STOP

READ THIS FIRST

Please set aside 15 minutes of time to complete the intake paper work prior to your evaluation.

If you do not have this paper work completed prior to your arrival, you will need to do so in-office. This will decrease your appointment time with the doctor. For your own benefit, please don't forget your paperwork at home/work.

Bring your completed paperwork and arrive a minimum of 15 minutes prior to your scheduled appointment time.

Arrive 30 minutes prior to your scheduled appointment time if you wish to fill out the paperwork in-office.

Thank you for your consideration.

Dr. Shane Conrad D.C.

Spine and Sport CENTER

Patient Intake Information

By filling out the proceeding information, you are granting ***Conrad Chiropractic & Wellness P.C.*** voluntary consent to perform all procedures deemed appropriate to assess and treat your current area of complaint. All information obtained during this process will remain strictly confidential; and the details of your case will be limited to only those parties directly responsible for your care.

Section 1 – Patient Information

Name: _____ **Home: ( ) ____-____**

Address: _____ **Mobile: ( ) ____-____**

City: _____ **Work: ( ) ____-____**

Zip Code: _____-_____ *May we contact you at work?* **YES NO**

E-Mail Address: _____

Date of Birth: ____/____/____
Month Day Year

Have you been to a Chiropractor before? **YES NO**

Were X-rays Taken? **YES NO**

Section 2 - Health History

What is your family doctor's name? _____

Phone Number: _____

If appropriate, may we contact him/her about your case? YES NO

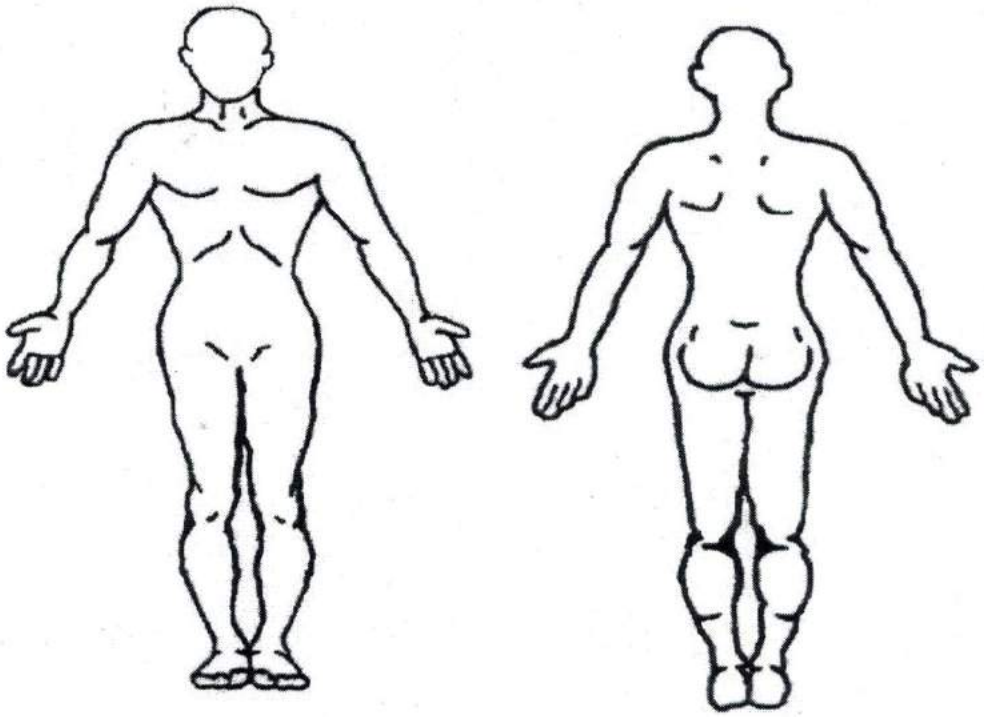
Do you have any of the following: (Please check all that apply)

- ☐ Diabetes (Type I or II)
- ☐ Osteoporosis
- ☐ High Blood Pressure
- ☐ Incontinence (Bladder or Bowel)
- ☐ Recent Infection or Fever
- ☐ Recent Trauma
- ☐ Past Surgery
- ☐ Numbness/Sensation Loss in the Saddle Area
- ☐ Personal History of Cancer
- ☐ Severe Night Pain
- ☐ Unrelenting Pain (even at rest)
- ☐ Unexplained Weight Loss (>5 lbs)
- ☐ Age > 55 or < 20 years
- ☐ Smoker (Past or Present)
- ☐ History of Heart Disease

☐ Use of: Steroids, Intravenous drugs, Immunosuppressive drugs

Pain Chart Diagram

In the diagram provided below, please mark the areas on your body that you feel best represent the pain(s) or sensations(s) you are **currently** experiencing. Please include all areas. Use the symbols provided below. Also, in order to complete the picture, please draw in your face.



Symbols:

Numbness	////// //////
Stabbing or Sharp	‖ ‖ ‖ ‖ ‖ ‖ ‖ ‖ ‖ ‖
Dull Ache	++++ ++++
Burning	xxxx xxxx
Stiff & Tight	==== ====
Pins & Needles	•••• ••••

1) What is your pain RIGHT NOW?

No pain _____ **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2) What is your TYPICAL or AVERAGE pain?

No pain _____ **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3) What is your pain level AT ITS BEST (How close to"0" does your pain get at its best)?

No pain _____ **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4) What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present.

An understanding of your health history will help us to determine appropriate care.

Full Name:_____

HEIGHT:_____ WEIGHT:_____ AGE:_____ DATE:_____

Review of Systems:

1. Do you have skin, hair or nail problems? ☐ Yes ☐ No _____
2. Do you have mouth and or throat problems? ☐ Yes ☐ No _____
3. Do you have nose and or sinus problems? ☐ Yes ☐ No _____
4. Do you have ear problems? ☐ Yes ☐ No _____
5. Do you have eye problems? ☐ Yes ☐ No _____
6. Do you have chest or lung (breathing) problems? ☐ Yes ☐ No _____
7. Do you smoke? ☐ Yes ☐ No Amount per day? How Long? _____
8. Do you have heart and or blood vessel problems? ☐ Yes ☐ No _____
9. Do you have blood or lymph node problems? ☐ Yes ☐ No _____
10. Do you have digestive problems? ☐ Yes ☐No _____
11. Do you have genital (e.g. prostate, testicular, vaginal) problems? ☐ Yes ☐ No _____
12. Do you have urinary (including kidney or bladder) problems? ☐ Yes ☐ No _____
13. **Females**, have you had menstrual problems? ☐ Yes ☐ No _____
    a) Have you ever taken birth control pills? ☐ Yes ☐ No For how long? _____
    b) Is there any chance that you are currently pregnant? ☐ Yes ☐ No _____
    c) Do you have any breast problems? ☐ Yes ☐ No _____
14. Do you have any nervous system diseases and or mental health problems? ☐ Yes ☐ No

    _____
15. Do you have any gland and or hormone problems? ☐ Yes ☐ No _____
16. Do you have allergy or immunity problems? ☐ Yes ☐ No _____
17. Do you have any muscle, tendon or ligament problems? ☐ Yes ☐ No _____
18. Do you have any bone or joint disease (i.e., bone=osteoporosis, joint=arthritis)? ☐ Yes ☐ No

    _____

Past History

19. List any diseases which you have had in the past, including childhood diseases:_____

    _____
20. Have you ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.:
    ☐ Yes ☐ No _____
21. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones?
    ☐ Yes ☐ No _____
22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):
    _____ Date:_____
    _____ Date:_____
    _____ Date:_____

CASE HISTORY

(CONTINUTED)

Full Name:_____ DATE:_____

1. Have you ever been hospitalized for any reason *other* than surgery? ☐ Yes ☐ No
2. **Medications:** Please list all medications (prescription & non prescription) you are currently taking or take on an occasional basis: _____
3. Your diet is: ☐ Balanced ☐ Fair ☐ Poor ☐ Excessive ☐ Restricted

Family History

4. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)? ☐ Yes ☐ No _____

Social History

5. In what position do you usually sleep, and how well?_____
6. Do you exercise on a regular basis? ☐ Yes ☐ No How and frequency?_____
   _____
7. How do you spend your spare time (hobbies, etc)?_____
8. Do you use: ☐ Caffeine ☐ Tobacco ☐ Nicotine ☐ Recreational Drugs ☐ Alcohol
9. Please describe your work.
   Type: ☐ Professional ☐ Physical Labor ☐ Drive ☐ Clerical ☐ Factory ☐ Homemaker
   Physical Demands: ☐ Heavy ☐ Moderate ☐ Mild ☐ Sedentary
   Stress Level: ☐ High ☐ Medium ☐ Low

Additional Questions

10. Do you have problems with recurring headaches? ☐ Yes ☐ No_____
11. Are you losing weight without trying? ☐ Yes ☐ No_____
12. Does your pain wake you up at night? ☐ Yes ☐ No_____
13. Have you had a change is bowel or bladder habits? ☐ Yes ☐ No_____
14. Have you had a sore that doesn't heal? ☐ Yes ☐ No_____
15. Have you recently had any unusual bleeding or discharge? ☐ Yes ☐ No_____
16. Do you have a thickening/lump in the breast or elsewhere? ☐ Yes ☐ No_____
17. Do you have indigestion or difficulty swallowing? ☐ Yes ☐ No_____
18. Have you had an obvious change is a wart or mole? ☐ Yes ☐ No_____
19. Do you have a nagging cough or hoarseness? ☐ Yes ☐ No_____
20. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.
    _____
    _____
21. Please describe your current complaint. In other words, what brought you here today? _____
    _____

PATIENT HEALTH SURVEY

FULL NAME_____ AGE_____ DATE_____

Have you ever (at any time) experienced any of the following?

Difficulty urinating	Y	N	Claustrophobia (fear of small spaces)	Y	N
Loss of bladder control	Y	N	Spinal Surgery	Y	N
Loss of bowel control	Y	N	Common cold/flu	Y	N
Temporary loss of vision (one eye)	Y	N	Carotid artery surgery	Y	N
Blood in urine	Y	N	Breast Removal	Y	N

Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fractured/broken vertebra	Y	N
Slipped disc	Y	N	Bleeding disorders	Y	N
Herniated disc	Y	N	High blood pressure	Y	N
Osteoporosis	Y	N	Blood in stool	Y	N
TIA's (pin or mini strokes)	Y	N	Cancer	Y	N
Drop attacks (collapsing/not fainting)	Y	N	AIDS	Y	N
Hardening of the arteries	Y	N	Kidney disease	Y	N
Partial or complete paralysis	Y	N	Prostate disease	Y	N

Do you currently have, or could you be, any of the Following?

Pregnant	Y	N
Taking birth control pills	Y	N
Receiving hormone therapy		
☐ Male ☐ Female	Y	N
Receiving chemotherapy	Y	N
Receiving radiation therapy	Y	N
Taking blood thinners	Y	N
A heavy smoker (1 or more packs/day)	Y	N
Surgical/medical implanted devices:		
Aortic clips	Y	N
Brain clips	Y	N
Artificial heart valves	Y	N
Rods, pins, screws	Y	N
IUD	Y	N
Surgical clips/wires	Y	N
Shunt	Y	N
Neurostimulator	Y	N
Dentures	Y	N
Pacemaker	Y	N
Hearing aid	Y	N
Insulin pump	Y	N
Joint replacement	Y	N
Cochlear implant(s) ear	Y	N
Other implanted devices:		
Metal fragments (head, eye, skin)	Y	N
Bullets/shrapnel	Y	N
Body piercing	Y	N
Tattoos	Y	N

In the past 14 days (2 weeks), have you experienced any of the following?

Nausea	Y	N
Vomiting	Y	N
Vertigo (spinning)	Y	N
Difficulty walking	Y	N
Incoordination	Y	N
Numbness (or other sensory complaints)	Y	N
Loss of consciousness	Y	N
Double vision	Y	N
Blurred vision	Y	N
Tinnitus (ringing in ears)	Y	N
Speech problems	Y	N
Clumsiness	Y	N
Memory Loss	Y	N
Travel by car/truck	Y	N
Personality changes	Y	N
Fever	Y	N
Recurrent headaches	Y	N
Diarrhea	Y	N
Used a tanning booth	Y	N
Skin rash/infection	Y	N
A major fall	Y	N
A minor fall	Y	N
An auto accident	Y	N
A work injury	Y	N
Loss of strength	Y	N
Pain moving bowels	Y	N
Head trauma	Y	N
Abnormal period	Y	N

Spine and Sport CENTER

5962 Stetson Hills Blvd
Colorado Springs, CO
80923-3579

Office: (719)596-8700
Fax: (719) 596-8704
info@spineandsportcenter.com

Where the best get better.

HIPAA RELEASE FORM

Unless you have provided a signed release form, we are prohibited from discussing any aspect of your medical information with anyone who is not directly involved in your care.

Please review the following items to either allow or deny us the ability to communicate on your behalf.

Your Name:_____
Date of Birth: _____
E-Mail: _____
Cell #: _____

Family Physician: _____

Whom may we contact to relay information about your condition, your treatment, and your progress/outcome related to our treatment? (Circle please)

Family Physician	**YES**	**NO**
Health Insurance Company	**YES**	**NO**
Auto Insurance Agency (if injured in auto accident)	**YES**	**NO**
Attorney (if injured in auto accident)	**YES**	**NO**
Other (including family members)	**YES**	**NO**

Name: _____ (printed)
Relation: _____

Name: _____ (printed)
Relation: _____

I have reviewed the above items and have answered all questions in regards to health disclosures in accordance with my personal wished. These disclosures can only be altered by means of a formal written request. I allow ***Dr. Shane R. Conrad D.C.*** and the employed office staff of ***Conrad Chiropractic and Wellness P.C.*** to operate within these provisions in accordance with HIPAA regulations.

Signed:_____ Date:_____