Chiropractic Neurology & Wellness Center

New Patient Intake Form

PLEASE PRINT CLEARLY

Todays Date: _____

Legal Name: _____ Gender: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ E-mail _____

Age _____ Date of Birth: _____ SSN: _____

Marital Status: ☐ Single ☐ Divorced ☐Widowed ☐ Married: Spouse's Name: _____

Children? How many: _____ Females: Last Menstrual Period: _____ Pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N

Work Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Student

Occupation: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State:___ Zip: _____

Name of Spouse, Parent or Guardian: _____

Spouses Occupation: _____

Employer: _____ Work Phone: _____

In case of an emergency contact: _____ Relationship: _____

Phone: _____ Cell: _____ Work Phone: _____

Do you have Medicare Insurance? ☐ Y ☐ N ☐ Medicare card copied by Office Staff ☐ Drivers license copied by Office Staff

Who may we thank for referring you? _____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

1. _____
2. _____
3. _____
4. _____

TREATMENT: What type of treatment are you looking for?

☐ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.

☐ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.

☐ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

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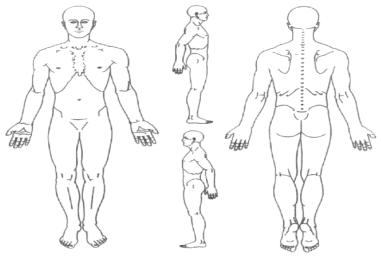
Please mark on the diagram to the right the following symbols as they relate to the patients' symptoms:	
SS = spasms	ST = stiffness
DP = dull pain	SP = sharp pain
SH = shooting pain	TI = tingling
NU = numbness	O = other



COMPLAINT/PROBLEM (In relation to your primary complaint)

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition: ☐ Y ☐ N What type of doctor? ☐ MD ☐ DO ☐ DC ☐ DDS ☐ Other: _____

Name of primary care doctor: _____

Treatment(s) used: ☐ Medication ☐ Surgery ☐ Lifestyle change ☐ Chiropractic ☐ other _____

Have you had any intolerance or reactions to treatments? ☐ Y ☐ N Describe: _____

_____

When did the problem start? _____ How did it originally occur? _____

Has it become worse recently? ☐ Y ☐ N ☐ Same ☐ Better ☐ Gradually worse

How frequent is the condition? ☐ Constant ☐ Daily ☐ Intermittent

How long does it last? ☐ All day ☐ Few hours ☐ Minutes

Is this condition interfering with your? ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Does anything relieve the symptom(s)? ☐ Y ☐ N If yes, what? ☐ Medication (prescription or OTC) ☐ Rest ☐ Exercise/Stretch

Other: _____

If no, what have you tried? ☐ Medication (prescription or OTC) ☐ Rest ☐ Exercise/Stretch ☐ Surgery ☐ Chiropractic

Other: _____

How long has it been since you really felt good? ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ More than10 years

Describe the pain/problem: ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing

Other: _____

What makes the problem worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting

Other: _____

What do you believe is cause of the problem?

_____

Are there any other conditions or symptoms that may be related to your major symptom? ☐ Y ☐ N

If yes, what? _____

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Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ over 5 years ☐ Never

Describe: _____

_____

Please check all of the symptoms that apply. (**P**=Past / **C**= Current)

P / C		P / C		P / C		P / C	
☐ ☐	Headache	☐ ☐	High Blood Pressure	☐ ☐	Tingling in Feet	☐ ☐	Facial Pain
☐ ☐	Low Blood Pressure	☐ ☐	Walking Problems	☐ ☐	Eye Pain	☐ ☐	Abdominal Pains
☐ ☐	Sore Muscles	☐ ☐	Blurred Vision	☐ ☐	Nausea/Vomiting	☐ ☐	Weak Muscles
☐ ☐	Dizziness	☐ ☐	Poor Appetite	☐ ☐	Paralysis	☐ ☐	Earache
☐ ☐	Fullness of Bladder	☐ ☐	Shakiness	☐ ☐	Forgetfulness	☐ ☐	Urination Difficulty
☐ ☐	Sweating	☐ ☐	Confusion	☐ ☐	Frequent Urination	☐ ☐	Insomnia
☐ ☐	Sinusitis	☐ ☐	Constipation	☐ ☐	Fainting	☐ ☐	Teeth Grinding
☐ ☐	Hemorrhoids	☐ ☐	Convulsions	☐ ☐	Dry Mouth	☐ ☐	Decreased Sex Drive
☐ ☐	Irritability	☐ ☐	Excessive Thirst	☐ ☐	Menstrual Irregularities	☐ ☐	Impatience
☐ ☐	Unpleasant Taste	☐ ☐	Elbow / Hand Pain	☐ ☐	Fatigue	☐ ☐	Neck Pain
☐ ☐	Tingling in Hands	☐ ☐	Feel Loss of Control	☐ ☐	Sore Throat	☐ ☐	Clammy Hands
☐ ☐	Lump in Throat	☐ ☐	Low Back Pain	☐ ☐	Swallowing Pain	☐ ☐	Hip Pain
☐ ☐	Unsteady Voice	☐ ☐	Knee Pain	☐ ☐	Shoulder Pain	☐ ☐	Poor Circulation
☐ ☐	Persistent Coughing	☐ ☐	Swollen Joints	☐ ☐	Chest Pressure	☐ ☐	Joint Stiffness
☐ ☐	Slow Heart Rate	☐ ☐	Swollen Ankles	☐ ☐	Rapid Heart Rate	☐ ☐	Ankle / Foot Pain

Other: _____

ALLERGIES/Sensitivities: Please check and list all allergies.

Food: ☐ Dairy ☐ Wheat ☐ Corn ☐ Soy ☐ Seafood ☐ Gluten ☐ Peanuts ☐ Fruits

Other: _____

Medications: ☐ Penicillin ☐ Sulfa Drugs ☐ Iodine ☐ Insulin ☐ Antibiotics

Other: _____

Seasonal/Other: ☐ Pollen ☐ Dust ☐ Hay ☐ Mold ☐ Chemical(s) ☐ Smoke ☐ Animals ☐ Insects

Other: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	**Date Started**
☐ Antacids		
☐ Antibiotics		
☐ Antidepressants		
☐ Anti-Diabetics		
☐ Anti-Inflammatory		
☐ Blood Pressure Lowering Meds.		
☐ Cholesterol Lowering Meds.		
☐ Hormone Replacements (HRT)		
☐ Oral Contraceptives		
☐ OTC (over the counter) other		

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SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? ☐Y ☐N

If yes, who recommended them? _____

SCARS / SURGICAL PROCEDURES: Have you had any surgical procedures? ☐ Y ☐ N Any Scars? ☐ Y ☐ N

SPINE: ☐ Cervical ☐ Thoracic ☐ Lumbar

EXTREMITIES: ☐ Shoulder/Elbow/Hand/Wrist ☐ R ☐ L ☐ Hip/Knee/Ankle/Foot ☐ R ☐ L

ABDOMINAL/CHEST: ☐ Appendix ☐ Colon ☐ Gall Bladder ☐ Heart ☐ Lungs ☐ Breast

Other: _____

HABITS

Alcohol:	☐ Heavy	☐ Moderate	☐ Light	☐ None
Coffee:	☐ Heavy	☐ Moderate	☐ Light	☐ None
Soda/Diet Soda:	☐ Heavy	☐ Moderate	☐ Light	☐ None
Tobacco:	☐ Heavy	☐ Moderate	☐ Light	☐ None
Drugs:	☐ Heavy	☐ Moderate	☐ Light	☐ None

Exercise: ☐ 5-7x/wk ☐ 3-5x/wk ☐ 1-2x/wk ☐ None Type: ☐Aerobic ☐ Weights

Sleep: ☐ 8+ hrs ☐ 7-8 hrs ☐ 6-7 hrs ☐ 5-6 hrs ☐ <5 hrs

Meals/Day: ☐ 5+ ☐ 4 ☐ 3 ☐ 2

Water/Day: ☐ 64+ oz ☐ 32-64 oz ☐ 16-32 oz ☐ <8 oz

Stress Level: ☐ Heavy ☐ Moderate ☐ Light

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking/Moving ☐ Driving

FAMILY HISTORY: Please check any conditions that you, or any of your family members have now or have had in the past. (**F =** Family, **P =** Personal History)

F / P		F / P		F / P		F / P	
☐☐	Alcoholism	☐☐	Eczema	☐☐	Miscarriage(s)	☐☐	Tumor(s)
☐☐	Anemia	☐☐	Emphysema	☐☐	Mumps	☐☐	Ulcer(s)
☐☐	Cancer	☐☐	Epilepsy	☐☐	Pleurisy	☐☐	Cold sores
☐☐	Goiter	☐☐	Pneumonia	☐☐	Deep vein thrombosis	☐☐	Gout
☐☐	Polio	☐☐	Detached retina	☐☐	Heart disease	☐☐	Rheumatic fever
☐☐	Diabetes	☐☐	HIV / AIDS	☐☐	Stroke		

Other: _____

_____

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Family Medical History

Check all that apply	Mother	Father	Brother	Sister	Children	Mother's Parents	Father's Parents	Aunts & Uncles
Ages						NA	NA	NA
Cancers	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Psoriatic Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hoshimoto's Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐
Lupus (SLE)	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Environmental Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Psoriasis/Eczema	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐	☐	☐	☐
ALS	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disease	☐	☐	☐	☐	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐	☐	☐
Other								
Other								

Patient Health Information

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Chiropractic Neurology & Wellness Center (CNWC) 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/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 CNWB 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 purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature:_____ Date: _____

Patient's Name:_____
PLEASE PRINT

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Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now or in the future render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications that may arise during a Chiropractic adjustment. Those complications may include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costrovertebral 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. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments, and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the Chiropractic adjustment and related treatment. 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 Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Chiropractic Neurology & Wellness Center
618 Frederick St., Santa Cruz, CA 95062
831-460-9200

Name of Doctor Treating this Patient
James M. Cartwright, D.C., D.A.C.N.B.
www.cartwrightwellnes.com

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed Name of Patient	Date
Signature of Patient	Date
Signature of Patient's Representative	Date
Witness Signature	Date