Chiropractor Intake Form

Title: (Circle one) Mr. Mrs. Ms. Miss Dr. Other _______

First Name __________________ **Middle Initial** ____ **Last Name** _________________________

Address ____

City ______________________________ **State** __________________ **Zip Code** _____________

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (____) ________-__________ **Work Phone** (____) _________-___________

Cell Phone (____) ________-__________ **Email** __________________________________

Date of Birth _____/_____/______ **Sex:** Male Female

Social Security Number: ______-_____-______ **Marital Status:** Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other_____

Employer Data

Employer ____

Your Occupation ____

Spouse Data

First Name _______________________ **Middle Initial** ____ **Last Name** ______________________

Home Phone (____) _______-__________ **Work Phone** (____) _______-____________

Spouse Date of Birth _____/_____/______

Emergency Contact

Contact Name ___________________________ **Relationship to Patient** __________________

Contact Home Phone (____) _______-________ **Cell Phone** (____) ________-______________

Doctor's Signature _______________________________________

How did you hear about our office? ____

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other ____________	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Breast Augmentation	Other ____________		

Allergies: (Circle all that apply to you)

Mold	Seasonal	Milk or Lactose	Animal
Chemical __________	Sulfites	Wheat/Glutens	Other ________

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Drink Water:	<64 oz/day	>64 oz/day	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Sleep:	<8 hours/night	>=8 hours/night	Insomnia
Other ______________			

Family History: (Circle all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling
Other ______________		

Occupational Activities: (Circle one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper
Other ______________			

Doctor's Signature ____________________________________

Patient Name ____ Date ________________

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular	Past	Present	No
Poor Circulation			
Hypertension			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of legs			

Genitourinary	Past	Present	No
Kidney Disease			
Burning Urination			
Frequent Urination			
Blood in Urine			
Kidney Stones			
Lower Side Pain			

Neurologic	Past	Present	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's			
Carpal Tunnel			
Vertigo			

Constitutional	Past	Present	No
Weight Loss/Gain			
Low Energy Level			
Difficulty Sleeping			

Respiratory	Past	Present	No
Asthma			
Tuberculosis			
Short Breath			
Emphysema			
Cold/Flu			
Cough			
Wheezing			

Eyes	Past	Present	No
Glaucoma			
Double Vision			
Blurred Vision			

Psychiatric	Past	Present	No
Depression			
Anxiety			
Stress			

Endocrine	Past	Present	No
Thyroid			
Diabetes			
Hair Loss			
Menopausal			
PMS			

Hematologic	Past	Present	No
Hepatitis			
Blood Clots			
Cancer			
Bruising			
Bleeding			
Fever, Chills			
Sweating			
Varicose Vein			

Allergic/Immunologic	Past	Present	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Ear, Nose and Throat	Past	Present	No
Difficulty Swallowing			
Dizziness			
Hearing Loss			
Sore Throat			
Nosebleeds			
Bleeding Gums			
Sinus Infections			

Gastrointestinal	Past	Present	No
Gall Bladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal	Past	Present	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			
Neck Pain			
Low Back Pain			
Upper Back Pain			

Please list all current medications being taken ____

____

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

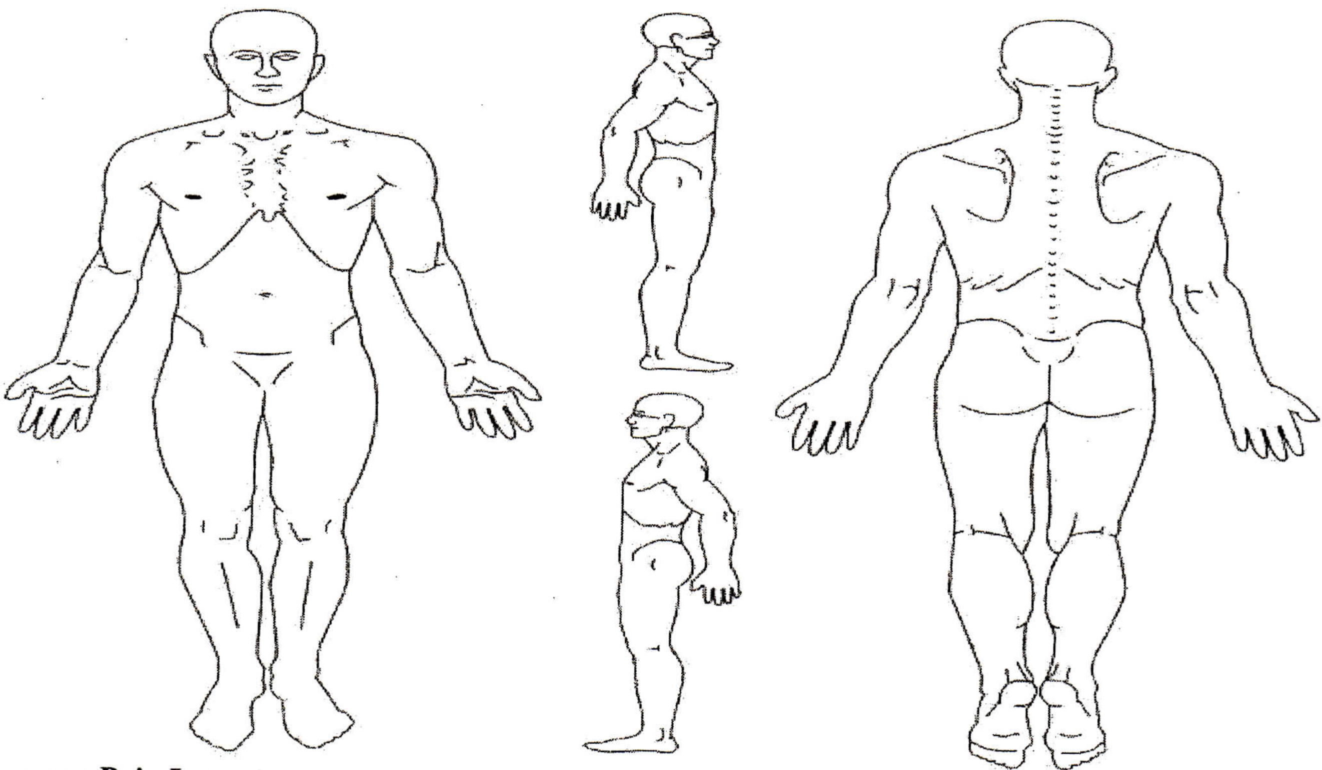
Are You Pregnant? (Check) ☐ **Yes** ☐ **No**

Doctor's Signature ______________________________

Patient Name____________________________________ **Date**________________

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No **If Yes, please list:**

When did your symptoms begin? ______________________________

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How did your symptoms begin? ______________________________

____

How often do you experience your symptoms?

Constantly (76-100% of the day)	Frequently (51-75% of the day)	Occasionally (26-50% of the day)	Intermittently (0-25% of the day)

What describes the nature of your symptoms?

Sharp	Ache	Numb	Shooting
Burning	Tingling	Throbbing	Other ______

Doctor's Signature ______________________________

Patient Name______________________________ Date____________________

Patient and Insurance Information

Name email Date

Address Apt #

Town State ZIP

Home Phone Work Phone Beeper

Drivers License # Birth Date Soc Sec #

Marital Status M S D Sep Spouse Name # of Children

Referred By: Age Range of Children

Employer Occupation

Address

Town State ZIP

Health Insurance Info

Carrier Ins Co phone

Address

Policy # Group #

Patient Relationship to the insured Self Spouse Child Other

If you are covered under another persons insurance…. Please complete

Name of Insured

Address of insured

Phone of insured Sex Birth date

Insured's Employer

Address

Employer Phone Plan Name

Auto Accident Insurance

Policy Number

Carrier

Address

City State ZIP Phone

Person To Contact… Claim #

Date of Accident Patient Relationship to the insured Self Spouse Child Other

Informed Consent for Chiropractic Care

Chiropractic treatment involves the science, philosophy, and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. I understand that the chiropractor will use his/her hands, or mechanical device upon my body to adjust vertebral segments, areas of the head and joints of extremities. This may cause an audible sound. I understand and am informed that, as in the practice of medicine, the practice of chiropractic involves some risks including, but not limited to, fractures, disc injuries, strokes, skin irritation, dislocations and sprains. I will rely on the doctor's training, judgment and expertise to provide the course of treatment which he/she feels, based upon the clinical assessment, is in my best interest.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me, by the doctor of chiropractic named below and/or by a trained assistant who is under the supervision of the doctor of chiropractic.

I have read the Informed Consent to Chiropractic Care 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.

_________________________ _________________________ _______________

Name (Printed) Signature Date signed

Consent to Evaluate and Treat a Minor Child

I, ____________________ being the parent or legal guardian of ____________________________

have read and fully understand the above Informed Consent and herby grant permission for my child to receive chiropractic care.

_________________________ _________________________ _______________

Name (Printed) Signature Date signed

THRIVE SPINE AND HEALTH CARE
JEFFREY H. DERKACH, D.C.

22219 Palos Verdes Blvd.
Torrance, CA 90505
(310) 954-2394 thrivespinecare.com

Patient Name: ______________________________

Date of Injury: ______________

MEDICAL LIEN

Attorney Name:

____

____

____

I hereby authorize and direct my attorney, to pay directly to Jeffrey H. Derkach, D.C. such sums as may be due and owing for professional services rendered to me both by reason of this accident and by reason of any other bills that are due to the provided and to withhold such sums from any settlement of judgment as is necessary to adequately protect the provider.

I hereby further give a lien to the provider on any proceeds to which I may become entitled as a result of any settlement of judgment in any claim or litigation arising out of the injuries for which I have been treated of injuries in connection therewith, whether such proceeds are remitted directly to me or to you my attorney.

I fully understand that I am directly responsible to the provider for all professional bills submitted by the provider for services rendered to me by the provider and that this agreement is made solely for the providers' additional protection and in consideration of the provider awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Attorney agrees to notify the doctors immediately of the name and contacting information of any attorney substituted in his or her place.

______________________________ ______________________
Print Patient Name Date

______________________________ ______________________
Signature of Patient Signature of Parent/Guardian

ACKNOWLEDGEMENT OF ASSIGNMENT & LIEN BY ATTORNEY

The undersigned being the attorney of record on his/her own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his/her stead for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Jeffrey H. Derkach, D.C.

______________________________ ______________________
Attorney's Signature Date

NOTE TO ATTORNEY

PLEASE SIGN AND RETURN ONE COPY TO THE PROVIDERS OFFICE; KEEP A COPY FOR YOUR RECORDS