Welcome to Planet Chiropractic!

NEW PATIENT INTAKE

FULL NAME: _____ **Today's Date:** _____

Preferred Name: _____ **Birth Date:** _____ **Social Security #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Age: _____ **Email Address:** _____ **Male:** _____ **Female:** _____

Home Telephone: ( ) _____ **Cell ( )** _____ **Work ( )** _____

Occupation: _____ **Employer Name:** _____

Single _____**Married** _____**Spouse's Name** _____ **Health Insurance: Yes No (circle one)**

Emergency Contact Name: _____ **Phone Number** _____

Whom may we thank for referring you to our office? _____

Are you seeing the doctor today due to a Work or Auto Accident Related Injury? Yes_ No_ Date of Injury _____

YOUR HEALTH SUMMARY

PLEASE CHECK ALL SYMPTOMS YOU HAVE EVER HAD, EVEN IF THEY DO NOT SEEM RELATED TO YOUR CURRENT PROBLEM:

- ❑ Headaches
- ❑ Pins and Needles in arms
- ❑ Dizziness
- ❑ Numbness in fingers
- ❑ Fatigue
- ❑ Sleeping problems
- ❑ Diarrhea
- ❑ Cold sweats
- ❑ Mood swings
- ❑ Pins and Needles in legs
- ❑ Loss of smell
- ❑ Buzzing in ears
- ❑ Numbness in toes
- ❑ Depression
- ❑ Neck stiff
- ❑ Constipation
- ❑ Lights in both eyes
- ❑ Menstrual Pain
- ❑ Fainting
- ❑ Back Pain
- ❑ Ringing in ears
- ❑ Loss of taste
- ❑ Irritability
- ❑ Cold hands
- ❑ Fever
- ❑ Problem urinating
- ❑ Menstrual irregularity
- ❑ Neck Pain
- ❑ Loss of balance
- ❑ Nervousness
- ❑ Stomach upset
- ❑ Tension
- ❑ Cold feet
- ❑ Hot flashes
- ❑ Heartburn
- ❑ Ulcers

List any medications you are taking _____

_____

_____

Planet Wellness conforms to the current HIPPA guidelines. You may request a copy of our HIPPA Policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature _____**Date** _____

Guardian Signature _____ **Date** _____

Planet Wellness CHIROPRACTIC

1409 Kempsville Road
Chesapeake, VA 23320

(757) 410-2793 Office
(757) 410-2807 Fax

TERMS OF ACCEPTANCE

When a person seeks Chiropractic care and we accept a person 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 person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease other than the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my chiropractor. I understand that Planet Wellness will prepare any necessary forms to assist me in submitting claims to my insurance provider and credit my account when payment is received. However, I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made. In the event of non-payment, it is agreed that I will be responsible for all costs of collections including collection agency fees of 25.0% of the amount owed and/or any related court costs/attorney's fees.

I _____ have read and fully understand the above statements.
(Print Name)

Signature: _____ **Date**: _____

CONSENT TO EVALUATE AND ADJUST A

I _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. If you agree, sign below:

Signature: _____ **Date**: _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge, I am not pregnant and the doctors at Planet Wellness and the staff have my permission to perform X-rays. I have been advised that an X-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Signature: _____ **Date**: _____

HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctor by providing past health history information for his review.

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Difficulty Sleeping							
Disc Problems							
Ear Problems							
Emphysema							
Epilepsy/Seizures							
Fatigue							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Neck Pain							
Numbness							
Pinched Nerve							
Scoliosis							
Sinus & Allergies							
Stomach Trouble							

Functional Rating Index

In order to properly assess your condition, we must understand how much your condition(s) has affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition <u>right now.</u>

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

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.)

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

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

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

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

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

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

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