Chiropractic Intake

Dr. Jim Cox; 471 E. Tahquitz Canyon Way, #221, Palm Springs, CA 92262; T 760.898.3860; F 760.406.4016; doc@drjimcox.com

Name: _____
Last First MI

DOB: ____ / ____ / ____ SSN: ____ - ____ - ____ **(Only if you have Medicare [redacted])**

Address: _____
Street City State Zip

Home Phone: _____ ☐ Primary Cell: _____ ☐ Primary Email: _____

Emergency Contact: _____
Name, relation & phone number.

Primary Physician: _____ _____
Name Location or phone number.

☐ My initials here authorize release of information to my primary care physician.

Occupation: _____

If you were involved in an accident, please complet the following:

Did the injury occur at work? Y / N Date of injury: _____ Time: _____

Has the injury been reported to your supervisor? Y / N Supervisor Name: _____

Is the injury a result of a car accident? Y / N Other? _____

MEDICARE Patients ONLY:

Group #: _____ Policy #: _____

Name of insured: _____
Last First MI

Relationship to insured: _____ SSN of insured: _____

Please initial one of the following statements.

☐ I have no health insurance or my health insurance does not cover chiropractic care.
☐ While Dr. Cox is not a provider with my insurance, he will furnish a superbill so that I may file for reimbursement .

My signature, below, certifies that I am aware that all services are payable when treatment is rendered; that I understand I will be responsible for payment to any other facilities and/or health care providers that I may be referred to by Dr. Cox and any emergency transportation that may be required thereto; that the preceding questions have been answered truthfully and complete to the best of my knowledge and belief.

Patient/Guardian signature: _____ Date: _____

Chiropractic Health Questionnaire

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Name: _____ DOB: _____

Chief complaint (why are you seeking treatment?) _____

How did this begin? _____

When did this begin? _____

Has this happened before? Y / N Were you treated for this before? Y / N

Previous treatment: _____

What makes your problem better? _____

What makes your problem worse? _____

Describe your pain/symptoms: _____ _____

Does your pain or do your symptoms radiate (into arms/legs etc)? _____

Since the problem began, it has: ☐ Improved ☐ Worsened ☐ Not changed

The problem bothers me:

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

Rate your pain as you feel today: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

No pain Moderate Unbearable

Do you notice your pain mostly in the: ☐ Morning ☐ Afternoon ☐ Night

Any other associated symptoms? _____

Social History:

Current or previous smoker? Y / N _____ Packs/day for _____ year(s); Quit _____ months/years ago.

Alcohol: ☐ Never ☐ Rarely ☐ Socially ☐ Daily; _____ Drink(s)/day.

Activity level: Sedentary Moderate Vigorous

Do you exercise? Y / N How? ☐ Walk ☐ Cardio ☐ Weight training _____ days/wk

Hobbies: _____

Hours of sleep per night: _____/night Quality: ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Rate your stress level: ☐ Very high ☐ high ☐ Medium ☐ Low ☐ Very low

What contributes to your stress? _____

Rate your diet: ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Caffeine intake: ☐ Coffee ☐ Tea ☐ Soda ☐ Energy drinks _____ cup(s) per day.

How would you describe your overall health? ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Patient/Guardian signature: _____ Date: _____

Review of systems: **Pt name and DOB:** _____

Please check if you currenlty have or have had in the past:

General
- ☐ History of cancer
- ☐ Diabetes
- ☐ Current or recent infection
- ☐ Immunosuppression medication and/or condition (HIV)
- ☐ Osteoprorosis
- ☐ Prolonged corticosteroids use

GI/GU
- ☐ Change in appetite
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Incontinence

Cardio/Respiratory
- ☐ Heart murmur
- ☐ Chest pain
- ☐ Palpitations
- ☐ Difficulty breathing
- ☐ Coughing
- ☐ Weezig
- ☐ Blue hands/feet
- ☐ Swollen extremities
- ☐ High blood pressure

Constitution
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Weakness
- ☐ Fatigue
- ☐ Weight loss

Eyes
- ☐ Difficulty seeing
- ☐ Pain
- ☐ Discharge
- ☐ Blurred/double vision

Ears
- ☐ Hearing loss
- ☐ Ringing
- ☐ Pain
- ☐ Discharge

Nose
- ☐ Pain
- ☐ Discharge
- ☐ Bleeding

Mouth/Throat
- ☐ Difficulty swallowing
- ☐ Pain
- ☐ Sores
- ☐ Change in taste

Skin
- ☐ Rash
- ☐ Itching
- ☐ Discoloration
- ☐ Hair changes
- ☐ Nail changes

Psych
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Memory loss

Neurological
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Convulsions
- ☐ Numbness

Breasts/Genitals
- ☐ Mass/lump
- ☐ Pain
- ☐ Discharge
- ☐ Self-exam

Musculoskeletal pain
- ☐ Neck
- ☐ Arm
- ☐ Upper back
- ☐ Legs
- ☐ Low back

History of accidents/surgeries/hospitalizations: _____

Current medications: _____

Family history:

- ☐ Cancer
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Stroke
- ☐ Aneurysm
- ☐ Diabetes
- ☐ Lung disease
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Migraine headache
- ☐ Alcohol dependence
- ☐ Seizures

Patient/Guardian signature: _____ Date: _____

Informed Consent

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To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment. The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may 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 a sense of movement.

Analysis/Examination/Treatment. As a part of the analysis, exam, and treatment, you are consenting to one or more of the following procedures: spinal manipulative therapy, soft tissue manipulation, palpation, vital signs, range of motion testing cryotherapy, orthopedic testing, basic neurological, muscle strength testing, postural analysis testing.

The material risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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 Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

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 (if warranted). Stroke and /or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

Other treatment options.

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed it with James Cox, DC (Lic#30853) 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 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.

Patient name (print) _____ Parent/Guardian name _____

Patient/Guardian Signature _____ Date _____

Chiropractor name James Cox

Chiropractor signature _____ Date _____