NEW PATIENT INTAKE

Name: ______________________________ Today's Date: __________

Address: ______________________ City __________ State _____ Zip _______

Home Telephone (   ) __________ Work (   ) __________ Cell (   ) __________

We use text messaging for appointment reminders. Who is your cell phone company? __________

Email Address: ______________________________ Male _____ Female _____

Social Security # ____________________ Birth Date: __________ Age: _____

Occupation: ______________________________

Employer Name and Address: ______________________________

Single _________ Married _________ Spouse's Name ____________________

Have you seen a Chiropractor before? Yes No If yes, when? __________

Whom may we thank for referring you to our office ? ____________________

YOUR HEALTH SUMMARY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problem.

- ☐ Headaches
- ☐ Pins and Needles in arms
- ☐ Dizziness
- ☐ Numbness in fingers
- ☐ Fatigue
- ☐ Sleeping problems
- ☐ Diarrhea
- ☐ Cold sweats
- ☐ Mood swings
- ☐ Pins and Needles in legs
- ☐ Loss of smell
- ☐ Buzzing in ears
- ☐ Numbness in toes
- ☐ Depression
- ☐ Neck stiff
- ☐ Constipation
- ☐ Lights bother eyes
- ☐ Menstrual Pain
- ☐ Fainting
- ☐ Back Pain
- ☐ Ringing in ears
- ☐ Loss of taste
- ☐ Irritability
- ☐ Cold hands
- ☐ Fever
- ☐ Problem urinating
- ☐ Menstrual irregularity
- ☐ Neck Pain
- ☐ Loss of balance
- ☐ Nervousness
- ☐ Stomach upset
- ☐ Tension
- ☐ Cold feet
- ☐ Hot flashes
- ☐ Heartburn
- ☐ Ulcers

List any medications you are taking ______________________________

____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: __________.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature ______________________________ Date __________

Guardian Signature ______________________________ Date __________

Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name ______________________________ Total Score __________
PRINTED

______________________________ __________
Signature Date

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Sallisaw Chiropractic Clinic

Dr. Matthew Bauer

502 E. Cherokee

Sallisaw, OK 74955

Date:_______________________ Patient Name:_____________________________

Height:_______ Weight:______

Personal History:

Childhood Diseases: Measles____Mumps_____Chicken Pox___Other_______________

Adult Illness or Conditions:____

Surgeries:____

Prescription Medications:___________________________ Medication Allergies:____________

Smoke:_______ Drink:_______ Supplements:________________________________

Female History

__Possible Pregnancy

Family History:

Family Diseases Known: TB____ Cancer_______Mental Illness_______Diabetes______Asthma______

Heart Disease________Stroke_______Kidney Disease______Lung Disease________Arthritis______

I, __________________, authorize the performance upon myself of the following procedures: ***Exam, Manipulation, X-Ray, Physical Therapies****, to be performed by or under the direction of Dr. Matthew Bauer. The nature and purpose of the procedures, possible alternatives, and the risks involved, the possible consequences, and the possibility of complications have been explained to me by the above stated doctor and his associates. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by the above named doctor and his associates or assistants.*

____________________________ ____________________________

Patient Signature *Social Security Number*

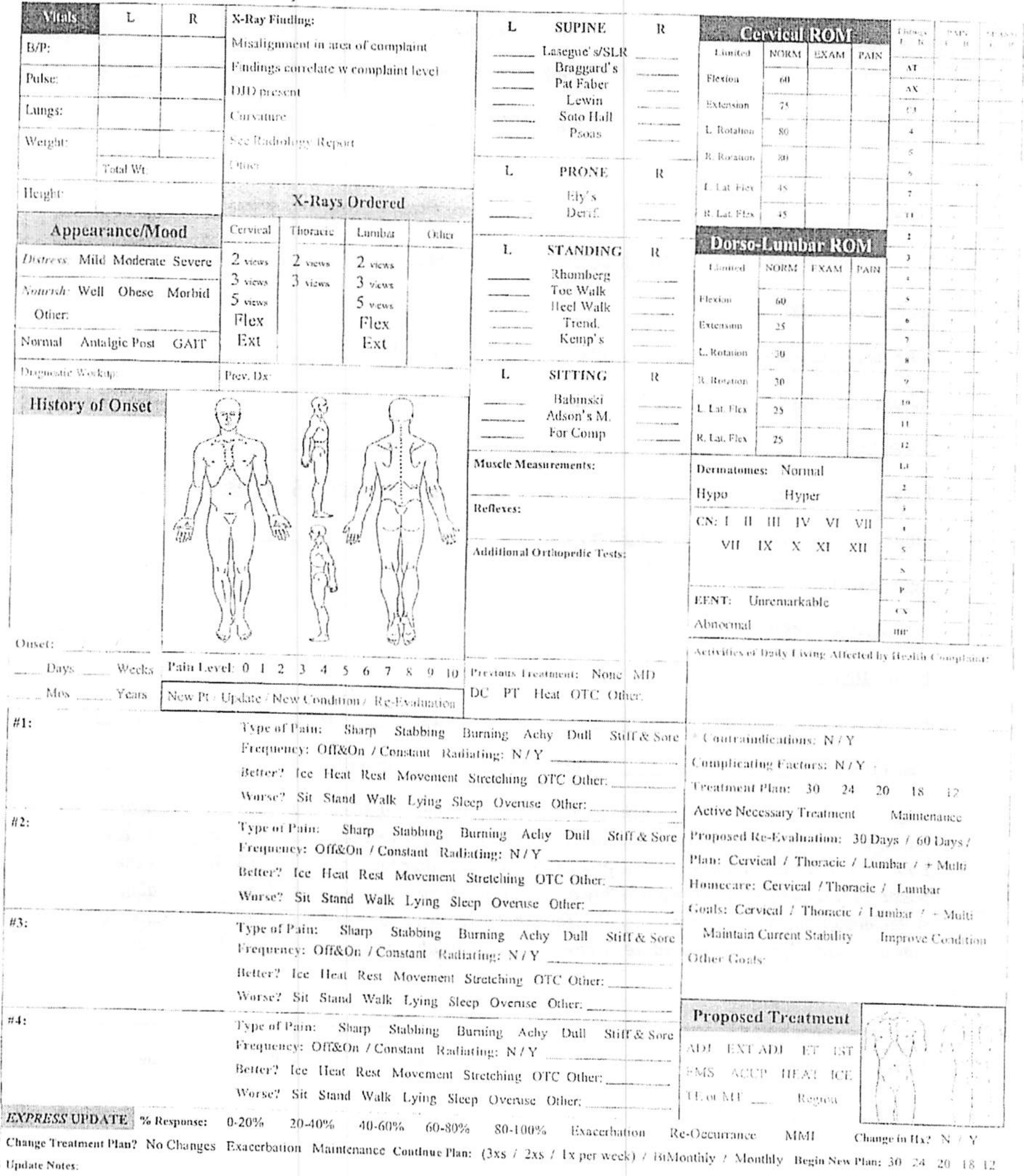
PHYSICAL EXAMINATION

Patient:

Examiner: (Matthew Bauer)

Patient No:

Date:



Vitals	L	R
B/P:		
Pulse:		
Lungs:		
Weight:		
	Total Wt.	
Height:		

X-Ray Finding:
Misalignment in area of complaint
Findings correlate w complaint level
DJD present
Curvature
See Radiology Report
Other

X-Rays Ordered

Cervical	Thoracic	Lumbar	Other
2 views	2 views	2 views	
3 views	3 views	3 views	
5 views		5 views	
Flex		Flex	
Ext		Ext	

Prev. Dx:

Appearance/Mood

Distress: Mild Moderate Severe
Nourish: Well Obese Morbid
Other:
Normal Antalgic Post GAIT

Diagnostic Workup:

L	SUPINE	R
______	Lasegue's/SLR	______
______	Braggard's	______
______	Pat Faber	______
______	Lewin	______
______	Soto Hall	______
______	Psoas	______

L	PRONE	R
______	Ely's	______
______	Derif.	______

L	STANDING	R
______	Rhomberg	______
______	Toe Walk	______
______	Heel Walk	______
______	Trend.	______
______	Kemp's	______

L	SITTING	R
______	Babinski	______
______	Adson's M.	______
______	For Comp	______

Muscle Measurements:

Reflexes:

Additional Orthopedic Tests:

Cervical ROM

Limited	NORM	EXAM	PAIN
Flexion	60		
Extension	75		
L. Rotation	80		
R. Rotation	80		
L. Lat. Flex	45		
R. Lat. Flex	45		

Dorso-Lumbar ROM

Limited	NORM	EXAM	PAIN
Flexion	60		
Extension	25		
L. Rotation	30		
R. Rotation	30		
L. Lat. Flex	25		
R. Lat. Flex	25		

AT, AX, C3, 4, 5, 6, 7, T1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, L1, 2, 3, 4, 5, S, P, CX, Ilr

Dermatomes: Normal
Hypo Hyper
CN: I II III IV VI VII
VII IX X XI XII

EENT: Unremarkable
Abnormal

Activities of Daily Living Affected by Health Complaint:

History of Onset

Onset:
____ Days ____ Weeks
____ Mos ____ Years

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

New Pt / Update / New Condition / Re-Evaluation

Previous Treatment: None MD DC PT Heat OTC Other:

#1:
Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Frequency: Off&On / Constant Radiating: N / Y ______
Better? Ice Heat Rest Movement Stretching OTC Other: ______
Worse? Sit Stand Walk Lying Sleep Overuse Other: ______

#2:
Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Frequency: Off&On / Constant Radiating: N / Y ______
Better? Ice Heat Rest Movement Stretching OTC Other: ______
Worse? Sit Stand Walk Lying Sleep Overuse Other: ______

#3:
Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Frequency: Off&On / Constant Radiating: N / Y ______
Better? Ice Heat Rest Movement Stretching OTC Other: ______
Worse? Sit Stand Walk Lying Sleep Overuse Other: ______

#4:
Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Frequency: Off&On / Constant Radiating: N / Y ______
Better? Ice Heat Rest Movement Stretching OTC Other: ______
Worse? Sit Stand Walk Lying Sleep Overuse Other: ______

Contraindications: N / Y
Complicating Factors: N / Y
Treatment Plan: 30 24 20 18 12
Active Necessary Treatment Maintenance
Proposed Re-Evaluation: 30 Days / 60 Days /
Plan: Cervical / Thoracic / Lumbar / + Multi
Homecare: Cervical / Thoracic / Lumbar
Goals: Cervical / Thoracic / Lumbar / + Multi
Maintain Current Stability Improve Condition
Other Goals:

Proposed Treatment

ADJ EXT ADJ ET IST
EMS ACUP HEAT ICE
TE or MT ____ Region

EXPRESS UPDATE % Response: 0-20% 20-40% 40-60% 60-80% 80-100% Exacerbation Re-Occurrance MMI Change in Hx? N / Y

Change Treatment Plan? No Changes Exacerbation Maintenance Continue Plan: (3xs / 2xs / 1x per week) / BiMonthly / Monthly Begin New Plan: 30 24 20 18 12

Update Notes:

Insurance Assignment, Information Release, and Payment Agreement

Patient Name: ____________________

Sallisaw Chiropractic Clinic

Dr. Matthew A. Bauer

502 E Cherokee / PO Box 641

Sallisaw, OK 74955

(918) 775-7100

- **Assignment of Insurance Benefits:** I authorize and direct that payment be made directly to:

Sallisaw Chiropractic Clinic
Dr. Matthew A. Bauer
502 E Cherokee / PO Box 641
Sallisaw, OK 74955

for any and all insurance benefits or reimbursement for services rendered by him which amounts would otherwise be payable to me under an insurance or pre-paid healthcare plan.

____________________ ____________________

Date Patient Signature

- **Release of Information:** I authorize the release of any information concerning my health and health care services to my insurance companies pre-paid health plan or Medicare.

____________________ ____________________

Date Patient Signature

- **Payment Agreement:** I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Not withstanding denial, reduction of benefits, or failure to pay for any reason, I understand that I am responsible for all remaining charges.

____________________ ____________________

Date Patient Signature