSMENT" section.)

☐ I **DO** have symptoms. **(List all of your symptoms on the lines below)**

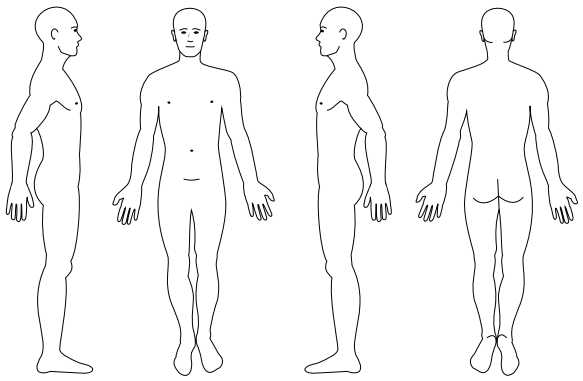
_____

_____

In the diagram to the right, mark the figures in relation to where you experience symptoms on your body. Use the symbols below to show what you are experiencing.

SYMBOLS

A	=	Aching	P	=	Pressure
B	=	Burning	R	=	Radiating
F	=	Stiff & Tight	S	=	Sharp & Stabbing
N	=	Numbness	T	=	Tingling



When did your symptom(s) begin? ☐ Today ☐ Days Ago ☐ Weeks Ago ☐ Months Ago ☐ Years Ago

Did your symptom(s) begin as a result of an injury? ☐No ☐Yes, (Explain): _____

_____

Since your symptom(s) began, is it: ☐ Getting Better ☐ Staying The Same ☐ Getting Worse

When do your symptom(s) occur? (Check all that apply): ☐ Morning ☐ Afternoon ☐ Constant All Day ☐ Night ☐ During Sleep ☐ Increases During The Day ☐ Decreases During The Day ☐ Comes & Goes During The Day ☐ Only During Specific Activities, (Explain): _____

☐ Other: _____

Does your symptom(s) move or travel from one area of your body to another? ☐ No ☐ Yes, (Explain):

_____

What have you already tried that **HAS NOT** helped to relieve your symptom(s)? _____

_____

What have you already tried that **HAS** helped to relieve your symptom(s)? _____

_____

Initials _____

INITIAL ASSESSMENT

NAME:_____ DATE:_____

Select which is true for you.

☐ I **DO NOT** have symptoms. **(If selected, move ahead to the "STRESS ASSESSMENT" section.)**
☐ I **DO** have symptoms. **(If selected, use the "EFFECT SCALE" to answer the statements below.)**

EFFECT SCALE





0	1 2 3	4 5 6	7 8 9	10
NO EFFECT	**MILD EFFECT**	**MODERATE EFFECT**	**LIMITING EFFECT**	**SEVERE EFFECT**
I am free from any symptom. I can do all of my daily activities. My quality of life is good. I am grateful for my good health.	I barely notice the symptom. I can do most of my daily activities. I don't think much about the symptom, but it does cause me some discomfort.	I notice the symptom and it causes me distress. I can do some of my daily activities. I can only ignore the symptom for a short period of time.	I experience constant distress from the symptom. I am unable to do many of my daily activities. I can not ignore the symptom, it disrupts my ability to think clearly, hold a job, and maintain social relationships.	I am in distress and excruciating pain from the symptom. I am unable to do any of my daily activities. I am weak, delirious and bedridden. (Very few people ever experience this level of pain. Suicide is often considered.)

Use the 0-10 "EFFECT SCALE" above to base your answer for each statement below.
List your symptom(s), then read each statement and place an "X" in the box to mark your rating.

List your main symptom here: _____	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											

If you have another symptom, List it here: _____	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											

If you have another symptom, List it here: _____	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											

*** If you have more then 3 symptoms, simply ask a team member for another form.**

STRESS ASSESSMENT

Select all of the emotional, physical, and chemical stress you have experienced in the past 3 months:

☐ Slip / Falls
☐ Car Accident
☐ Sports Injury
☐ Depression
☐ Anxiety
☐ Poor Diet / Nutrition
☐ Excessive Sitting
☐ Excessive Standing
☐ Lack of Exercise
☐ Increase of Exercise
☐ Lack of Sleep
☐ Death of A Loved One
☐ Hospitalization
☐ Surgery / Operation
☐ Change In Medication
☐ Occupational Stress
☐ Financial Stress
☐ Other: _____
_____
_____

Initials _____

ACTIVITIES OF DAILY LIVING

Read each activity listed below and place an "X" in the box to rate if you feel any symptom(s) when doing the activity. Use the 0-10 "EFFECT SCALE" from the previous page to base your answer.
Select "N/A" for any activity Not Applicable to you.

0	1	2	3	4	5	6	7	8	9	10
NO EFFECT	MILD EFFECT			MODERATE EFFECT			LIMITING EFFECT			SEVERE EFFECT

PERSONAL HYGIENE & DAILY CARE

ACTIVITY	RATING												ADDITIONAL NOTES:
	N/A	0	1	2	3	4	5	6	7	8	9	10	
Bathing / Showering													
Grooming Hair													
Brushing Teeth													
Using The Toilet													
Dressing The Upper Body													
Dressing The Lower Body													

DAILY PHYSICAL ACTIVITIES

ACTIVITY	RATING												ADDITIONAL NOTES:
	N/A	0	1	2	3	4	5	6	7	8	9	10	
Standing													
Sitting													
Squatting													
Kneeling													
Reaching Overhead													
Bending Forward													
Turning Left													
Turning Right													
Move From Lying to Sitting													
Move From Sitting to Standing													
Move From Standing to Sitting													

FUNCTIONAL ACTIVITIES

ACTIVITY	RATING												ADDITIONAL NOTES:
	N/A	0	1	2	3	4	5	6	7	8	9	10	
Sleeping													
Eating													
Going Up & Down Stairs													
Getting In & Out of Car													
Driving													
Using A Computer													
Focusing/ Concentrating													
Preparing Food													
Household Chores													
Lifting Children													
Carrying Bag / Purse													

SOCIAL, RECREATIONAL, & OTHER ACTIVITIES

ACTIVITY	RATING												ADDITIONAL NOTES:
	N/A	0	1	2	3	4	5	6	7	8	9	10	
Competitive Sports													
Running / Jogging / Hiking													
Other Recreation Activities													
Hobbies													
Sexual Activity													

Initials _____

FAMILY HEALTH HISTORY

Place an "X" in the box below to show if you or your family members have ever had the following conditions.

- **If there is more than one family member per category, use an "X" to represent each individual.**
- **If you are helping someone fill out this form, use "SELF" to represent his or her conditions.**

CONDITION	SELF	SPOUSE	SON(S)	DAUGHTER(S)	FATHER	MOTHER	SIBLING(S)
Acid Reflux / Heartburn / GERD							
ADD / ADHD							
Allergies							
Anxiety							
Arthritis / Joint Pain							
Asthma / Difficulty Breathing							
Bed Wetting							
Birth Defect							
Cancer							
Colic							
Convulsions / Epilepsy							
Deceased							
Depression							
Diabetes							
Digestive Problems							
Disc Problems							
Ear Problems / Hearing loss							
Fibromyalgia / Muscle Pain							
Frequent Cold / Flu							
Gall Bladder Problems							
Headache / Migraines							
Heart Problems							
High / Low Blood Pressure							
HIV / AIDS							
Impotence / Sexual Dysfunction							
Kidney Problems							
Learning Disability							
Liver Problems							
Menstrual Dysfunction							
Mood Changes / Irritable							
Neck Pain / Back Pain							
Prostate Problems							
Sciatica							
Scoliosis							
Sinus / Drainage Problems							
Skin Problems							
Sleep Problems							
Thyroid Problems							
Tremors							
Vertigo / Dizziness							
Vision Problems							
Other:							

Initials _____

TERMS OF ACCEPTANCE

Here at Summit Family Chiropractic the term **Practice Member** is used instead of "patient" as "patient" suggests illness or injury, and many whom we serve are healthy and seeking wellness rather than symptom management. A Practice Member is an active participant in his or her chiropractic care, and is therefore invited to ask any questions or express any concerns that he or she may have. Practice Members can expect quality service and leadership as they regain control of their health. With the utilization of state of the art advanced technology, a complete analysis of your spine will be administered first to detect the presence of vertebral subluxation complex and to monitor your progress. Please read and sign this form stating that you understand the items explained below. If there is anything that is unclear please ask questions before you sign. If you refuse to sign this form, the doctor reserves the right to refuse care.

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby consent to give the doctor of chiropractic, and anyone working in the Summit Family Chiropractic office authorized by the chiropractor, permission and authority to care for me. Chiropractic tests, diagnosis, analysis, and adjustments are very safe and beneficial and rarely cause any risks. In rare cases, underlying physical defects, deformities or pathologies may make the Practice Member prone to injury. It is the responsibility of the practice member to make it known, or to learn through health care procedures if he or she is suffering from latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the chiropractor. The doctor of chiropractic will not give any treatment or care if he or she is aware that such care should not be used for a particular condition or circumstance. Your doctor of chiropractic is a licensed primary care provider, and is available to work with all other types of providers. I understand that if I am accepted as a Practice Member at Summit Family Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. I understand that following the doctor's recommended care plan is essential to maximizing my healing and reaching optimal health through chiropractic. Furthermore, any questions that I have regarding chiropractic care, will be explained to me upon my request.

AUTHORIZATION FOR X-RAYS

Specific postural x-rays may be necessary for the identification of the location, type, and severity of vertebral subluxation, as well as for the diagnosis and identification of latent or dangerous conditions requiring medical attention. X-rays may also be used to show progress after a period of recommended chiropractic care. At your request, you can receive a copy of your x-rays to a disc for the mandated fee of $15.00.

By signing this page below, I authorize Summit Family Chiropractic to perform diagnostic x-rays of me.

Females, select which is true for you:

☐ To the best of my knowledge, there is no chance that I am pregnant at this time.

☐ I know or believe that I may be pregnant at this time and therefore I **DO NOT** authorize Summit Family Chiropractic to perform diagnostic x-rays of me.

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFIT

By signing below, I recognize that I am financially responsible for all services rendered to me regardless of insurance or benefits. I further understand that any health insurance policy is an arrangement between me and my insurance carrier and that I may be required to pay for some or all of the fees charged to my account. I hereby authorize Summit Family Chiropractic LLC to release all necessary information concerning my health condition to any billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition I authorize Summit Family Chiropractic LLC to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Summit Family Chiropractic LLC to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

_____

Signature of Practice Member Date

Initials _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to your health information and records.

Summit Family Chiropractic LLC, understands the importance of privacy and we are committed to maintaining the confidentiality of your protected health information **(PHI)** in compliance with the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)**. We have developed office policies and procedures that protect your personal and health information when used within our office and any devices used to copy or transfer this data. We assure you that your information will only be shared as required and only for the purpose of administering your case and obtaining payment for services. Be assured that without your permission, your health information will not be used for any other purpose.

The following ways are how your PHI may be used within our office to provide you the best care and services possible:

- To provide treatment, obtain payment, and conduct health care operations.
- To schedule appointments and send reminders.
- To communicate with your family, friends, emergency contact, and/or caregivers with your authorization.
- As permitted or required by the law.
- For certain activities when the law requires it.

The following describes your rights regarding your PHI. You may:

- Request to inspect any copy of your records.
- Request to amend incomplete or inaccurate information in your records.
- Receive an accounting of certain disclosures of your health information.
- Ask for additional privacy protections (although your request may be declined).
- Ask for confidential communications in a particular manner.
- Receive a paper copy of this Notice.
- File a complaint without penalty

Summit Family Chiropractic reserves the right to change this privacy policy as allowed by law and to make the new notice apply to health information already received as well as any information received in the future. A copy of our current notice is available upon request. The notice will display the effective date.

If you believe that we have not properly respected the privacy of your PHI, you may file a complaint with our office by calling (615)-583-9788, sending a letter to our office address: 11227 Lebanon Rd Mount Juliet, TN 37122 or by emailing infosfctn@gmail.com.

I confirm that I have received and reviewed this notice and understand how health information about me may be used and disclosed and how I can get access to my health information and records.

Signature of Practice Member _____ Date _____

TESTIMONIAL CONSENT

IN OFFICE	I DO	I DO NOT
Photographs		
Written Testimonials		
Video Testimonials		
My First Name		
ON SOCIAL MEDIA	**I DO**	**I DO NOT**
Photographs		
Written Testimonials		
Video Testimonials		
My Profile Name		

Summit Family Chiropractic is happy to celebrate and display written testimonials, photographs, and videos in our office and on our social media outlets to educate others about the benefits of chiropractic.

Place an "X" in the boxes to the left to select your preferences.

- **Selecting <u>I DO</u> authorizes Summit Family Chiropractic to display the item.**
- **Selecting <u>I DO NOT</u> does not authorize Summit Family Chiropractic to display the item.**

Attending Doctor's Signature _____ Date _____