New Patient Intake Form

Patient Information

Name: ______________________________ Date of Birth: ______________Today's Date: ______________

Address: ______________________________ City: ____________________ State: _____ Zip: ____________

Telephone: __________________Email: ________________________

Gender: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

How did you hear about our office?____

Emergency Contact Name: ____________________Relationship: __________Telephone #: ___________

Employment Information

Current Employment: □ Employed □ Unemployed □ Homemaker □ Student □ Other

Employer's Company Name: ______________________________Job Title:__________________________

Here for: □ Alignment □ Posture □ Athletic Performance □ Pain Relief

Presenting problem

What is the presenting problem/chief complaint?____

When/how did this start?____

Have you had this or similar conditions in the past? □ Yes □ No

Is this condition getting (circle): Worse Better Same Recurring

Is this pain (circle): Dull Achy Sharp Electrical Throbbing Stiffness Cramps

Rate pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)

Frequency: (Percentage of day symptoms felt) 0%-25% 26%-50% 51%-75% 76%-100%

Any (circle): Numbness / Tingling / Weakness / Changes in Bowel or Bladder habits/ Head Ache / Nausea / Pain with Sneezing, Coughing, Straining / Dizziness / Fever / Fatigue

How does this condition interfere with your daily routine? ____

What aggravates your condition? ____

What relieves your condition? ____

Types of previous treatment and/or surgery for this condition? ___________________________________

Personal Health History

Overall Stress Level 0 1 2 3 4 5 6 7 8 9 10

Overall Health Level 0 1 2 3 4 5 6 7 8 9 10

Medications, including over the counter, you currently take:_____________________________________

____

Allergies: ____

Vitamins/Supplements you currently take: ____

List any serious illness you have had: ____

Date of last physical examination: ____________ Please list any abnormal findings:_________________

____

Surgeries:____

Have you ever been diagnosed with cancer? □ Yes □ No If yes, what kind? ______________________

Family health history: describe any conditions/diseases(i.e. heart disease, diabetes, other inherited diseases) suffered by family members:____

Patient Signurature____Date_________________

Maple Ridge Chiropractic & Massage ~ *Dr. Reed Richards, Chiropractic Physician*
655 E 400 S Suite D, Springville, UT 84663 P:(801)655-3989 F:(208)692-3202 mapleridgechiropractic@gmail.com

Informed Consent

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.

Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a 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. 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. It is important that you also 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.

Consent of Professional Services and Release of Information

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 hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies, laboratory procedure, chiropractic care, massage therapy or any clinic services that he/she deems necessary in my case; and further authorize him/her to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services, companies, insurance companies, workers compensation carriers, welfare funds or the patients' employer. I authorize Maple Ridge Chiropractic & Massage to contact me through mail, fax, phone, voicemail, and/or text regarding my care.

Patient Name: ________________________________ Signature: ___________________________ Date: _________
Parent or Guardian: ___________________________ Signature:____________________________ Date:_________

MOTOR VEHICLE COLLISION QUESTIONNAIRE

Name: ______________________________ **Date:** ____________ **Date of accident:** ____________

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type: Year________ Make______________ Model_________________

Your Position in vehicle: ☐ Driver ☐ Front right ☐ Rear left ☐ Rear right ☐ Rear middle

Speed of vehicle: _____MPH ☐ Slowing ☐ Accelerating ☐ Stopped

Collision type: ☐ Driver side impact ☐ Passenger side impact ☐ Head on ☐ Rear impact

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type: Year________ Make______________ Model_________________

CONDITIONS AT TIME OF ACCIDENT

Road conditions: ☐ Dry ☐ Wet ☐ Snow covered ☐ Icy ☐ Traffic

Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark

Visibility: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you ☐ Unaware of impending accident ☐ Aware ☐ Braced for it ☐ Wearing seat belt

If you were the driver, was your foot on the brake pedal? ☐ Yes ☐ No

Was the airbag deployed? ☐ Yes ☐ No

Was your headrest ☐ lowered ☐ middle position ☐ highest position

Position of head at impact: ☐ Facing straight ahead ☐ Tilted forward ☐ Rotated right ☐ Rotated left

Position of body at impact: ☐ Facing straight ahead ☐ Tilted forward ☐ Rotated right ☐ Rotated left

Damage to the vehicle you were in: ☐ Minimal ☐ Moderate ☐ Severe/totaled

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS DID YOUR BODY STRIKE?

Head ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Left door
☐ Right door ☐ Left window ☐ Right window ☐ Center console ☐ Front seat ☐ Back seat

Right arm ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Left door
☐ Right door ☐ Left window ☐ Right window ☐ Center console ☐ Front seat ☐ Back seat

Left arm ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Left door
☐ Right door ☐ Left window ☐ Right window ☐ Center console ☐ Front seat ☐ Back seat

Right leg ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Left door
☐ Right door ☐ Left window ☐ Right window ☐ Center console ☐ Front seat ☐ Back seat

Left leg ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Left door
☐ Right door ☐ Left window ☐ Right window ☐ Center console ☐ Front seat ☐ Back seat

Torso ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Armrest ☐ Headrest ☐ Left door
☐ Right door ☐ Left window ☐ Right window ☐ Center console ☐ Front seat ☐ Back seat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness? ☐ Yes ☐ No

Were you able to walk unaided? ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No If yes, which one___________________________

Did you receive care from an ambulance? ☐ Yes ☐ No

Immediately following the accident, did you feel: ☐ Dizzy ☐ Weak ☐ Dazed ☐ Nauseas ☐ Disoriented

Next day discomfort? ☐ Increased ☐ Decreased ☐ Same

Did your major complaints exist BEFORE the accident? ☐ Yes ☐ No

Name: ___________________________________ Date of Birth: ______________ Date: ______________

In what areas did you IMMEDIATELY feel pain?

☐Head	Shoulder	☐Left	☐Right	Hip	☐Left	☐Right
☐Neck	Arm	☐Left	☐Right	Thigh	☐Left	☐Right
☐Upper back	Elbow	☐Left	☐Right	Knee	☐Left	☐Right
☐Mid back	Wrist	☐Left	☐Right	Calf	☐Left	☐Right
☐Ribs	Hand	☐Left	☐Right	Ankle	☐Left	☐Right
☐Chest	Fingers	☐Left	☐Right	Foot	☐Left	☐Right
☐Abdomen	Buttock	☐Left	☐Right	Toes	☐Left	☐Right
☐Low Back	☐Pelvis					

Where did you experience pain on the days FOLLOWING the accident?

☐Head	Shoulder	☐Left	☐Right	Hip	☐Left	☐Right
☐Neck	Arm	☐Left	☐Right	Thigh	☐Left	☐Right
☐Upper back	Elbow	☐Left	☐Right	Knee	☐Left	☐Right
☐Mid back	Wrist	☐Left	☐Right	Calf	☐Left	☐Right
☐Ribs	Hand	☐Left	☐Right	Ankle	☐Left	☐Right
☐Chest	Fingers	☐Left	☐Right	Foot	☐Left	☐Right
☐Abdomen	Buttock	☐Left	☐Right	Toes	☐Left	☐Right
☐ Low Back	☐Pelvis					

Health Issues

☐Numbness	☐Nausea	☐Shortness of Breath
☐Paralysis	☐Vomiting	☐Irregular Heart Rate
☐Dizziness	☐Diarrhea	☐Lung Problems
☐Forgetfulness	☐Constipation	☐Varicose Veins
☐Confusion	☐Hemorrhoids	☐Ankle Swelling
☐Convulsions	☐Gall Bladder Trouble	☐Vision Problems
☐Allergies	☐Weight Gain/Loss	☐Dental Problems
☐Loss of Sleep	☐Abdominal Pain	☐Sore Throat
☐Fever	☐Heartburn	☐Ear Aches
☐Headaches	☐Bladder trouble	☐Hearing Difficulty
☐Change in Appetite	☐Discolored/Painful Urination	
☐Excessive Thirst	☐Chest Pain	

Automobile Insurance Information

Do you or someone else have insurance coverage for the vehicle you were in? ☐ Yes ☐ No

If someone else, please list their name: ____

How is this person related to you? ☐ Parent ☐ Friend ☐ Other: ___________________________

Medical Benefits Coverage: ☐ Yes ☐ No Limit: ☐ $3,000 ☐ $5,000 ☐ $15,000 ☐ Other: __________

Date of Injury: __________ Location of Incident (City, State): ______________________________

Automobile Insurance Carrier Name: ____

Auto Carrier Telephone #:_______________ Driver's Claim #: ___________________________

Do you have secondary insurance (Blue Cross, Aetna, etc.)? ☐ Yes ☐ No

Name of Secondary Insurance: ____

Attorney

Do you have an attorney representing you? ☐ Yes ☐ No ☐ Not yet

Attorney Name: ____

Telephone #: ___________________________ Fax: ____________________________

Have you had any other exam/treatment provided for your injuries prior to our office? ☐ Yes ☐ No

I authorize payment to be made directly to Maple Ridge Chiropractic & Massage.

Patient's Signature:_________________________________ Date: _______________