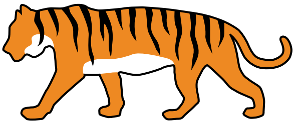


Tiger Family Chiropractic & Wellness Center

Feel like yourself again.

Patient Intake Form *PLEASE PRINT CLEARLY*

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our Patient Intake Form. Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

DATE ______________________

PERSONAL INFORMATION

FIRST NAME __________________________ MIDDLE ____________

LAST NAME ____

PREFERRED NAME _______________________________________

GENDER ☐ Male ☐ Female PRONOUN OF CHOICE _________________

SOCIAL SECURITY # _________-_____ __-_________

DATE OF BIRTH (MM/DD/YYYY) _______/_______/___________

HEIGHT ______________ WEIGHT ______________

MARITAL STATUS
☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Other

SPOUSE/PARTNER NAME ___________________________________

NUMBER OF CHILDREN ___________

EMERGENCY CONTACT ____________________________________

RELATIONSHIP ________________________

PHONE (________) _________-___________

CONTACT INFORMATION

EMAIL ____

(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

HOME PHONE (_______) ________-__________

CELL PHONE (_______) ________-__________

CELL PROVIDER ____

WORK PHONE (_______) ________-__________

ADDRESS ____

____

CITY ________________________________ STATE __________

ZIP _______________

(Students, please use your permanent address)

CHIROPRACTIC EXPERIENCE

How did you hear about us? Choose all that apply.

☐ Advertisement ☐ Another Provider ☐ Attorney ☐ Community Event ☐ Employee ☐ Existing Patient ☐ Friend ☐ Google ☐ Internet ☐ Local Merchant ☐ Mailing ☐ Newspaper ☐ Physician ☐ Provider Manual ☐ Sign ☐ Yelp.com ☐ Other ______________________

If you were referred by someone, please let us know their name.

REFERRING PHYSICIAN ___________________________________

REFERRING PATIENT _____________________________________

Have you been adjusted by a chiropractor before? ☐ Yes ☐ No

If yes, what was the reason for those visits? _______________

____

DOCTOR'S NAME _______________________________________

APPROX. DATE OF LAST VISIT ___________________________

EMPLOYMENT INFORMATION

Regular Work Status

☐ Employed ☐ Part-Time Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired ☐ Homemaker

EMPLOYER NAME

____

EMPLOYER ADDRESS

____

CITY ________________________________ STATE __________

ZIP _______________

Occupation _____________________________________

Physical Work Duties _____________________________________

____

Primary Complaint Information

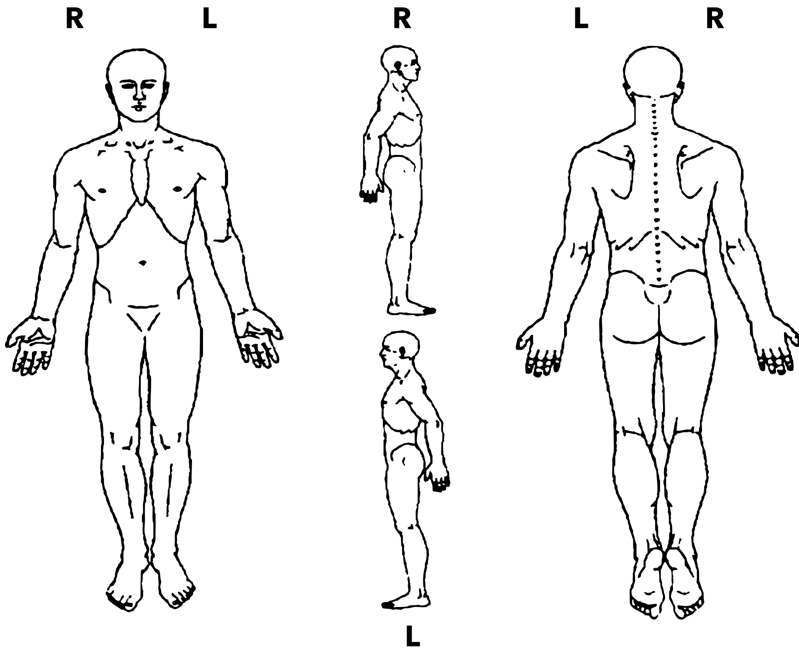
What is the purpose of your visit? ☐ Chronic Discomfort ☐ Consultation ☐ Injury ☐ New Condition ☐ Second Opinion

When did this condition begin? ____________________

How long have you had this condition? ☐ 5 days or less ☐ More than 5 days but less than 30 days ☐ More than 30 days

Pain Assessment

Where is the area of discomfort?



How would you rate the pain right now?

(best) 1 2 3 4 5 6 7 8 9 10 *(worst)*

What percentage of the day do you feel the discomfort?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the pain at its worst?

(best) 1 2 3 4 5 6 7 8 9 10 *(worst)*

How good is the pain at its best?

(best) 1 2 3 4 5 6 7 8 9 10 *(worst)*

How was the onset? ☐ Gradual ☐ Sudden

When did the discomfort begin? *(Please circle)*

Last few hours	1 day ago	5 days ago	3 weeks ago	Other__________
Since this morning	2 days ago	6 days ago	4 weeks ago	
Since last visit	3 days ago	1 week ago	5 weeks ago	
All Day	4 days ago	2 weeks ago	6 weeks ago	

Since the problem began, the symptoms have gotten: ☐ Better ☐ Worse ☐ Same

What aggravates the discomfort? *(Please circle all that apply)*

Bending	Coughing	Exercising	Meditating	Sex	Stomping	Walking
Bowling	Crawling	Golf	Medication	Sitting	Swinging	Working
Carrying	Cycling	Jumping	Pulling	Sleeping	Tennis	
Cleaning	Dressing	Kneeling	Reading	Sliding	Turning	
Climbing	Driving	Lifting	Resting	Sneezing	Twisting	
Cooking	Eating	Lying down	Running	Study	Typing	

How much worse is the discomfort after it is aggravated?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How many minutes will the discomfort remain that way? ______________

(CONTINUED ON NEXT PAGE)

What relieves the discomfort? *(Please circle all that apply)*

Bending	Coughing	Exercising	Meditating	Sex	Stomping	Walking
Bowling	Crawling	Golf	Medication	Sitting	Swinging	Working
Carrying	Cycling	Jumping	Pulling	Sleeping	Tennis	
Cleaning	Dressing	Kneeling	Reading	Sliding	Turning	
Climbing	Driving	Lifting	Resting	Sneezing	Twisting	
Cooking	Eating	Lying down	Running	Study	Typing	

How much better is the discomfort following these activities?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How many minutes does the relief last? ______________

What is the quality of discomfort? *(Please circle all that apply)*

Aching	Depression	Insidious	Mild	Pain	Soreness
Anguishing	Despair	Intense	Moderate	Random	Superficial
Burning	Dull	Intermittent	Numb	Severe	Throbbing
Continuous	Discomfort	Malaise	Numbness	Self-loathing	Tingle
Deep	Frequent	Melancholy	Occasional	Sharp	Tension

When is the discomfort at its worst? ☐ In the morning ☐ In the afternoon ☐ In the evening ☐ Before bed

Have you ever had any previous episodes of this condition? ☐ Yes ☐ No

In what ways does this condition affect your life and your ability to function? Choose all that apply:

☐ Bending over ☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing myself ☐ Driving a car ☐ Exercising ☐ Getting in or out of car
☐ Getting to sleep ☐ Grocery shopping ☐ Household chores ☐ Lifting objects ☐ Looking over shoulder ☐ Love life ☐ Lying down
☐ Reaching overhead ☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing ☐ Staying asleep ☐ Using a computer
☐ Walking ☐ Yard work ☐ OTHER

Social History & Life Choices

Alcohol
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Drinks & Products
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Diet Food Products
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Recreational Drugs
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Energy Products or Over-the-Counter Stimulants
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Exercise
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Fresh & Homemade Foods
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Preprocessed, Packaged, & Restaurant Food
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Soft Drinks
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Tobacco
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Water
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Review of Systems

Please indicate if you have a concern in any of these areas:

Musculoskeletal ☐ No additional musculoskeletal complaints ☐ Osteoporosis ☐ Back problems ☐ Arthritis ☐ Hip disorders ☐ Scoliosis
☐ Knee injuries ☐ Joint or muscle pains/stiffness ☐ Foot/ankle pain ☐ Cramping ☐ Shoulder problems ☐ Swelling, redness deformity of joint(s)
☐ Elbow/wrist pain ☐ Fractures ☐ Poor posture ☐ Implants, plates, pins or screws ☐ Gout ☐ Neck pain

Neurological ☐ No additional neurological complaints ☐ Anxiety and/or panic ☐ Pins and needles ☐ Depression ☐ Numbness ☐ Memory issues
☐ Loss of smell or taste ☐ Sleeping issues ☐ Temporary loss of vision ☐ Headache ☐ Difficulty concentrating ☐ Dizziness ☐ Stroke
☐ Weak muscles ☐ Epilepsy or seizures

Head, Eyes, Ears, Nose & Throat ☐ No complaints ☐ Headaches or migraines ☐ Dental problems ☐ Eye or vision problems ☐ Gum problems
☐ Eyeglasses or contact lenses ☐ TMJ problems ☐ Eye surgery ☐ Sore throat ☐ Cataracts ☐ Postnasal drip ☐ Glaucoma ☐ Swollen lymph nodes
☐ Nose congestion or sinus trouble ☐ Ear or hearing problems ☐ OTHER

Cardiovascular ☐ No cardiovascular complaints ☐ Chest pain or tightness ☐ Rheumatic fever ☐ Palpitations ☐ Leg pain upon walking
☐ Swollen legs or feet ☐ Blood clots ☐ High blood pressure ☐ Varicose veins ☐ Low blood pressure ☐ Dizziness ☐ High cholesterol or triglycerides
☐ Excessive bruising ☐ Heart attack ☐ Coronary artery disease ☐ Heart murmur ☐ Congenital heart defects ☐ OTHER

Respiratory ☐ No respiratory complaints ☐ Persistent cough ☐ Blood in sputum ☐ Wheezing ☐ Asthma ☐ Shortness of breath ☐ Apnea
☐ Snoring issues ☐ Emphysema ☐ Tuberculosis ☐ Hay fever ☐ Pneumonia ☐ OTHER

Gastrointestinal ☐ No gastrointestinal complaints ☐ Abdominal pain ☐ Black or bloody stool ☐ Nausea or vomiting ☐ Colon cancer or colon polyps
☐ Bloating ☐ Hemorrhoids ☐ Heartburn ☐ Food sensitivities ☐ Ulcer ☐ Constipation ☐ Difficulty swallowing ☐ Severe diarrhea ☐ Jaundice
☐ Irritable Bowel Syndrome ☐ Liver disease ☐ Crohn's disease ☐ Gallbladder problems ☐ Gastric reflux ☐ Pancreatitis ☐ Collitis
☐ Change in bowel habits ☐ OTHER

Genitourinary ☐ No genitourinary complaints ☐ Painful or frequent urination ☐ Sexual dysfunction ☐ Blood in urine ☐ Incontinence
☐ Kidney stones ☐ Urinary infections ☐ OTHER

Endocrine ☐ No endocrine complaints ☐ Feeling hot or cold all the time ☐ Hyperparathyroidism ☐ Thyroid problems ☐ Testosterone deficiency
☐ Diabetes ☐ Cushing's syndrome ☐ Increase urination ☐ Steroid treatments ☐ Excessive thirst ☐ Hyperthyroidism ☐ OTHER

Dermatological & Bleeding ☐ No skin or bleeding complaints ☐ Skin trouble or rashes ☐ Skin cancer ☐ Flushing ☐ Skin pigmentation issues
☐ Change in hair or nails ☐ Blood in stool ☐ Excessive acne ☐ Easy bruising ☐ Eczema ☐ Gum bleeding ☐ Psoriasis ☐ OTHER

Insurance & Payment for Care

How do you plan to pay for care? ☐ Personal Insurance ☐ Third-Party Insurance ☐ No Insurance, Self-Pay

Name of Party Responsible for Payment ______________________ Responsible Party Phone (_______) ________-__________

Primary Insurance

INSURANCE NAME ______________________ PHONE (_______) ________-__________

ADDRESS ______________________ CITY ______________________

STATE __________ ZIP ______________ ID/POLICY # ______________________ GROUP # ______________________

INSURED'S NAME ______________________ INSURED'S DATE OF BIRTH (MM/DD/YYYY) _______/_______/____________

Secondary Insurance

INSURANCE NAME ______________________ PHONE (_______) ________-__________

ADDRESS ______________________ CITY ______________________

STATE __________ ZIP ______________ ID/POLICY # ______________________ GROUP # ______________________

INSURED'S NAME ______________________ INSURED'S DATE OF BIRTH (MM/DD/YYYY) _______/_______/____________

Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge.

I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions.

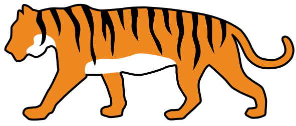
I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purposes of treatment, payment, and health care operations the chiropractic physician has the right to refuse to give care. I have and understand how my Patient Health Information will be used and I agree to these policies and procedures.

☐ **I agree with this statement of authorization.**

SIGNATURE ____ **DATE** ______________



Tiger Family Chiropractic & Wellness Center

Feel like yourself again.

Informed Consent *PLEASE PRINT CLEARLY*

PATIENT NAME ____

CLINIC NAME Tiger Family Chiropractic & Wellness Center DOCTOR chiropractors employed by Tiger Family Chiropractic & Wellness Center

ADDRESS 3700 I-70 Drive SE, Suite 110, Columbia, MO 65201

PHONE (573) 443-1414 FAX (573) 443-1416

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

- **The nature of the chiropractic adjustment.**
  I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- **The material risks inherent in chiropractic adjustment.**
  As with any health care procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

- **The probability of those risks occurring.**
  Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

- **Ancillary treatment.**
  In addition to chiropractic adjustments, I intend to use the following treatments:

  ____

  ____

  These treatments involve the following additional significant risks:

  ____

  ____

(Continued on next page)

- **The availability and nature of other treatment options.**
  Other treatment options for your condition include:
  - Self-administered, over-the-counter analgesics and rest.
  - Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
  - Hospitalization with traction.
  - Surgery.

- **The material risks inherent in such options and the probability of such risks occurring include:**
  - Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.
  - Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.
  - Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.
  - The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

- **The risks and dangers attendant to remaining untreated.**
  Remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed with the doctor any questions, and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended.

HAVING BEEN INFORMED OF THE RISKS, I HEREBY GIVE MY CONSENT TO THAT TREATMENT.

______________________________ ______________________________

PRINTED NAME DATE

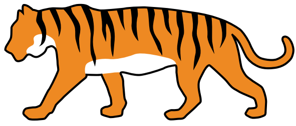
______________________________ ______________________________

SIGNATURE SIGNATURE OF PARENT OR GUARDIAN (IF A MINOR)

WITNESSES

______________________________ ______________________________

PRINTED NAME SIGNATURE



Tiger Family Chiropractic & Wellness Center

Feel like yourself again.

Goals

PATIENT NAME ____ DATE ____________________

It is important to identify goals for your care program. Please indicate below which of these goals you would like to see incorporated into your care plan.

Please check any box below that would apply:

- ☐ Stronger
- ☐ Be more alert
- ☐ Sleep better
- ☐ More flexible
- ☐ Less nervous
- ☐ Better posture
- ☐ More relaxed

Please mark any below that you would like to improve upon, I would like to:

- ☐ Walk _______ minutes without pain
- ☐ Stand _______ minutes without pain
- ☐ Ride in a car _______ minutes without pain
- ☐ Sit _______ minutes without pain
- ☐ Work _______ hour(s) without pain. Type of work? ____________________
- ☐ Lift _______ pounds without pain
- ☐ Bend without pain
- ☐ Sleep _______ hour(s) without pain
- ☐ Please indicate any other goals you have for care: ____

____

____

____

Please list anyone you would like to give us permission to share information with upon request.

(Ex. spouse/significant other, children, sister/brother, etc.) You do not need to list parents/legal guardians if patient is a minor.

Name of Contact	Relationship to Patient	Phone Number	Okay to leave a message?
1.			Yes / No
2.			Yes / No
3.			Yes / No
4.			Yes / No

☐ I do not wish to list anyone at this time

I, _______________________________, hereby give my permission to the doctors and staff of Tiger Family Chiropractic to discuss with the person(s) mentioned above any information – including but not limited to my health, claims, charges and payments – pertaining to my treatment at Tiger Family Chiropractic. I reserve the right to revoke this permission, in writing, should I so choose.

____ ________________________

PATIENT SIGNATURE DATE