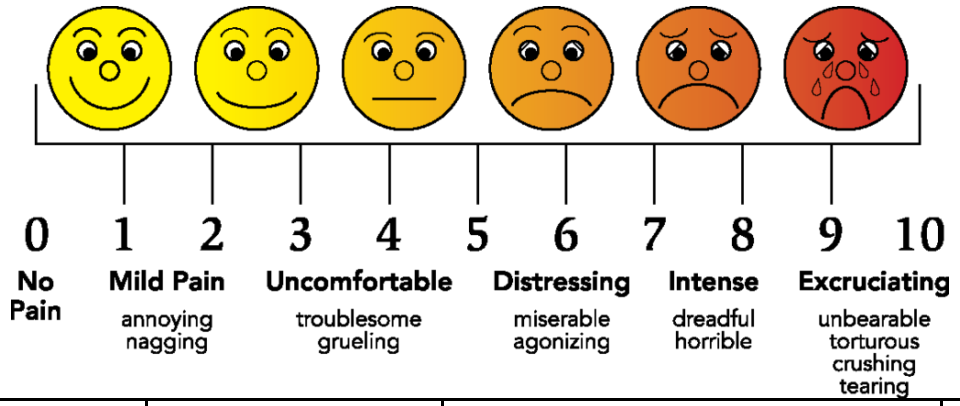


Pain Type	Pain score 1-10 (Pain at its worst)	Pain Frequency (circle one that applies)	Numbness (Yes/No)
Headache		Less than 25% More than 26% less than 50% More than 50% less than 74% More than 75%	
Neck pain/Soreness		Less than 25% More than 26% less than 50% More than 50% less than 74% More than 75%	
Arm/Hand Symptoms		Less than 25% More than 26% less than 50% More than 50% less than 74% More than 75%	
Mid back pain		Less than 25% More than 26% less than 50% More than 50% less than 74% More than 75%	
Low back pain		Less than 25% More than 26% less than 50% More than 50% less than 74% More than 75%	
Leg/Foot Symptoms		Less than 25% More than 26% less than 50% More than 50% less than 74% More than 75%	
Other:		Less than 25% More than 26% less than 50% More than 50% less than 74% More than 75%	

Name:_____ **Signature:**_____ **Date:**_____

Patient Name _____ Date _____

Activities of Daily Living											
How does this condition currently interfere with your life and ability to funtion? 0 being no effect, 10 being severe effect											
Sitting	0	1	2	3	4	5	6	7	8	9	10
Rising out of chair	0	1	2	3	4	5	6	7	8	9	10
Standing	0	1	2	3	4	5	6	7	8	9	10
Walking	0	1	2	3	4	5	6	7	8	9	10
Lying down	0	1	2	3	4	5	6	7	8	9	10
Bending over	0	1	2	3	4	5	6	7	8	9	10
Climbing stairs	0	1	2	3	4	5	6	7	8	9	10
Using a computer	0	1	2	3	4	5	6	7	8	9	10
Getting in/out of car	0	1	2	3	4	5	6	7	8	9	10
Driving a car	0	1	2	3	4	5	6	7	8	9	10
Looking over shoulder	0	1	2	3	4	5	6	7	8	9	10
Caring for family	0	1	2	3	4	5	6	7	8	9	10
Grocery shopping	0	1	2	3	4	5	6	7	8	9	10
Household chores	0	1	2	3	4	5	6	7	8	9	10
Lifting objects	0	1	2	3	4	5	6	7	8	9	10
Reaching overhead	0	1	2	3	4	5	6	7	8	9	10
Showering or bathing	0	1	2	3	4	5	6	7	8	9	10
Dressing myself	0	1	2	3	4	5	6	7	8	9	10
Love life	0	1	2	3	4	5	6	7	8	9	10
Getting to sleep	0	1	2	3	4	5	6	7	8	9	10
Staying asleep	0	1	2	3	4	5	6	7	8	9	10
Concentrating	0	1	2	3	4	5	6	7	8	9	10
Exercising	0	1	2	3	4	5	6	7	8	9	10
Yard work	0	1	2	3	4	5	6	7	8	9	10
Work related	0	1	2	3	4	5	6	7	8	9	10

Signature _____

New Patient Intake Form

Title: (Circle one) ☐ Mr. ☐ Mrs. ☐Ms. ☐ Miss ☐ Dr. ☐ Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Other

Spouse's Name: _____

Spouse's Employer & Occupation: _____

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Employer Data _____

Employer _____

Your Occupation _____

Emergency Contact _____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

How did you hear about our office? _____

Patient name: _____ Date: _____

Medical Conditions: (Circle all that apply to you)

□ Arthritis	□ Cancer	□ Diabetes	□ Heart Disease
□ Hypertension	□ Psychiatric Illness	□ Skin Disorder	□ Stroke
□ Other _____	□ Fibromyalgia	□ Asthma	□ Osteoporosis

Surgeries: (Circle all that apply to you)

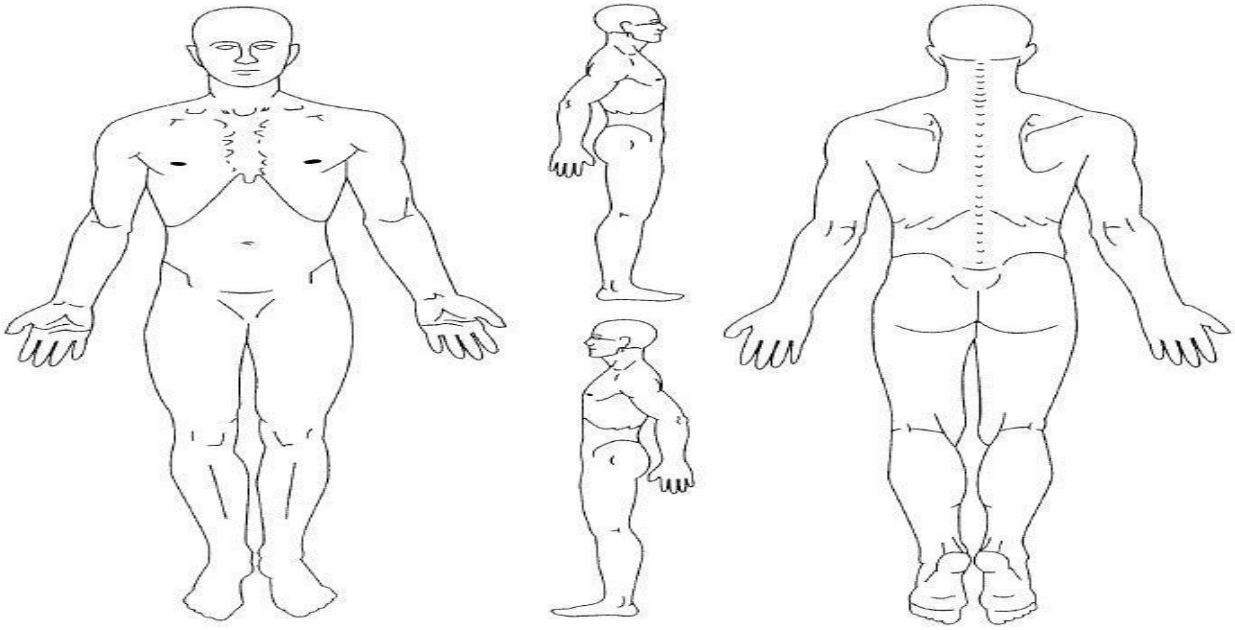
□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia
□Breast Augmentation	Other _____		

Allergies: (Circle all that apply to you)

□ Mold	□ Seasonal	□ Milk or Lactose	□ Animal
□ Chemical _____	□ Sulfites	□ Wheat/Glutens	□ Other _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Sharp T=Tingling A=Dull Ache



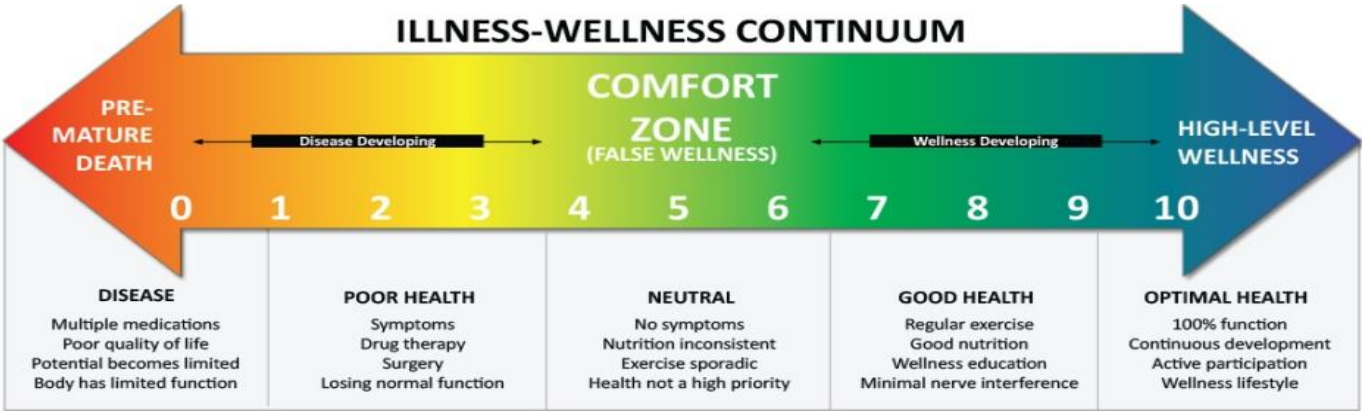
When did your symptoms begin? _____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident □ Other_____

How did your symptoms begin? _____

_____

Patient Initial: _____ **Doctor Initial:** _____



On the arrow diagram above:

A. What number do you think best represents your health today? _____

B. In what direction is your health currently headed? _____

Health goals:

Immediate: _____

Short Term: _____

Long Term: _____

1.What is a major stressor in your life _____

2.How much sleep do you average per night ____hours

3. Approximate age of mattress and pillows? _____

4. Preferred sleeping position? _____

5.Describe your eating habits:
☐ skip breakfast ☐two meals a day ☐ three meals ☐ snacking between Meals

What would be the most significant thing you could do to improve your health?

_____

In addition to the main reason for your visit today, what additional health goals do you have?

_____

Patient Initial: _____ **Doctor Initial:** _____

Patients name: _____ **DOB**: _____

Acknowledgements:
To set clear expectations, improve communication and clarify the exam/screening process.
Please read each statement and initial your agreement.

_____ I understand the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restriction of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure and name disease or entity.

_____ I may request a copy of the privacy policy and understand how my personal health information is protected and released on my behalf for seeing reimbursement form any involved third party.

_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (mm/dd/yyyy)_____

_____I grant permission to be called/Text to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.

_____I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____

Patient (Guardian's) Signature **Date**

JON R. gray CHIROPRACTIC CENTER

Mahogany Business Park • 13238 W Persimmon Ln, Ste. 102 • Boise, ID 83713
(On McMillan between Cloverdale and Eagle Road in front of Pioneer Elementary)
Ph: 208-854-0600 Fax: 208-375-5545 E-mail: drgray@qwest.net

INFORMED CONSENT

PATIENT NAME _____

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)