Normal
CHIROPRACTIC

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issue you face and ensure the best possible treatment.

New Patient Intake Form

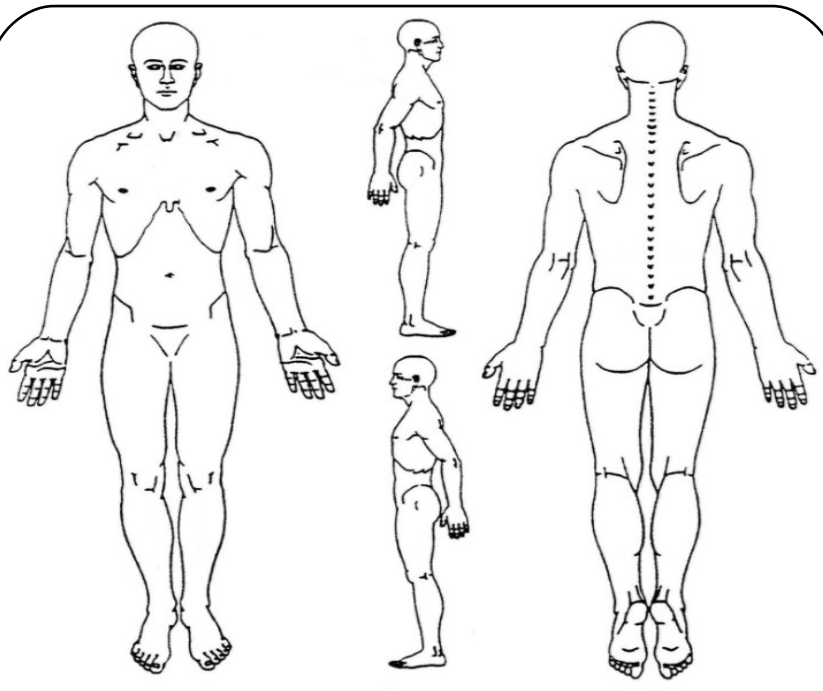
Demographics

Name _____ Date _____
Date of Birth _____ ( ) Male ( ) Female
Address _____
Phone # (_____) _____ E-mail _____
Occupation _____Employer_____
Emergency contact _____ Relationship _____ Phone # (_____) _____
Do you have Medicare or Medicaid? _____ Is your condition due to an accident? _____
Who is your primary care physician (PCP)? _____ Office Phone # (____) _____
May we update your PCP on your treatment at Normal? (Y / N) How did you hear about us? _____

Condition

Reason for visit _____
Give a brief description of the problem(s) _____
_____
_____
_____
What are your goals with care? ( ) Pain relief ( ) Wellness ( ) Other _____
How long have you had this condition? _____ Is it getting better/worse? _____
What seemed to be the initial cause? _____
How often do you have this pain? _____ Is it constant? _____
Rate the severity of your pain from 0 (no pain) to 10 (worst pain imaginable) _____
Have you been treated for this condition in the past? By who? _____
If so, what have you had done? _____
Have you had any imaging done? When?
(X-ray, MRI, CT, Ultrasound)
_____
_____
_____
Have you had any relevant surgeries?
_____
_____
_____
Are there any related medical conditions that we should be aware of?
_____
_____
_____

Please mark any and all areas of pain, numbness, etc.



Past Health History

Indicate any conditions you have and indicate the age of onset if relevant

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis
  Type? _____
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defecation
- ☐ Vomiting

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Coughing up phlegm / blood
- ☐ Wheezing

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Angina
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of the ankles

Genitourinary
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Incontinence
- ☐ Painful urination
- ☐ Decreased urinary flow

Women only
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Miscarriage
- ☐ PCOS / Ovarian cyst
- ☐ Vaginal discharge

Are you pregnant?
- ☐ Yes
  How many months?
  _____
- ☐ No

Health Conditions
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
  Type? _____
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Myofascial pain syndrome
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medications you are currently taking

_____
_____
_____
_____
_____

- ☐ Have you been hospitalized in the last 5 years? If so why? _____
- ☐ Have you had a major surgery? If so what? _____
- ☐ Are you under the care of a Neurologist, Rheumatologist or Orthopedist? _____

Family History

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleed easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

Normal Chiropractic, pllc
140 E. 9th street
Tyler, Texas 75701

Informed Consent

Please read this entire document before signing. It is important that you understand the information contained in this document. If anything is unclear, please ask before signing.

The nature of the chiropractic adjustment

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination and treatment, you may be asked to consent to the following procedures:

- Spinal manipulative therapy, Manual therapy, Massage therapy, Acupuncture and/or Dry needling
- Palpation, Vital signs, Range of motion testing, Orthopedic testing, Basic neurological testing, Muscle strength testing and/or Postural analysis testing
- Hot/cold therapy, Electrical muscle stimulation and/or Therapeutic exercise/rehabilitation
- Medical imaging: X-ray, Ultrasound, CT, MRI

At any point in your care you have the right to refuse services verbally.

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor’s attention it is your responsibility to inform the Doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all, it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk for arterial stroke.

The risks associated with acupuncture and dry needling

There is a chance of local bruising and bleeding which is higher for people taking blood thinners. While remote, needling in proximity to the lungs presents a risk of pneumothorax. Infection at the site of insertion is very rare but present even with full sterile technique in place.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers.
- Hospitalization
- Surgery

If you chose to use one of the above noted treatment options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize the treating chiropractor to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter _____. This authorization also extends to all other doctors and office staff members and in intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way. I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND ALL OF THE THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the chiropractor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks. I hereby give my consent to that treatment.

Dated: _____ Dated: _____

_____ _____
Patient's Name Doctor's Name

_____ _____
Signature Signature

_____
Signature of Parent or Guardian (if a minor)

Normal Chiropractic, PLLC
140 E 9th Street
Tyler, TX 75701
(903) 218-2238

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**____/____/_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Normal Chiropractic.

I understand that the Notice describes the uses and disclosures of my protected health information by Normal Chiropractic and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

****FOR OFFICE USE ONLY****

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):

_____ _____

Employee Name *Today's Date*

Initial Exam
*** For Doctors Use Only ***

Patient Name: Date / / Doctor:

Subjective:

Denies: □ LOC □ Bowel/Bladder dysfunction □ Related trauma □ Recent illness/Fever □ Radiation of pain □ Numbness/Tingling □ Developing weakness □ Relevant Imaging □ Relevant Surgeries

Objective Findings:

Insp: □ WNL □ Aox3 □ Dress/Behavior appropriate for age □ Ant head/shoulder

Palp: □ As noted □ WNL □

ROM: □ Not tested

	Cervical	Thoracic	Lumbar
Flexion	↑ ↓ P	↑ ↓ P	↑ ↓ P
Extension	↑ ↓ P	↑ ↓ P	↑ ↓ P
Left Lateral Flexion	↑ ↓ P	↑ ↓ P	↑ ↓ P
Right Lateral Flexion	↑ ↓ P	↑ ↓ P	↑ ↓ P
Left Rotation	↑ ↓ P	↑ ↓ P	↑ ↓ P
Right Rotation	↑ ↓ P	↑ ↓ P	↑ ↓ P
WNL	□	□	□

Ortho: □ No change □ Not tested

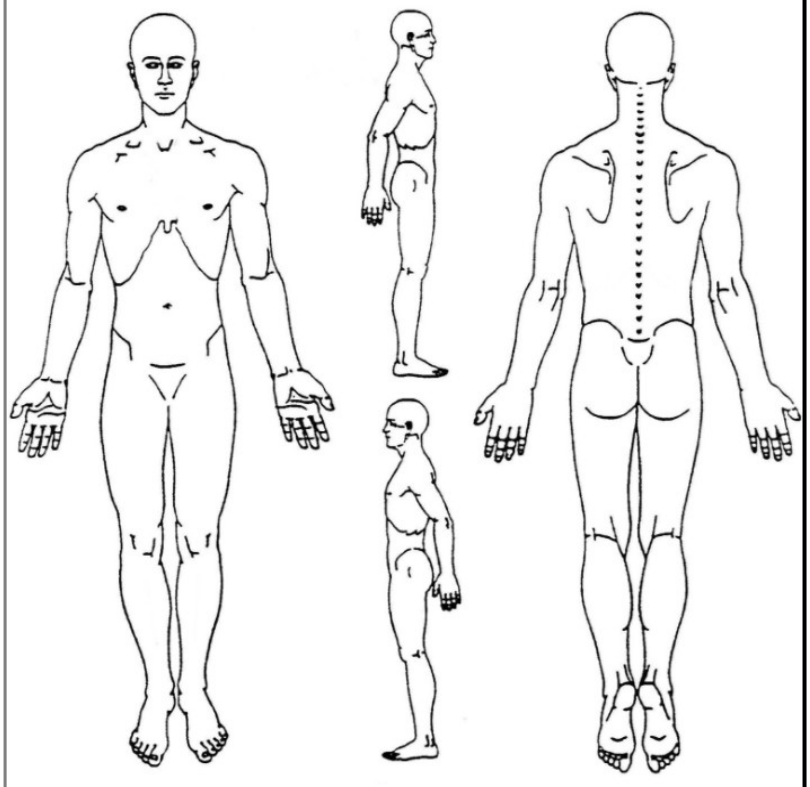
□ Adams □ Minors WNL
□ Cervical Dist □ Spurlings □ Shoulder Depression □ Soto Hall
□ SLR □ WLR □ Kemps □ Yeomans □ Illiac Comp □ Obers □ Trendelenburg

Neuro: □ UE WNL □ LE WNL □ Not tested

DTR: □ Trap □ Biceps □ Brachioradialis □ Patellar □ Achilles WNL
Sensory: □ C4 □ C5 □ C6 □ C7 □ C8 □ Thoracic □ L3 □ L4 □ L4 □ S1
Muscle strength: □ Trap □ Delt □ Biceps □ Brochioradialis □ Wrist Flex □ Wrist Ext
□ Finger Flex □ Interossei □ Hip Flex □ Quad □ Tib A □ Ext Hallucis Long □ Peroneii
□ Heel/Toe walk
CN: □ Smell □ Sight □ EOM □ Masseter & V1/V2/V3 □ Facial Muscles □ Tongue □ Uvula
□ Hoffmans □ Babinskis □ PEERLA

Other:

Tender point (x or X) Restriction (o) Paresthesia (///) Stim (Θ) Tight/Hypertonic (T) Needle (!)
Edematous/Swollen (E) Hematoma (H) LLI (↑) Headache (HA)



Pain: Dull (D) Sharp (|) Cramp/Spasm (S) Burning (B) Numb (=) Tingling (:) Radiation (→)

Assessment:

Goals:

Modalities/Procedures:
□ E-stim, unattended (97012) __min □ E-stim, attended (97032) __min
□ Massage (97124) ___min [*Gk3 / Manual / LMT*]
□ Manual therapy (97140) □ 59 __min [*Brief / Add-on / Full*]
□ Acupuncture (97811) □ W/Stim (97813) __min [*Brief / Add-on / DN*]
□ Traction, mechanical (97012) __min [*Cervical __lbs / Lumbar __lbs*]
□ Cupping __min □ K/T tape w/movement instruction __min
□ Therapeutic exercise (97110) __min [*Brief / Add-on / Full*]
□ Exam & management of new patient __min (99202)

Manipulative Procedures: (HVLA or Mobilization)
□ Regular □ Express/Wellness
□ 1-2 (98940) □ 3-4 (98941) □ 5 (98942) □ ROM Only
□ Occiput/Cranial
□ Cervical
□ Thoracic
□ Lumbar
□ Sarcral/Pelvic
□ Extremity (Upper / Lower)

Levels/Part:
Lt / Rt
1 2 3 4 5 6 7
1 2 3 4 5 6 7 8 9 10 11 12
1 2 3 4 5
Lt / Rt

Notes:

Recommendations: □MD consult □ ER/Urgent care □ PT □ Imaging (MRI / X-ray / CT)

Return: □ 2-3 days □ 3-5 days □ 1 Week □ 2 weeks □ As needed
□ Begin therapeutic exercises as instructed @ home □ Ice □ Rest □ Heat □ Brace

Treatment Response:

□ All treatments tolerated well
□ Pt. appeared happy with care
□ Pt. acknowledged the Dx and treatment plan

Signed: