FIT for Life CHIROPRACTIC
700 N Splitrock Blvd
Brandon, SD 57005

INTAKE FORM

PERSONAL INFORMATION

Name _____ Gender ❑ M ❑ F
*If Female, are you pregnant? ❑ No ❑ Yes
Today's Date _____ Birthdate _____
Address _____
City _____ State _____ Zip _____
Phone Number _____ Email Address _____
What is your occupation? _____ Employer:_____
Have you seen a chiropractor before? ❑ No ❑ Yes, Who? (most recent)_____
Emergency Contact Name _____ Relationship_____
Emergency Contact Phone Number _____
Social Security Number (For VA Patients only) _____-_____-_____ ❑ N/A
Are you ❑ Military ❑ Veteran ❑ Military/Veteran Spouse ❑ N/A
How did you hear about us? ❑ Facebook ❑ Google Search ❑ Referred by_____ ❑ Other _____

OFFICE VISIT REASON

CHIEF COMPLAINT

1. _____
How long has this been an issue? _____ From 1-10, with 10 being the worst, how would you rate this issue? _____
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? _____ From 1-10, with 10 being the worst, how would you rate this issue? _____
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? _____ From 1-10, with 10 being the worst, how would you rate this issue? _____
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_____

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INTAKE FORM

GENERAL HEALTH HISTORY

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

❑ Anemia
❑ Arthritis (Type_____)
❑ Asthma
❑ Chronic Fatigue Syndrome (CFS)
❑ Chronic Kidney Disease (CKD)
❑ Obstructive Pulmonary Disease (COPD)
❑ Clotting Disorder
❑ Congestive Heart Failure
❑ Crohn's Disease
❑ Depression
❑ Diabetes
❑ Emphysema
❑ Endocrine Problems
❑ Gastrointestinal Reflux Disease (GERD)
❑ Hepatitis
❑ HIV/AIDS
❑ Hypertension
❑ Irritable Bowel Syndrome (IBS)
❑ Kidney Disease
❑ Migraines
❑ **CANCER** _____

PERSONAL SURGICAL HISTORY

Have you had any surgeries? ❑ No ❑ Yes, Explain (Type and Year) _____

_____

_____

_____

INJURY HISTORY

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

Please describe _____

FAMILY HISTORY

Are there any relevant diseases in your immediate family such as cancers or heart conditions? ❑ No ❑ Yes,

Please describe _____

Was this injury due to an auto accident? ❑ No ❑ Yes (If yes, please fill out below)

AUTO ACCIDENT

Date of accident? _____

Adjusters name? _____

Adjusters phone # (if known) _____ Email Address _____

Number of passengers? _____

Do you have MEDPAY/PIP? ❑ Unknown ❑ No ❑ Yes, Do you know your limit ? _____

Who is **YOUR** auto insurance carrier_____ What is **YOUR** Claim #? _____

Were you seen at a medical facility since the accident occurred? ❑ No ❑ Yes

If yes, please provide Clinic/Doctor/Hospital Name & City:

1. _____

2. _____

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.)*

INFORMED CONSENT FOR CHIROPRACTIC CARE

THE NATURE OF CHIROPRACTIC TREATMENT

Chiropractic treatment primarily involves the manual manipulation of the treated area using the chiropractor's hands or mechanical devices. During treatment, you may experience sensations like clicks, pops, and movement. Additionally, our office may utilize various modalities in your care, as recommended by your chiropractor based on their professional judgment.

POSSIBLE RISKS

Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slightly increased pain in the treated area, possibly due to minor muscle, tendon, or ligament strain. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

It's important to note that serious bodily harm is extremely rare and not an inherent risk of chiropractic treatments. Various factors can influence one's health, including prior injuries, medications, and underlying medical conditions like osteoporosis, cancer, and other illnesses. When such conditions are present, chiropractic treatment may carry the risk of serious adverse events, including fractures, dislocations, or the exacerbation of previous injuries to ligaments, intervertebral discs, nerves, or the spinal cord. It's essential for patients to remain vigilant and seek medical and/or chiropractic care if they experience symptoms suggestive of stroke or cerebrovascular injury. Your chiropractor is well-informed about this association and will assess for relevant symptoms when appropriate. It is imperative to disclose your full medical history, including medications, surgeries, and all relevant health conditions like osteoporosis, heart disease, cancer, stroke, fractures, or prior severe injuries.

OTHER OPTIONS FOR THE TREATMENT OF PAIN INCLUDE

Apart from chiropractic care, alternative approaches to managing pain include doing nothing and living with it, over-the-counter medications, physical therapy, medical interventions, injections, or surgery. There is a multitude of pain management options, each carrying potential benefits and risks. We encourage you to ask any questions you may have about the potential risks associated with chiropractic treatment.

I, the undersigned, confirm that I have read and understood the information provided above, including the potential risks associated with chiropractic treatment, and have had the opportunity to inquire about any concerns I may have. I have disclosed my relevant medical history, as well as any conditions that have previously caused me pain.

Patient Name	Signature	Date

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