Body Harmony Chiropractic
4051 Kirkpatrick Rd, Suite 300
Flower Mound, Tx 75028
940-594-0795

PATIENT INTAKE FORM

Name_______________________________Birthdate____/____/____ Age_____ Today's date____/____/____

Address_____________________________________City________________________ State______________

Zip____________ Home # (_____)_________________ Work # (_____)_________________Ext._________

Cellular # (_____)_______________ E-Mail Address____

Occupation_______________________Employer's Name____

Employer'sAddress______________________City________________________State______Zip__________

Male ____Female _____ # of Kids______ ____Single ____Married ____Divorced ____Widowed_______

Name of Spouse_________________Name of Kids____

Reason for consulting our office?

____

____

____

Referred by____

Your Health Profile

Why this form is important: At Body Harmony Chiropractic, we are a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes not until it's too late! Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status and more accurately determine your true health potential.

The Beginning Years - Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

Birth History- Please check those items that apply to you (How you were born)
____Mother smoked/drank/drugs in pregnancy ____Epidural/Meds in labor ____Breech Vaginal Delivery
____C-Section
____Forceps Delivery ____Vacuum Extractor used ____Labor Induced
____Complications If so, please list:____
____Other____

Childhood Years(Age 0-17 yrs) - Please check those items that apply to you
____Childhood Illness ____Serious Falls ____Active in Sports
____Very Inactive
____Car Accident(s) ____Surgery/Stitches ____Alcohol/Drug Abuse
____Smoker
____Antibiotics/Other Meds ____Vaccinated ____Under Chiropractic care
____Broken Bones
____Severe Emotional
Trauma(s)____

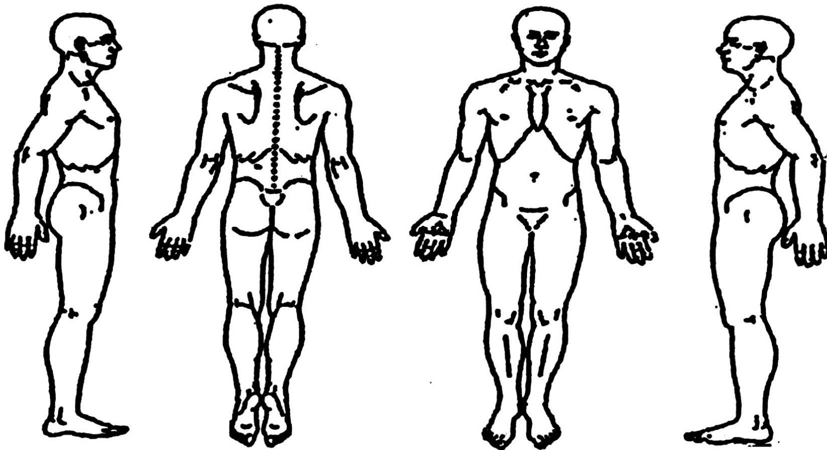
Adult Years(Age 18 to present) - Please check those items that apply to you
____Present Smoker ____Former Smoker ____Consume "sugar-free" or
Packs/day_____ Packs/day____ "diet" sodas/foods
____Alcohol Use
____Surgery/Stitches ____Play Sports ____Car Accidents
____Work Injury
____High Job Stress ____High Personal Stress ____Sit a lot
____Drive a lot
____Poor Sleep ____Not Enough Sleep ____Poor/Inadequate Diet
____No Exercise
____Flat Feet ____Wear Orthotics/Lifts ____Severe Health Problems
____Hard Falls
____Broken Bones ____Other
____OTC/Prescription Meds(Please list name & reason for taking them)
____
____
Injuries____

____Have been under chiropractic care in the past - How long ago was your last adjustment?
____

Addressing the issues that brought you to our office:
**If you have no symptoms or complaints and you are here for wellness care, please initial here ____"I Wish to have Chiropractic Wellness Services" and skip to the symptoms check list near the bottom of this form. Otherwise, please continue.

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:___________________

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____________
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? ___________

11. How do you think your problem began?

____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

15. What is your: Height___________ Weight _____________ Date of Birth ___________
Occupation ____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:______________________________				

20. List all prescription medications you are currently taking:

____

21. List all of the over-the-counter medications you are currently taking:

____

22. List all surgical procedures you have had:

____

23. What activities do you do at work?

□ **Sit:** □ Most of the day □ Half the day □ A little of the day
□ **Stand:** □ Most of the day □ Half the day □ A little of the day
□ **Computer work:** □ Most of the day □ Half the day □ A little of the day
□ **On the phone:** □ Most of the day □ Half of the day □ A little of the day

24. What activities do you do outside of work?

____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why ____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge.
I agree to allow **Dr. Amelie Biskup** to examine me for further evaluation.
I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.
I acknowledge that upon request, Body Harmony Chiropractic will provide a Notice of Privacy Practices that was effective March of 2003.

Patient Signature____________________________________ **Date:**____________________

INFORMED CONSENT

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes Chiropractic care. We want you to be informed about potential problems associated with Chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the Doctor's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking " sound/sensation in the areas being treated.

In this office, the Doctor will perform your consultation, examination, physical therapy application, traction, massage therapy, exercise instruction, nutritional guidance, etc.

Stroke: Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The Chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA. Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per 3,000,000 upper neck adjustments. This means that an average Chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disk Herniations: Disk herniations that created pressure on a spinal nerve or the spinal cord are frequently successfully treated by Chiropractors and Chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, Chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disk problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft Tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a Chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify there probability.

Rib Fracture: The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a Chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs primarily only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify there probability.

Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for Chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform the Doctor.

Other Problems: There may be other problems or complications that might arise from Chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have nay questions on the above information, please ask your Doctor. Once you have a full understanding, please sign and date below.

I hereby authorize **Dr. Amelie Biskup** at Body Harmony Chiropractic to examine, diagnose, and provide chiropractic treatment based on my examination findings.

Patient's Name (Printed)____ Date ______________________

Patient's Signature ____

Guardian's Signature (if patient is a minor)____