MERRILL CHIROPRACTIC

INTAKE FORM

PERSONAL INFORMATION

Name (first/last) _____ Today's Date_____

Gender ❑ M ❑ F *If Female, are you pregnant? ❑ Yes ❑ No Date of Birth _____

Address _____

City _____ State _____ Zip _____ Phone Number _____

Email Address _____

Significant Other's Name _____

Your Employer _____ Type of Work _____

Have you seen a chiropractor? ❑ Yes ❑ No

If yes, Who was the last chiropractor you saw? _____

Emergency Contact Name _____ Emergency Contact Phone Number _____

How did you hear about us? ❑ Social Media ❑ Google Search ❑ Referred by_____ ❑ Other _____

OFFICE VISIT REASON

CHIEF COMPLAINT

1. _____

How long has this been an issue? _____ How bad is this complaint 1-10 ____

What does the pain feel like? ❑ Aching ❑ Throbbing ❑ Sharp ❑ Shooting ❑ Numb ❑Tingling

Since the onset, it has: ❑ Stayed the same ❑ Gotten better ❑ Gotten worse

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

What makes it better? _____ ❑ Nothing

What makes it worse?_____ ❑ Nothing

Have you had this issue treated before? ❑ No ❑ Yes

If Yes, What type of treatments?_____

What were the results of the treatment?: ❑ Same ❑ Better ❑ Worse ❑ Other_____

OTHER COMPLAINTS

2. _____

How long has this been an issue? _____ How bad is this complaint 1-10 ____

What does the pain feel like? ❑ Aching ❑ Throbbing ❑ Sharp ❑ Shooting ❑ Numb ❑Tingling

Since the onset, it has: ❑ Stayed the same ❑ Gotten better ❑ Gotten worse

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

What makes it better? _____ ❑ Nothing

What makes it worse?_____ ❑ Nothing

Have you had this issue treated before? ❑ No ❑ Yes

If Yes, What type of treatments?_____

What were the results of the treatment?: ❑ Same ❑ Better ❑ Worse ❑ Other_____

3. _____

How long has this been an issue? _____ How bad is this complaint 1-10 ____

What does the pain feel like? ❑ Aching ❑ Throbbing ❑ Sharp ❑ Shooting ❑ Numb ❑Tingling

Since the onset, it has: ❑ Stayed the same ❑ Gotten better ❑ Gotten worse

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

What makes it better? _____ ❑ Nothing

What makes it worse?_____ ❑ Nothing

Have you had this issue treated before? ❑ No ❑ Yes

If Yes, What type of treatments?_____

What were the results of the treatment?: ❑ Same ❑ Better ❑ Worse ❑ Other_____

MERRILL CHIROPRACTIC

INTAKE FORM

GENERAL HEALTH HISTORY

Do you have or have you had any of the following conditions? (Check if Yes)

- ❑ Anemia
- ❑ Arthritis / Rheumatoid Arthritis
- ❑ Allergies / Asthma
- ❑ Cancer
- ❑ Chronic Fatigue Syndrome (CFS
- ❑ Clotting Disorder
- ❑ Congestive Heart Failure
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Issues / IBS
- ❑ Emphysema
- ❑ Endocrine Problems / Thyroid Disorders
- ❑ Fainting
- ❑ Fibromyalgia
- ❑ Gall Bladder Trouble
- ❑ Gastrointestinal Reflux Disease (GERD)
- ❑ Hands or Feet Cold / Numbness/Tingling
- ❑ Heart Disease / Pacemaker
- ❑ High / Low Blood Pressure
- ❑ High Cholesterol
- ❑ HIV/AIDS / Hepatitis
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Medication Side Effects
- ❑ Migraine / Headaches
- ❑ Multiple Sclerosis (MS)
- ❑ Osteoporosis
- ❑ Parkinson's Disease
- ❑ Peptic Ulcer Disease
- ❑ Seizures
- ❑ Shortness of Breath / COPD
- ❑ Sleeping Problems
- ❑ Stroke
- ❑ Ulcerative Colitis

PERSONAL SURGICAL HISTORY

Have you had any surgeries? ❑ No ❑ Yes,

Explain _____

INJURY HISTORY

Is there a history of any other injuries? ❑ No ❑ Yes,

Please describe _____

FAMILY HISTORY

Are there any relevant diseases in your family? ❑ No ❑ Yes,

Please describe _____

Was this injury due to a Work or Car accident? ❑ No ❑ Yes (If yes, please fill out below)

WORK ACCIDENT

Date of accident? _____

Please describe what happened _____

_____

_____

_____

_____

_____

What is your Claim #? _____

Who is handling your case? _____

What is their Phone #? _____

CAR ACCIDENT

Date of accident? _____

Adjusters name? _____

Adjusters phone # (if known) _____

Number of passengers? _____

Were you at fault? ❑ No ❑ Yes ❑ Unknown

Do you have MEDPAY/PIP? ❑ Unknown ❑ No ❑ Yes,

*If yes, do you know your limit ? _____

What is your Claim #? _____

Do you have an attorney? ❑ No ❑ Yes

*If yes, whom? _____

PATIENT SIGNATURE

Patient Signature _____ *Date* _____

I agree to pay a no-call, no-show fee on subsequent appointments if I have a scheduled appointment and don't show up. (Reschedules are always welcome.)

MERRILL CHIROPRACTIC

INFORMED CONSENT FOR CHIROPRACTIC CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____
Parent or Guardian: _____ Signature:_____ Date: _____

MERRILL CHIROPRACTIC

Paying for your care is easy here!

Mark and initial which one is you:

No Insurance: Easy! Our care plans and simple payment arrangements have helped over 1,000 people and will work great for you too!

*Initial*_____

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 benefits you may have and send your claims into 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 advanced. We will never surprise you with a bill in the mail.

*Initial*_____

Auto Injury: Auto related injuries are typically covered 100% in Wisconsin. Even if you were at fault or were a passenger. You can get the care you meed. Great for you!

*Initial*_____

Work Injury: Work injuries are covered at 100% for up to 12 weeks of care.
All we need is your claim number and workman's comp. insurance information

*Initial*_____

Medicare: Regardless of your condition, Medicare pays for up to a maximum of 12 weeks of care. They have very strict rules and limitations.
After this, your will receive a significant Medicare discount. We simply need a copy of your Medicare card.
Medicare supplements normally don't pay anything

*Initial*_____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____