Keystone Spinal Care New Patient Intake Form

Date:_____

Name: _____ Home Phone #: _____

Address: _____ Cell Phone #: _____

_____ Date of Birth: _____

Email: _____ Insurance Type: _____

How did you hear about Keystone Spinal Care? _____

HIPPA Privacy Notice

I acknowledge that have read a HIPPA Privacy Notice in the past or was provided one at this office to read. I fully understand that these privacy practices will be followed by Keystone Spinal Care to ensure the privacy of my personal health information. I understand that this will be placed in my chart and maintained for 6 years.

Patient Name (Printed) _____ Signature_____ Date_____

Term of Acceptance

At Keystone Spinal Care we do not offer to diagnose or treat any disease or condition other than the spinal misalignment, however, it is possible that you will feel better after having your spine re-aligned. If the doctor during your exam or treatment encounters a non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnostics, or treatment for those findings, we will recommend that you seek the services of health care provides who specialize in that area. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice on how to treat a health condition. We only focus on structure and function of the human body and making sure the body has the raw nutritional materials to heal and thrive.

I _____have read and fully understand the above statements. All the questions regarding the doctor's objective pertaining to my care in this office have been answered. I, therefore, accept chiropractic spinal corrective care on these bases.

Signature: _____ Date: _____

Consent to evaluate a minor and adjust a minor (child)

I, _____ being the legal guardian of _____have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify to the best of my knowledge I am not pregnant, and the above doctor have my permission to perform an X-ray evaluation that might harm my unborn child. Last Period: _____ Initials: _____

Permission to Bill Insurance/ My Responsibility/Cash Patient

I understand Keystone Spinal Care will bill my insurance and I will pay the remaining balance. Initials: _____

I understand that my insurance is not accepted at this office, and I will be a cash patient. Initials: _____

Reason for Your Visit

Please Print the Top 2 reasons for your Visit:

1._____ Pain Level 0-10 (0 is no pain/10 is worst pain) _____

How Frequent do you have this problem: Hourly Daily Few times a week Weekly Monthly

How long have you had this condition? Days Months 6 Months 1 year 2 years or more

What have you done in Past to help with condition? _____

_____

2._____ Pain Level 0-10 (0 is no pain/10 is worst pain) _____

How Frequent do you have this problem: Hourly Daily Few times a week Weekly Monthly

How long have you had this condition? Days Months 6 Months 1 year 2 years or more

What have you done in Past to help with condition? _____

_____

List Medications You are taking: _____

_____

Circle all Health Conditions that you Have:

Asthma / Allergies/ Ringing in ears/ Lack of taste or smell / Facial pain/dysfunction / Jaw Pain /Skull pain

Neck Pain / Arm/hand numbness / Thyroid problems / Dizziness / Heart issues/ Breathing Issues/Liver issues/

Kidney Issues/ Spleen Issues/Stomach issues/Gallbladder issues/ Bladder Issues/ Mid-back pain/

Lower back pain/ Numbness in legs/feet/ Hip pain/Knee Pain/Ankle Pain/Shoulder Pain/Elbow Pain/AnklePain

How often do you Lift weights or use body weight exercises? 3X Weekly 2X Weekly 1X Weekly None

How often do you do cardio (walk, run, row, biking, etc.) ? 3X Weekly 2X Weekly 1X Weekly None

How often do you eat breads/pasta/bake goods/sodas per day? 3X daily 2X daily 1 X daily None

Are you able to get to sleep quickly at night? Yes No

Do You consider your sleep restful, deep, and feels refreshed in morning? Yes No

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Drs. Exam

Short leg R L _____ Low Hip R L _____ Low Shoulder R L _____ Twisted Torso Post. R L

Head Tilt R L N Head Rotation R L N Atlas Tender R L N Neck Ext. N AB P

AROM: Neck Flex. N AB P **L Rot.** N AB P **R. Rot.** N AB P **L. Lat. Bend** N AB P **R. Lat. Bend** N AB P

Touch Toes: + - P Squat + - P Balance: L. leg + - R. Leg + - Torso twist pain no pain