

304.428.9355
923 Emerson Ave | Parkersburg, WV | 26104
www.dawnwellness.com



Patient Name: _____ Date: _____ Birthdate: _____

Address: _____ City/St: _____ Zipcode: _____

Home Phone: _____ Cell: _____ Work: _____

Social Security # _____ Sex: _____ Race: _____

Email: _____ Family Doctor: _____

Marital Status: _____ Name of Spouse: _____

Emergency
Contact: _____ Phone: _____

Insurance: _____

How did you hear about us? _____

Have you had an X-ray CT scan or MRI in the past month? _____

Have you ever had a massage before? Yes or No

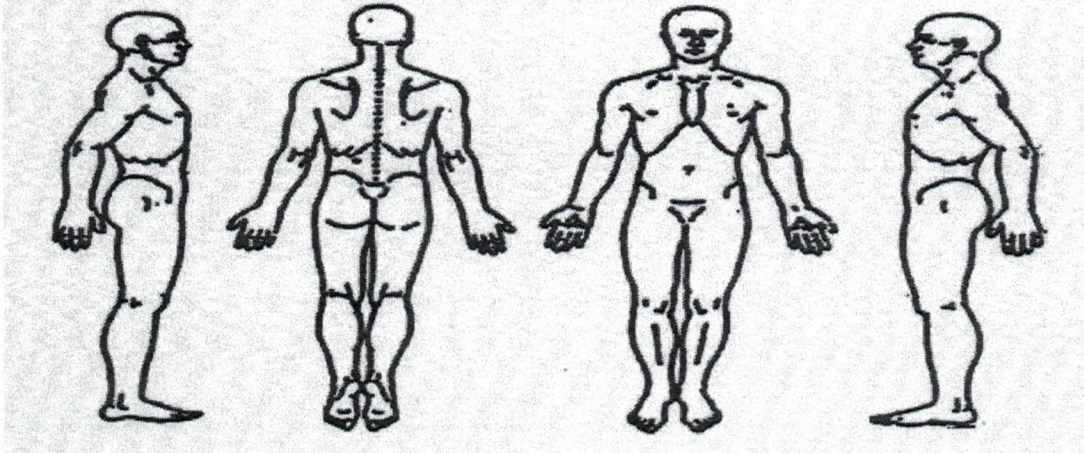
***Please notify us if you have seen another Chiropractor or been to Physical Therapy in the past year, if yes when? _____**

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- ☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion
☐ Stiff ☐ Other: _____

5. How are your symptoms changing with time?

- ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social activities?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. Who else have you seen for your problem?

- ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER physician ☐ Orthopedist ☐ Other: _____
☐ Massage Therapist ☐ Physical Therapist ☐ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- ☐ Yes ☐ Yes, at times ☐ No

13. What aggravates your problem?

14. What alleviates your problem?

15. What concerns you the most about your problem; what does it prevent you from doing?

16. What is your: Height _____ Weight _____ Date of Birth _____
Occupation _____

17. How would you rate your overall Health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

18. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

19. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

For Females Only

☐ Birth Control Pills
☐ Hormonal Replacement
☐ Pregnancy

21. List all prescription medications you are currently taking:(or please give a list to be copied)

22. List all of the over-the-counter medications you are currently taking.

23. Do you have any drug allergies?

24. List all surgical procedures you have had:

25. What activities do you do at work?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

26. What activities do you do outside of work?

27. Have you ever been hospitalized? ☐ No ☐ Yes

if yes, why _____

Have you ever been to a Chiropractor before? If yes, how were your results?

28. Have you had significant past trauma? ☐ No ☐ Yes

Patient Signature _____ Date: _____

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

Patient's Signature

Date

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

- ☐ There is a possibility that I may be pregnant at this time.
- ☐ Yes. I am definitely pregnant Due Date _____
- ☐ No. I am definitely not pregnant at this time

Patient's Signature

Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge receipt of the Notice of Privacy Practices for (Name of clinic) regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Clinic and my respective rights contained there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting (Clinic Privacy Officer, telephone number and address).

My signature herein below constitutes full acknowledgement that I have furnished a copy of the Notice of Privacy Practices for Dawn Wellness Center.

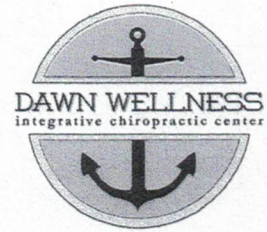
Patient Signature

Date

Patient's Legal Representative
if required

Date

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Medical/Financial Information Disclosure

I, _____, the undersigned, hereby authorize Dawn Wellness, it's representatives, Doctors and Staff, to share any and all medical and financial information with the following individual(s). The individuals listed below are involved with my care and have authorization to talk to your staff on the phone and/or in the office.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Authorized by _____ (Patient Sign)

NOTICE TO PATIENTS SCHEDULING AND RECEIVING MASSAGE THERAPY

I understand that by making a massage therapy appointment that I am responsible to show up and be on time. If I do not cancel at least 24 hours prior to the appointment time, I will personally be billed **\$25.00**. Furthermore, after 3 missed massage appointments without prior notice, I will no longer be permitted to schedule future massage therapy appointments.

Signature: _____

Date: _____

MEDICAL RECORDS REQUEST

DATE:

To: _____

I, _____ hereby request that my complete medical records be released to:

-

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at any time. This consent will automatically expire without my expressed revocation 90 days from the date on this form.

PATIENT NAME: _____

PATIENT ADDRESS: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____