ABOUT THE PATIENT

614 CHIROPRACTIC
HEALTH • INJURY CARE

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Marital Status: _____Gender ❑ M ❑ F Significant Other's Name _____

Have you been to a chiropractor before? ❑ No ❑ Yes When was your last Chiropractic Appointment? _____

Your Employer _____ Type of Work _____

E-Mail Address _____ Who Referred you to us?_____

Emergency Contact _____ Ph # _____

Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize 614 Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- Understand that your health information is protected by the Health Insurance Portability and Accountability Act of 1996. If you have any questions, please talk to the front desk.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

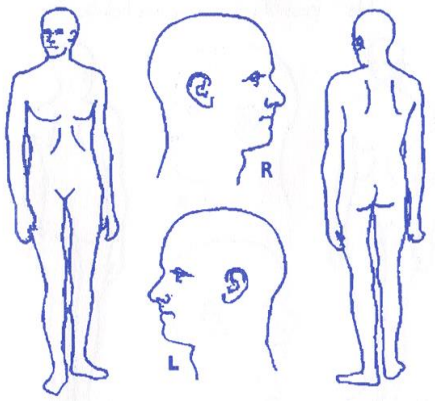
NOTES: _____

_____

_____

Are you pregnant?
❑ Yes ❑ No
How far along? _____
Due Date: _____

Please mark all areas of concern.



PATIENT INTAKE + BASELINE OUTCOME FORM

Name: _____ Date: _____

Date of Injury / Onset: _____ DOB: _____

1. PRIMARY COMPLAINTS

Check all that apply:

☐ Neck ☐ Mid Back Pain ☐ Low Back Pain

☐ Shoulder Pain ☐ Hip Pain

☐ Radiating Pain (Specific Area):_____

☐ Other: _____

2. PAIN SCORING

Current Pain (0-10): _____ Worst Pain (0-10): _____

Best Pain (0-10): _____

Pain Type:

☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Stiff

☐ Radiating ☐ Intermittent ☐ Constant

3. IMPACT SCORE (ANNOYANCE / DISRUPTION)

How much does this affect your daily life?

0 = no impact 10 = completely disrupts life

Score: _____ / 10

4. FUNCTIONAL TOLERANCE (CORE METRICS)

Before symptom onset, patient could:

	Before	Now
Sitting	_____ minutes	_____ minutes
Standing	_____ minutes	_____ minutes
Walking	_____ minutes	_____ minutes
Lifting	_____ lbs	_____ lbs
Driving	_____ hours	_____ hours

5. SLEEP QUALITY

☐ No Disruption ☐ Severe Disruption

☐ Mild Disruption Hours slept nightly: _____

☐ Moderate Disruption Wakes due to pain? ☐ yes ☐ no

6. ADL IMPACT (SIMPLIFIED, HIGH VALUE)

Check all affected:

☐ Work ☐ Sitting ☐ Driving ☐ Sleeping

☐ Exercise ☐ Household Tasks ☐ Self-care ☐ Recreation

Top 3 most affected ADL's:

1. _____
2. _____
3. _____

7. WORK PROFILE

Occupation: _____

Sitting hours per day:_____Break frequency: _____

Work Impact: ☐ None ☐ Mild ☐ Moderate ☐ Severe

8. EXERCISE / PRIOR ATTEMPTS

Have you tried exercises or stretching? ☐ yes ☐ no

If yes: What specifically? _____

Duration tried: _____

Result: ☐ Helpful ☐ Temporary ☐ No Change ☐ Worse

9. MEDICATION USE

☐ Tylenol ☐ Ibuprofen / NSAIDs ☐ Muscle Relaxers

☐ None ☐ Other: _____

Frequency: ☐ Daily ☐ Weekly ☐ Occasional

10. PRIOR CARE

☐ Chiropractic ☐ Physical Therapy ☐ Massage

☐ Dry Needling ☐ None

Outcome: ☐ Helpful ☐ Temporary ☐ No Change ☐ Worse

11. GOALS (CHECK ALL):

☐ Pain Reduction ☐ Sleep Improvement ☐ Return to Exercise

☐ Work Without Discomfort ☐ Improve Mobility ☐ Improve Sitting Tolerance

12. BASELINE SUMMARY SCORE (STAFF CALCULATED LATER)

Category	Score (0-10)	Notes:	Category	Score (0-10)	Notes:
Pain (Current)	_____	_____	Sleep Quality	_____	_____
Impact (Disruption)	_____	_____	ADL Impact	_____	_____
Function (Tolerance)	_____	_____	**Total Score:**	_____ / 50	

GENERAL HEALTH HISTORY

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. **List any medications you are taking:**_____

_____

2. **Please list all doctors you are currently seeing:** _____

_____

3. **Has any Doctor or other professional advised you to "Go to a Chiropractor ":** ❑ No ❑ Yes, Name_____

_____

_____

PAST HISTORY

4. **List any past auto collisions:**_____ **Was any care received?**_____
5. **List any past work injuries:** _____ **Was any care received?**_____
6. **List any past sport, recreational, or home injuries**_____
7. **Please describe any past conditions and treatment received:** _____

_____

8. **Please list any past hospitalizations and surgeries:** _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

Informed Consent

Section 1: Informed Consent for Chiropractic Care
We are committed to providing you with safe, effective, and natural chiropractic care. Please read this form carefully.
What is Chiropractic Care? Chiropractic care at our office, provided by Dr. Nicholas Esser, focuses on gentle, specific adjustments to the spine and other joints to improve alignment, movement, and overall function.
What to Expect During Your Care:
- Thorough health history and physical exam (posture, movement, muscle strength, etc.).
- X-rays may be recommended.
- Personalized care plan that may include adjustments, soft tissue therapies, exercises, or referrals if needed.

Benefits of Chiropractic Care:
- Reduced pain or discomfort in back, neck, or joints
- Improved mobility, flexibility, and posture
- Enhanced overall wellness, energy, and physical performance

Understanding Rare Risks: Chiropractic care is very safe, but like any healthcare approach, there are rare risks:
- Temporary soreness or discomfort after adjustments
- In very rare cases, minor muscle or ligament strain
- Extremely rare risks involving neck adjustments (estimated at less than 1 in 1 million)

What Happens if You Choose Not to Pursue Care?
You may continue to experience discomfort, limited mobility, or other symptoms. Untreated issues could worsen over time.
Other Care Options: Rest, over-the-counter pain relievers, physical therapy, medications, injections, or surgery.

Section 2: SoftWave (ESWT) Suitability Questions
Please **answer** the following to help us determine if SoftWave Tissue Regeneration is appropriate for you:
- Have you been injected with cortisone this month? Yes / No
- Have you been diagnosed with cancer/tumor within the last 12 months? Yes / No
- Have you been diagnosed with a skin infection in the last 12 months? Yes / No
- Are you pregnant or do you suspect you may be pregnant? Yes / No
- Are you under 16 years of age? Yes / No

Our Commitment to You We adhere to the highest professional standards to ensure your care is safe and effective. Our goal is to support your health naturally and respectfully.

Section 3: Decompression Suitability
Please **circle** any that apply to you:

• Pregnant • Metal implants in spine • Advanced Osteoporosis • Hernia • Blood Thinners • Spinal Fusion • Fractured or Broken Vertebra • Failed Back Surgery • Tumor • Cardiac or Pulmonary Disease • Abdominal Aortic Aneurysm
- Other (related to today's treatment): _____

Your Rights and Responsibilities: ·
Your Right to Choose: You can stop or modify your care plan at any time. Just let us know what you're comfortable with. ·
Your Responsibility: Please share all relevant health information (e.g., past injuries, medical conditions, or medications) to help us provide the safest and most effective care.
Photos and Text Reminders: By signing this form, you also agree to the following (please cross out any that you want to opt out of): ·
Photos for Social Media: I allow my image to be shared on 614 Chiropractic LLC's social media or website for positive, professional purposes (e.g., celebrating patient milestones). I understand I may request removal of my photo at any time. · **Text Appointment Reminders**: I agree to receive text reminders for my appointments to help me stay on track.
Your Consent: By signing below, I confirm that:
I have read and understood this form, and my questions have been answered to my satisfaction.
I understand the benefits, rare risks, and alternatives to chiropractic care.
I consent to the recommended care plan for my current condition and any future conditions I seek treatment for at 614 Chiropractic LLC.
I understand I can stop or change my care plan at any time.

Patient Name (Printed):

_____

Patient Signature:

_____

Date:_____

Parent/Guardian Name (if applicable):

_____

Parent/Guardian Signature:

_____

Date:_____