PATIENT INTAKE FORM

Happy Back CHIROPRACTIC

Please fill in all the information as accurately as possible.
The information you provide will assist in formulating a complete health profile. All answers are confidential.

Date: _____ /_____ /_____

Name: _____ Nick Name: _____

Address: _____ Date of Birth: _____ Age: _____

City / State / Zip: _____ /_____ /_____ Gender: ☐ M ☐ F

Email: _____ Phone: _____

Occupation: _____ Company: _____

Children & Age(s): _____ Spouse / Partner: _____

Marital Status
- ☐ Single
- ☐ Married
- ☐ Partner
- ☐ Other

Work Status
- ☐ Employed
- ☐ Student
- ☐ Retired
- ☐ Other

How'd you find us ?
- ☐ Store Front Sign
- ☐ Google / Online Search
- ☐ Facebook
- ☐ Friend / Family Referral
- ☐ YouTube Video

Height ____' _____"

Weight _____ lbs.

Shoe Lift? ☐ Y ☐ N
Heel Lift? ☐ Y ☐ N
Orthotics? ☐ Y ☐ N

MEDICATIONS

Include any Occasional "Over the Counter" Drugs?

1. _____ For _____
2. _____ For _____
3. _____ For _____
4. _____ For _____
5. _____ For _____

If more than 5, Please Provide List

YOUR HEALTH GOALS

Improve or Better:
- ☐ Athletic Performance
- ☐ Balance
- ☐ Breathing
- ☐ Diet / Nutrition
- ☐ Digestion / Metabolism
- ☐ Energy Level
- ☐ Fitness / Body Comp.
- ☐ Flexibility / Mobility
- ☐ Hormonal Imbalance
- ☐ Immune Response
- ☐ Posture
- ☐ Quality Bowel Movement
- ☐ Quality Sleep
- ☐ Quality Time with Family
- ☐ _____

Return to:
- ☐ Work
- ☐ Sport / Activity
- ☐ Hobbies
- ☐ Normal Lifestyle
- ☐ _____

Better Manage
- ☐ Mental Stress
- ☐ Physical Stress
- ☐ Metabolism
- ☐ Weight
- ☐ _____

Desire to:
- ☐ ↑ Muscle _____ lbs.
- ☐ ↓ Fat _____ lbs.
- ☐ _____

Reduce Symptom(s) / Pain

☐ Inflammation	☐ Heartburn / Reflux			
☐ Irritability	☐ Bowel Issues			
☐ Headaches	☐ Muscle Tension / Tight			
☐ Migraines	☐ Neck Pain	L	R	Both
☐ Memory Loss / Decline	☐ Shoulder Pain	L	R	Both
☐ Dizziness / Vertigo	☐ Chest Pain	L	R	Both
☐ Sinus / Congestion	☐ Arm Pain	L	R	Both
☐ Jaw Pain / TMJ Syndrome	☐ Back Pain	L	R	Both
☐ Brain Fog	☐ SI Joint Pain	L	R	Both
☐ High Blood Pressure	☐ Hip Pain	L	R	Both
☐ Poor Circulation	☐ Leg Pain / Cramps	L	R	Both
☐ Tire Easily	☐ Knee Pain	L	R	Both
☐ Insulin Resistance	☐ Ankle Pain	L	R	Both
☐ _____	☐ _____			

QUALITY OF SYMPTOM(S)

Frequency of main problem

- ☐ Occasional 1-25%
- ☐ Intermittent 25-50%
- ☐ Frequent 50-75%
- ☐ Constant 75-100%

Quality of Pain

- ☐ Dull ache
- ☐ Sharp
- ☐ Burning
- ☐ Stiffness
- ☐ Numb / Tingling
- ☐ Radiates
- ☐ Throbbing
- ☐ _____

0-10, pain on a "good day"? _____

0-10, pain on "bad day"? _____

0-10, pain on average day? _____

0-10, pain right now? _____

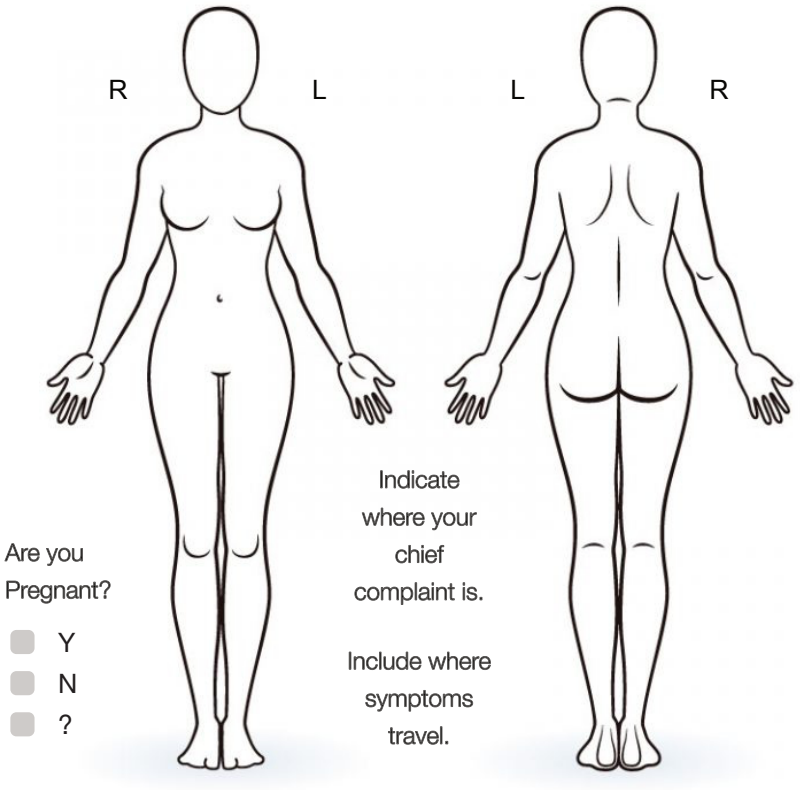
	Feels Better	Worse	No Change	Don't Know
In the morning	☐	☐	☐	x
By mid-day	☐	☐	☐	x
By evening / night	☐	☐	☐	x
Sitting / Driving	☐	☐	☐	x
Standing	☐	☐	☐	x
Bending	☐	☐	☐	x
Lying down / Resting	☐	☐	☐	x
Sleeping	☐	☐	☐	x
Walking / Moving	☐	☐	☐	x
Coughing / Sneezing	☐	☐	☐	x
Stress / Fatigue	☐	☐	☐	☐
Lifting / Chores	☐	☐	☐	☐
Work activities	☐	☐	☐	☐
Stretching / Exercise	☐	☐	☐	☐
Heat	☐	☐	☐	☐
Ice	☐	☐	☐	☐
Soft Tissue Therapy	☐	☐	☐	☐
Chiropractic Treatment	☐	☐	☐	☐
Massage	☐	☐	☐	☐
Medication / Pain Killer	☐	☐	☐	☐

SURGICAL HISTORY

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____
4. _____ Year _____
5. _____ Year _____

Please provide list if more than 5

Happy Back CHIROPRACTIC



FRONT BACK

Are you Pregnant?

- ☐ Y
- ☐ N
- ☐ ?

Indicate where your chief complaint is.

Include where symptoms travel.

Have you seen other doctors for this problem? ☐ Y ☐ N

If yes, treatment received? _____ Did it help? ☐ Y ☐ N

Seen a Chiropractor before? ☐ Y ☐ N

If yes, when? _____ Where? _____

How many Minor Auto Accidents have you been in? _____ ☐ None

If yes, _____ MPH ☐ Rear ☐ Front ☐ Side Collision

How many Major Auto Accidents have you been in? _____ ☐ None

If yes, _____ MPH ☐ Rear ☐ Front ☐ Side Collision

How many Work Related Injuries? _____ ☐ None

How many Sports Related Injuries? _____ ☐ None

How many Child Related Falls / Injuries? _____ ☐ None

How many Adult Related Falls / Injuries? _____ ☐ None

How many broken bones or concussions in lifetime? _____ ☐ None

CURRENT OR PAST HEALTH HISTORY

Allergies
- Chemical
- Codeine
- Eggs
- Latex
- Milk / Lactose
- Peanuts
- Pets
- Seasonal
- Shellfish
- Soy
- Sulfa
- Wheat / Gluten
- _____

Allergy / Immunity
- Allergy Shots
- Chronic Allergies
- HIV / AIDS
- Hives

Blood / Lymph
- Blood Clots
- Easy Bleeding
- Easy Bruising
- Hepatitis
- Leukemia

Constitutional
- Difficulty Sleeping
- Energy Problem
- Weight Loss / Gain

Cardiovascular
- Blood Pressure
- Cholesterol
- Congestive Heart Failure
- Heart Attack
- Heart Disease
- Irregular Heartbeat
- Pacemaker
- Stroke

Ear / Nose / Throat
- Frequent Ear Infections
- Hearing Loss
- Nose Bleeds
- Ringing / Tinnitus
- Sinus / Chronic
- Sinus / Occasional

Endocrine
- Diabetes
- Menopause
- Menstrual Problems
- Thyroid

Eyes
- Blindness
- Cataracts
- Detached Retina
- Double Vision
- Glaucoma

Gastrointestinal
- Constipation
- Crohn's Disease
- Diarrhea
- Diverticulitis
- Gall Bladder
- Nausea / Vomiting
- Poor Appetite
- Reflux
- Ulcers

Genitourinary
- Frequent Infection
- Frequent Urination
- Kidney Disease
- Kidney Stones
- Prostate

Musculoskeletal
- Arthritis
- Fibromyalgia
- Gout
- Joint Stiffness
- Muscle Weakness
- Osteoporosis
- Scoliosis

Neurological
- Autism
- Carpal Tunnel
- Dizziness / Vertigo
- Head Injury
- Headache / Migraine
- Loss of Balance
- Memory Loss
- Multiple Sclerosis
- Neuropathy
- Parkinson's
- Restless Leg Syndrome
- Seizures

Psychiatric
- Anxiety
- Bi-Polar Disorder
- Depression
- Unusual Stress

Respiratory
- Asthma
- Chronic Cough
- COPD
- Emphysema
- Pneumonia
- Sleep Apnea
- Tuberculosis

Skin
- Eczema
- Psoriasis
- Rashes
- Shingles

- None of these symptoms apply to my past health history.

PAST OR CURRENT FAMILY HEALTH HISTORY

	Spouse Child(ren)	Parent(s) Sibling(s)
Allergies		
Anxiety		
Arthritis		
Auto Accident		
Back or Neck Pain		
Cancer		
Constipation		
Diabetes		
Disc Problems		
Epilepsy		
Frequent Cold / Flu		
Gassy / Bloating		
Headache		
Heart Trouble		
Heartburn		
High Blood Pressure		
Low Energy		
Migraine		
Nervousness		
Pinched Nerve		
Scoliosis		
Shoulder Pain		
Sinus Trouble		
Sleeping Problems		
Other: _____		
_____		
_____		

LIFESTYLE

CHEMICAL / MENTAL	Daily	1-4x week	1x month	Rare	Never
Sugar / Sweets	☐	☐	☐	☐	☐
Processed / Packaged Foods	☐	☐	☐	☐	☐
Soft Drink Beverages	☐	☐	☐	☐	☐
Caffeine Beverages	☐	☐	☐	☐	☐
Alcohol Beverages	☐	☐	☐	☐	☐
Cigarettes	☐	☐	☐	☐	☐
Marijuana / Gummies, other	☐	☐	☐	☐	☐
Cigar, Pipe, Vape, Dip	☐	☐	☐	☐	☐
CBD Products	☐	☐	☐	☐	☐
Supplements / Protein, etc.	☐	☐	☐	☐	☐
Mental Stress	☐	☐	☐	☐	☐

HABITS	Daily	1-4x week	1x month	Rare	Never
Walking	☐	☐	☐	☐	☐
Stretching	☐	☐	☐	☐	☐
Exercise / Workout	☐	☐	☐	☐	☐
Balance Exercises	☐	☐	☐	☐	☐
Meditation	☐	☐	☐	☐	☐
Breathing Exercise	☐	☐	☐	☐	☐
Flossing	☐	☐	☐	☐	☐

HOBBIES / SPORTS / RECREATION

P = Past **C** = Current

P	C	
		Sports
☐	☐	Baseball / Softball
☐	☐	Basketball
☐	☐	Boxing / Kickboxing
☐	☐	Cheerleading
☐	☐	Combat Sports
☐	☐	Football / Rugby
☐	☐	Golf
☐	☐	Gymnastics / Parkour
☐	☐	Ice Hockey
☐	☐	Racquetball / Tennis
☐	☐	Running / Cross Country
☐	☐	Soccer
☐	☐	Swimming
☐	☐	Track & Field
☐	☐	Volleyball
☐	☐	Wrestling
		Exercise
☐	☐	Calisthenics
☐	☐	Resistance Training
☐	☐	Stretching / Pilates / Yoga
☐	☐	_____

P	C	
		Active Lifestyle
☐	☐	Bicycle Riding
☐	☐	Camping / Backpacking
☐	☐	Dancing / Ballroom
☐	☐	Gun Range Shooting
☐	☐	Hiking
☐	☐	Horseback Riding
☐	☐	Hunting / Fishing
☐	☐	Kayaking / Rafting
☐	☐	Motorcycle / Motocross
☐	☐	Off Roading 4x4
☐	☐	Rock Climbing
☐	☐	Skateboarding
☐	☐	Sky Diving
☐	☐	Snow Skiing
☐	☐	Surfing
☐	☐	Swimming
☐	☐	Table Tennis / Ping Pong
☐	☐	Walking
☐	☐	Water Skiing / Jet Ski
☐	☐	_____
☐	☐	_____

P	C	
		Outdoors
☐	☐	Gardening
☐	☐	Yard work / Lawn Care
		Skill
☐	☐	Baking / Cooking
☐	☐	Event Planning
☐	☐	Home Repair / Handyman
☐	☐	Woodworking
		Creative
☐	☐	Art / Draw, Paint, Sculpt,
☐	☐	Graphic Design
☐	☐	Music Instrument / Play
☐	☐	Photography
		Indoors
☐	☐	Board or Card Games
☐	☐	Video Games
		Work Life
☐	☐	Desk Job
		Other
☐	☐	_____
☐	☐	_____
☐	☐	_____

OFFICE POLICIES

CANCELLATION AND NO-SHOW

At Happy Back we strive to deliver the highest standard and efficiency of care possible. To do this, we need your help! No Shows and Late Cancelations inconvenience the people on our wait list who need access to our services rendered in a timely manner. Therefore, we request you give 24-hour notice in the event you need to reschedule your appointment. Our office number is 615-632-0904 and email is DrRawson@HappyBackChiropractic.com

Initial here _____

If an appointment is not canceled or rescheduled outside of 24-hours of your scheduled appointment, a $30 late fee will be assessed to you. In addition, if you miss an appointment and do not give 24-hour advance notice, a $50 “no-show” fee will be assessed to you. If you are late for an appointment, please know we will see you as soon as possible but your visit, depending if it includes a time based service (extended soft tissue therapy), may be shortened in length. Additionally, if you are 10 minutes late to your appointment, a $30 late fee will be assessed to you. Our office makes reminder calls the day before your scheduled appointment or through text that you’ll indicate preferences for on your intake paperwork. It is ultimately the patient’s responsibility to remember their scheduled appointments.

Late “24-hr Notice” Fee	$ 30
“No-show” Fee	$ 50
10-min “Late Appt” Fee	$ 30

Initial here _____

This fee will be billed to you directly. If you don’t have a future appointment scheduled, this fee will need to be collected in a timely manner otherwise will be subject to a collections service agency.

PLEASE NOTE: Due to recent pandemic, we are unable to offer returns or refunds on any supplements, oils or equipment purchased in our office. **ALL SALES FINAL.**

We acknowledge there may be times when you miss an appointment due to emergencies or obligations to work or family; however, our opportunities to treat patients are limited by our treatment regime, therefore the patient acknowledges that if the patient **“No Shows” for more than four (4) appointments that they may be dismissed from care.** The Practice will notify you if you are discharged from care.

Initial here _____

INFORMED CONSENT

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that there are risks associated with all diagnostic and therapeutic procedures, including those used at Happy Back. The procedures ordered by the staff clinicians are recommended because the potential benefits are greater than the potential risks.

NO promise or guarantee of a cure or outcome has been given. While the Happy Back staff will attempt to work with any patient we feel we can assist in recovery or improvement, we also reserve the right to deny or suspend care should the patient’s condition warrant it. Neither the patient or any assigns will hold Happy Back Chiropractic, its staff, or its volunteers liable for any actions, non-actions or outcomes associated with the diagnosis, treatment and recommendations of the staff.

Initial here _____

OFFICE POLICIES

Happy Back CHIROPRACTIC

FINANCIAL POLICY

Happy Back Chiropractic appreciates your trust by choosing us to provide for your health care needs. The service you have elected to participate in implies complete financial responsibility on your part.

At no time will HBC be obligated to communicate or bill any insurance company. We will provide you with a detailed statement of services provided should you wish to seek reimbursement independently.

I have read the above policy regarding my financial responsibility to Happy Back Chiropractic for providing services to myself or the above-named patient. I certify the information is, to the best of my knowledge, true and accurate. Payment in full and the entire amount of bill incurred by me or the above-named patient is due prior to service rendered.

Initial here _____

VIDEO & PHOTOGRAPHY CONSENT

Occasionally, Happy Back will conduct filming and/or photography for promotional materials as well as for training purposes. The patient and/or their legal guardian is responsible for ensuring they are not incidentally recorded should they refuse this consent.

Initial here _____

While relatively uncommon, we will ask to record patients for testimonials or photograph for promotional materials. General information may be shared such as a brief description of your condition, your first name and/or initials and statements you may wish to make. Should you be asked and agree to provide a testimonial, there will be no reimbursement and the product, including the rights to use your likeness, will become the sole property of HBC.

You are free to refuse your consent to be recorded or photographed with NO EFFECT on your care.
I have read the above policies and wish to give my consent to:

Initial here _____

- ☐ Both educational and promotional use
- ☐ Only educational use
- ☐ No to both

_____ _____ ____ /____ /____

Print Name Signature Date