

ABOUT THE PATIENT

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: _____

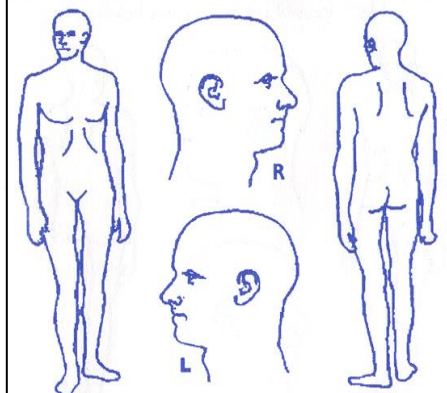
Are you pregnant?

☐ 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: _____

3. IMPACT SCORE (ANNOYANCE / DISRUPTION)

How much does this affect your daily life?

0 = no impact 10 = completely disrupts life

Score: _____ / 10

5. SLEEP QUALITY

- ☐ No Disruption ☐ Severe Disruption
☐ Mild Disruption Hours slept nightly: _____
☐ Moderate Disruption Wakes due to pain? ☐ yes ☐ no

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

10. PRIOR CARE

- ☐ Chiropractic ☐ Physical Therapy ☐ Massage
☐ Dry Needling ☐ None
Outcome: ☐ Helpful ☐ Temporary ☐ No Change ☐ Worse

12. BASELINE SUMMARY SCORE (STAFF CALCULATED LATER)

Category	Score (0-10)	Notes:
Pain (Current)	_____	_____
Impact (Disruption)	_____	_____
Function (Tolerance)	_____	_____

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

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

6. ADL IMPACT (SIMPLIFIED, HIGH VALUE)

Check all affected:

- ☐ Work ☐ Sitting ☐ Driving ☐ Sleeping
☐ Exercise ☐ Household Tasks ☐ Self-care ☐ Recreation

Top 3 most affected ADLs:

1. _____
2. _____
3. _____

9. MEDICATION USE

- ☐ Tylenol ☐ Ibuprofen / NSAIDs ☐ Muscle Relaxers
☐ None ☐ Other: _____
Frequency: ☐ Daily ☐ Weekly ☐ Occasional

11. GOALS (CHECK ALL):

- ☐ Pain Reduction ☐ Sleep Improvement ☐ Return to Exercise
☐ Work Without Discomfort ☐ Improve Mobility ☐ Improve Sitting Tolerance

GENERAL HEALTH HISTORY

Patient Name _____ *Mark the conditions that apply to you.*

Past Present

- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ Shortness of Breath
- ☐ ☐ Allergies / Asthma
- ☐ ☐ Medication Side Effects
- ☐ ☐ Diabetes
- ☐ ☐ Hands or Feet cold
- ☐ ☐ Muscle aches
- ☐ ☐ Trouble Walking
- ☐ ☐ Leg / Foot Numbness
- ☐ ☐ Fainting
- ☐ ☐ Gall Bladder Trouble
- ☐ ☐ Ringing in Ears
- ☐ ☐ Ear Problems
- ☐ ☐ Sleeping Problems
- ☐ ☐ Vision Problems
- ☐ ☐ Thyroid Problems
- ☐ ☐ Liver Disease
- ☐ ☐ Kidney Problems
- ☐ ☐ Light Bothers Eyes
- ☐ ☐ Other _____

Past Present

- ☐ ☐ Urinary Problems
- ☐ ☐ Easy Bruising
- ☐ ☐ Tobacco Use
- ☐ ☐ Dental Problems
- ☐ ☐ Fibromyalgia
- ☐ ☐ Blood Thinner use
- ☐ ☐ HIV Positive
- ☐ ☐ Cancer
- ☐ ☐ Depression
- ☐ ☐ Alcohol Use
- ☐ ☐ ___ High or ___ Low Blood Pressure
- ☐ ☐ Stroke History
- ☐ ☐ High Cholesterol
- ☐ ☐ TMJ
- ☐ ☐ Digestive Problems
- ☐ ☐ Pain all Over
- ☐ ☐ Tension / Irritability
- ☐ ☐ Chest Pains
- ☐ ☐ Heart Pacemaker
- ☐ ☐ Heart Problems

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: _____



Paying for your care is easy here!



Initial which one is you:

☐ **No Insurance:**

- Easy! Our Chiropractic, Decompression Care Plans and simple payment arrangements have helped over 2500 people and will work great for you too!
- Insurance pays very little and maybe not at all for necessary services like Lasik, or necessary cosmetic surgery or our incredible Decompression & SoftWave Tissue Regeneration protocols.

Initial_____

☐ **Health Insurance:**

- These days, insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!
- We will verify any benefits you may have and send your claims in to your insurance for you.
- If they pay anything after your deductible is met, we will accept payment directly from them.
- You are responsible for any deductible, co-insurance, co-pays and unpaid visits.
- Of course you can use your HSA, HRA and Flex dollars here!
- For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

Initial_____

☐ **Auto Injury**

- Most Auto related injuries are covered 100% in Ohio for patients not at fault. You can get the care you need and it normally costs nothing. Great for you!
- All we need is your claim number and insurance information.

Initial_____

☐ **Medicare**

- Medicare pays for much of your care making it quite easy.
- We simply need a copy of your Medicare card.
- Medicare supplements normally don't pay anything.

Initial_____

You have made a great decision to get care here!
Our goal is to be your family chiropractor for life!