INSIDE OUT
CHIROPRACTIC

New Client Intake Form

Please fill out this form as completely and accurately as possible.

Today's Date	

About You

Name			
Age			
Date of Birth			
Home Address			
City	State	ZIP	
Home Phone	Work Phone		
Cell Phone	E-mail Address		
Social Security Number	☐ Male ☐ Female		
Emergency Contact	Phone		
Occupation			
Employer Name			
Business Address			
City	State	ZIP	

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Separated

Spouse/Partner's Name

Names and Ages of Children

How did you hear about InsideOut-Chiropractic?

If you were referred to us who can we thank?

Health Care Practitioner History

Have you ever received chiropractic care? ☐ Yes ☐ No

If yes, approximate date of last visit

Name of chiropractor

Reason for care ☐ Injury/Crisis (symptom focused) ☐ Wellness (focused on health and peak performance) ☐ Other

Reason for ending care

Are you currently receiving medical attention? ☐ Yes ☐ No

If yes, for what?

Please list any medications you are currently taking (prescription and over the counter), reason for taking and for how long.

*NOTE: It is imperative that you list **all** medications as they may have an influence on your care in this office*

Have you consulted or do you regularly consult any of the following practitioners? (Check all that apply)

☐ Naturopath ☐ Acupuncturist ☐ Homeopath ☐ Massage Therapist
☐ Psychotherapist ☐ Energy Healer ☐ Dentist

Reason why?

Your Health Profile

As a full spectrum Chiropractic office, we focus on your body's ability to function optimally and to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of optimal health and wellbeing into the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and compromise one's potential for optimal health. Most often the effects are gradual and not even felt until they become more serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

BIRTH HISTORY	Did your mother smoke/drink/do drugs during pregnancy?	☐ Yes	☐ No	☐ Unsure
	Were you vacuum extracted?	☐ Yes	☐ No	☐ Unsure
	Were you a forceps delivery?	☐ Yes	☐ No	☐ Unsure
	Did your mother have a C-section?	☐ Yes	☐ No	☐ Unsure
	Did your mother have an epidural/medication during labor?	☐ Yes	☐ No	☐ Unsure
	Was labor Induced?	☐ Yes	☐ No	☐ Unsure
CHILDHOOD YEARS	Did you have any childhood illnesses?	☐ Yes	☐ No	☐ Unsure
	Did you have any serious falls?	☐ Yes	☐ No	☐ Unsure
	Were you active in sports?	☐ Yes	☐ No	☐ Unsure
	Did you use drugs or alcohol?	☐ Yes	☐ No	☐ Unsure
	Did you have any surgeries?	☐ Yes	☐ No	☐ Unsure
	Did you have any broken bones?	☐ Yes	☐ No	☐ Unsure
	Were you involved in any car accidents?	☐ Yes	☐ No	☐ Unsure
	Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐ Yes	☐ No	☐ Unsure
	Did you experience any other trauma (physical or emotional)?	☐ Yes	☐ No	☐ Unsure
	Were you vaccinated?	☐ Yes	☐ No	☐ Unsure
	As a child, were you under regular chiropractic care?	☐ Yes	☐ No	☐ Unsure

Adult History (18 To Present)

Do / did you smoke?	☐ Yes	☐ No
Do / did you drink alcohol?	☐ Yes	☐ No
Do / did you use recreational drugs?	☐ Yes	☐ No
Do / did you use prescription or over the counter medications?	☐ Yes	☐ No
Do you consume caffeine / sugar / artificial sweetener?	☐ Yes	☐ No
Have you been in any accidents?	☐ Yes	☐ No
Have you had any surgeries?	☐ Yes	☐ No
Do / did you play sports?	☐ Yes	☐ No
Do / did you participate in extreme sports?	☐ Yes	☐ No

Other...

Dr. Doug Barnard | doug@insideout-chiropractic.com | (509)-637-0969 410 | E Jewett Blvd, White Salmon, WA 98672

Quality of Life

How would you describe your...

...occupational stress level?	☐ Low	☐ Moderate	☐ High
...personal stress level?	☐ Low	☐ Moderate	☐ High
...physical health?	☐ Excellent	☐ Good	☐ Poor
...mental/emotional health?	☐ Excellent	☐ Good	☐ Poor
...overall "quality of life"?	☐ Excellent	☐ Good	☐ Poor

Do you exercise regularly? If yes, what type and how often?

Do you take nutritional supplements? If yes, please list:

Do you follow a special dietary regime? If yes, describe:

Goals for Care

People choose to receive chiropractic care for many different reasons. What best describes your choice? (Check all that apply)

☐ Relief from your pain or symptoms
☐ To be more connected to your body
☐ To optimize your function and performance
☐ To experience a new level of health and wellbeing
☐ Not sure
☐ Other:

Addressing the Issues that Brought You to the Office

If you do not currently have a complaint and you are here for the chiropractic wellness experience, please check (✔) here ☐ and skip to the next section.

Briefly describe your ***chief area of complaint***, including how it started:

Date of Onset ____ / ____ / ____

Please describe the quality of the problem (Check all that apply):

☐ Deep ☐ Dull ☐ Achey ☐ Throbbing ☐ Stabbing
☐ Sharp ☐ Numb ☐ Tingling ☐ Cramping ☐ Travels

How often are you aware of the problem? (Check the most appropriate option):

☐ Constant (75%-100%) ☐ Frequent (51%-75%) ☐ Occasional (26%-50%) ☐ Intermittent (0%-25%)

Since the onset of the problem, is it (Check the most appropriate option):

☐ Getting better ☐ Getting worse ☐ About the same ☐ Coming and going

What makes it better?

What makes it worse?

Grade the Intensity of the problem (Circle): 0 1 2 3 4 5 6 7 8 9 10

Briefly describe your ***second area of complaint***, including how it started:

Date of Onset ____ / ____ / ____

Please describe the quality of the problem (Check all that apply):

☐ Deep ☐ Dull ☐ Achey ☐ Throbbing ☐ Stabbing
☐ Sharp ☐ Numb ☐ Tingling ☐ Cramping ☐ Travels

How often are you aware of the problem? (Check the most appropriate option):

☐ Constant (75%-100%) ☐ Frequent (51%-75%) ☐ Occasional (26%-50%) ☐ Intermittent (0%-25%)

Since the onset of the problem, is it (Check the most appropriate option):

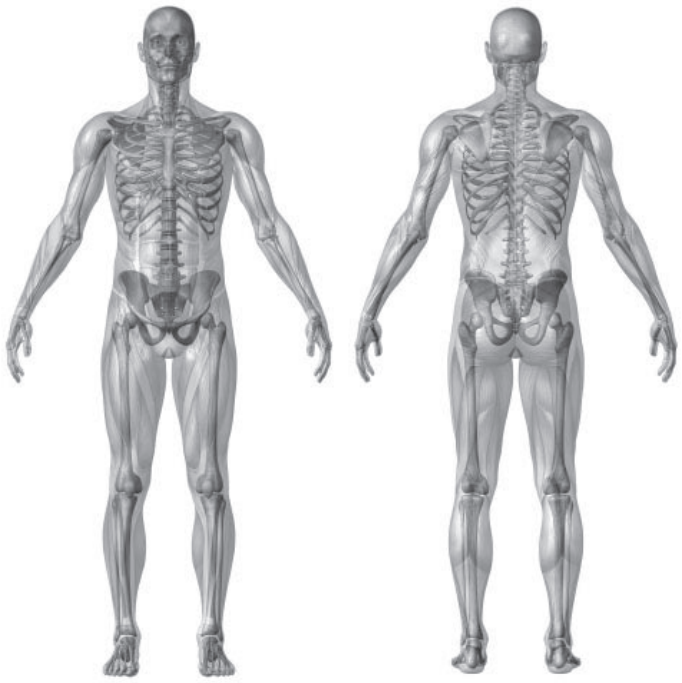
☐ Getting better ☐ Getting worse ☐ About the same ☐ Coming and going

What makes it better?

What makes it worse?

Grade the Intensity of the problem (Circle): 0 1 2 3 4 5 6 7 8 9 10

If applicable, please illustrate the location of your current complaints on the diagram below:



Symptoms

Please check (✔) all symptoms you have ever experienced, even if they do not seem related to the reason for your current visit

☐ Headaches	☐ Vertigo	☐ Fatigue	☐ Diarrhea	☐ Mood swings	☐ Rashes/Excema
☐ Pins and needles in legs	☐ Dizziness	☐ Depression	☐ Constipation	☐ Menstrual pain	☐ PMS
☐ Fainting	☐ Ringing in ears	☐ Irritability	☐ Fever	☐ Menstrual irregularity	☐ Cancer
☐ Neck pain	☐ Nervousness	☐ Tension	☐ Hot Flashes	☐ Ulcers	☐ HIV
☐ Pins and needles in arms	☐ Numbness in fingers	☐ Sleeping problems	☐ Cold sweats	☐ Poor concentration	☐ Weight changes
☐ Loss of smell	☐ Numbness in toes	☐ Neck stiff	☐ Lights bother eyes	☐ High blood pressure	☐ Heart conditions
☐ Back pain	☐ Loss of taste	☐ Cold hands	☐ Urinary changes	☐ Allergies	☐ Shortness of breath
☐ Loss of balance	☐ Stomach problems	☐ Cold feet	☐ Heartburn	☐ Eating disorders	

This information I have provided on this form is true and accurate to the best of my knowledge and I agree to allow Dr. Barnard to examine me for further evaluation.

Patient / Guardian Signature

Date

Dr. Doug Barnard | doug@insideout-chiropractic.com | (509)-637-0969 410 | E Jewett Blvd, White Salmon, WA 98672

Financial Agreement

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

Please select your form of payment.

☐ Cash ☐ Check ☐ Credit Card ☐ HSA ☐ FSA

Patient / Guardian Signature _____ Date _____

Terms of Acceptance

When a patient accepts chiropractic care, it is essential for both the patient and the chiropractor to be working towards the same objective. It is only when the patient understands the objective that they will be able to attain it. This will prevent any confusion of disappointment.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease.

Interference to the function of the nerve system distorts the clear communication of energy and information between the brain and the body, lessening one's innate potential to achieve optimal health.

Adjustments are specific force applications that facilitate the release of nerve system interference to enhance the communication of energy and information between the brain and the body.

Chiropractic is not a substitute, an alternative, or a preventative form of medicine. We do not offer to diagnose or treat any disease or condition. The only objective of this office is to facilitate the optimal function of the Nerve System and to support you and your body in integrating this process. However, if during the course of chiropractic care, non-chiropractic or unusual findings are encountered, these will be brought to your attention. If you desire any advice, diagnosis, or treatment for those findings, I encourage you to seek the council of a medical disease care specialist.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient / Guardian Signature _____ Date _____

Witness Signature (Office Staff) _____ Date _____

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic working at this office.
I understand and I am informed that chiropractic care, while offering considerable benefit, like all forms of health care, there is also an associated level of risk. The types of complications that have been reported secondary to chiropractic care include, but are not limited to, fractures, irritation of a disc condition, sprain/strain injuries, dislocations, and rarely, a vertebral artery injury that could lead to stroke.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interest.

I have had the opportunity to discuss with the doctor of chiropractic and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures.

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

Patient Name (Please Print) _____

Patient / Guardian Signature _____ Relationship to Patient _____ Date _____

Witness Signature (Office Staff) _____ Date _____

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient Name (Please Print) _____

Patient / Guardian Signature _____ Relationship to Patient _____ Date _____