Envision Health Chiropractic and Wellness Center
Casandra J. McFarland, DC

CONFIDENTIAL PATIENT INTAKE Date:_____

Name:_____
First Middle Last Maiden (if applicable)

Address:_____
Street City State Zip

Social Security #:_____-_____-_____ Age:___ DOB: ____/____/____

Marital Status: M S W D Spouses Name:_____

Children: _____ Spouses Work # _____
Names & Ages

Occupation:_____ Employer:_____

Home phone: (____)_____ Work phone:(____)_____

Cell: (____)_____ Email: _____

Name of emergency contact_____

Relationship to patient:_____ Phone: (____)_____

The undersigned patient specifically acknowledges responsibility for prompt payment of all services provided.

Date:_____
Patient's Signature

To be completed in case of Motor Vehicle or Worker's Compensation Accident only

Date of Injury:_____ Insurance Company:_____

Address of Company:_____
Street City State Zip

Adjuster:_____ Phone:_____

Policy Number:_____Claim Number:_____

CONFIDENTIAL PATIENT HISTORY

What brings you in today? (present health complaints)

_____

_____

How and when did your problems begin? (be as specific as possible)_____

_____

How intense is your pain ***today?*** minimal mild moderate severe

How intense is your pain ***usually?*** minimal mild moderate severe

Is your pain/symptoms: increasing □decreasing staying the same

How often do you have pain/symptoms: (please circle only one)

Occasional (25% of time) Intermittent (50% of time)
Frequent (75% of time) Constant (100% of time)

Please describe the character of your pain/symptoms: (circle all that apply)

Stabbing Sharp Aching Soreness Numbness Weakness Shooting
Tingling Burning Throbbing Stiffness Paralysis Tightness/spasm
Other (explain)_____

Have you tried anything to alleviate your symptoms? _____

_____

What types of activities (work or social) aggravate your condition: _____

_____

_____

Are your symptoms affecting any of the following (circle all that apply)
Sleeping Walking Sitting Lifting Driving Standing Running
Working Other(explain)_____

Have you seen anyone else for your present complaint(s)? Yes No

If yes, list facility and/or health care provider name:_____

If so, what was their diagnosis and treatment?_____

_____

Since your symptoms began, have you noticed any changes or problems with the following? (circle all that apply)

Bowel/Bladder Digestion Nausea Vomiting Swallowing Vision Hearing Sexual Function Breathing Coughing Weakness Numbness Dizziness Smelling Tasting Other(please explain)_____

Lifestyle

Are you currently taking any prescription medication(s)? Yes No

If yes, what for?_____

Names of medication(s):_____

Are you currently taking any non-prescription medication (aspirin, Advil, Tums, etc) Yes No If yes, what types? _____

Are you taking any nutritional supplements or herbs? Yes No

If yes, what types?_____

_____

Do you do any of the following? (please circle all that apply)

Smoke	How much? _____
Use alcohol	How much/often? _____
Drink coffee/tea	How much/day? _____
Drink soda	How much/day? _____
Drink water	How much/day? _____

Medical History

Please list any past hospitalizations, surgeries, broken bones, accidents/falls, and that date involved._____

_____

Who is your Family Doctor/Primary Care Physician? _____

What is the name of their facility and the location?_____

_____

Is there any family history of (circle all that apply):

Arthritis Cancer Diabetes Heart Disease/Attacks
High Blood Pressure Depression Stroke

Please list any other health concerns that were not adequately addressed in these forms:_____

_____

Mark the intensity of your pain today

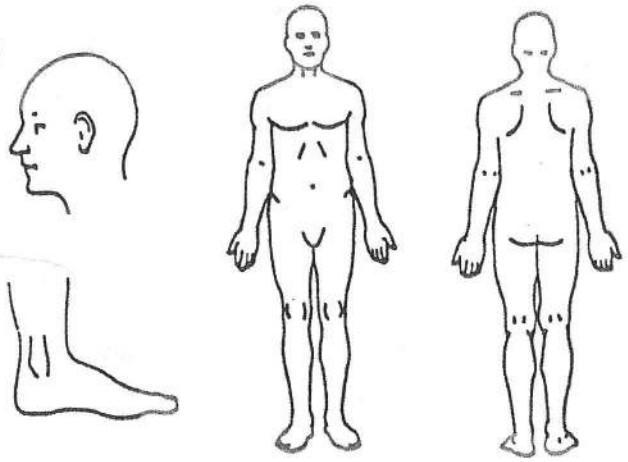
1—no pain 10-intense pain

example _____
1 2 3 4 5 6 7 8 9 10

1. _____
1 2 3 4 5 6 7 8 9 10

2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10



Mark area & type of pain on drawing using code below:
N-Numb P-Pain T-Tingling A-Ache S-Sore S-Stiff

_____Please Do Not Write Below This Line_____

_____

_____

_____

_____

_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes an alteration of nerve function and interference to the transmission of nerve impulses. This results in a lessening of the body's innate ability to express maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral and extremity subluxation. Our chiropractic method of correction is by specific adjustment of the spine and extremities.

Health: A state of optimal physical, mental, and social well-being -- not merely absence of dis-ease or infirmity.

We do not offer to diagnose or treat any disease of condition other than subluxations of primarily the vertebrae, and secondly the extremity. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider that specializes in that arena.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. The ONLY practice objective is to eliminate a major interference to the expression of the body's innate wisdom. The ONLY method is specific adjustments to correct subluxations.

I, _____, have read and fully understand the above
(print name)
statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____

(signature) (date)