



## ADULT INTAKE PAPERWORK

HELLO AND WELCOME TO VIRTUE CHIROPRACTIC!

Who may we thank for referring you/how did you hear about us? \_\_\_\_\_  
Have you received chiropractic care in the past?  No  Yes (from whom?) \_\_\_\_\_

Please fill out the following information completely and to the best of your ability.  
Remember to initial the bottom of each page.

## PERSONAL INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ Gender:  Male  Female  
Email: \_\_\_\_\_ Marital Status:  S  M  D  W  
Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Occupation/Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship to You: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Hobbies: \_\_\_\_\_  
Name(s) & Age(s) of Children: \_\_\_\_\_

## PERSONAL HEALTH HISTORY

**List your current:**

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.

Weight: \_\_\_\_\_ lbs.

**What is your typical daily work activity?**

Sitting  Standing  Light Lifting  Heavy Lifting  Driving

Working at a Computer  Manual Labor  Other: \_\_\_\_\_

Do you have any genetic disorders or disabilities?  No  Yes (if yes, *explain*):

Indicate if you have experienced any of the following:

- Serious illnesses, operation, or health emergency
- Been unconscious due to an illness or injury

N/A

- Been in a motor vehicle accident
- Fractured a bone

Explain (include year(s)): \_\_\_\_\_

List any over-the-counter/prescription drugs and vitamins/supplements that you are currently taking:

N/A \_\_\_\_\_

## SOCIAL HISTORY

Do you smoke?

- Never  In the Past  Occasionally  Daily

Are you exposed to secondhand smoke?

- Never  In the Past  Occasionally  Daily

Do you drink alcohol?

- Never  In the Past \_Drinks/Week  Daily

Do you use recreational drugs?

- Never  In the Past  Occasionally  Daily

How often do you exercise?

- Never  In the Past  Occasionally  Daily

## CHIEF COMPLAINT/HISTORY OF PRESENTING ILLNESS

What is the **MAIN** symptom/pain/reason you are seeking chiropractic care?

**PROBLEM/CONCERN #1:** \_\_\_\_\_

- WHEN did this problem begin? \_\_\_\_\_ Is it constant or intermittent? \_\_\_\_\_
- Did you do something/did something happen that aggravated the problem?  No  Yes  
Explain: \_\_\_\_\_
- WHEN is the problem at its worst?  Morning  Mid-day  Evening   
Other \_\_\_\_\_
- Does the problem RADIATE outward from a source? \_\_\_\_\_
- What RELIEVES the problem? \_\_\_\_\_
- What makes the problem WORSE? \_\_\_\_\_

Are there any **SECONDARY** health concerns you wish to bring to our attention?  No  Yes

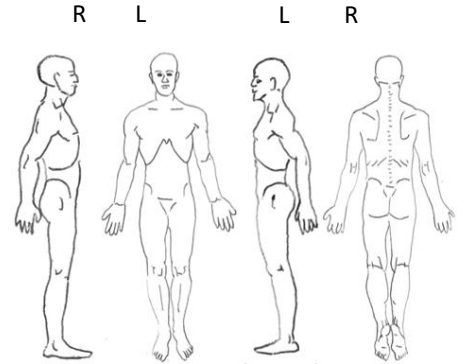
**PROBLEM/CONCERN #2:**  N/A \_\_\_\_\_

- WHEN did this problem begin? \_\_\_\_\_ Is it constant or intermittent? \_\_\_\_\_
- Did you do something/did something happen that aggravated the problem?  No  Yes  
Explain: \_\_\_\_\_
- WHEN is the problem at its worst?  Morning  Mid-day  Evening  Other \_\_\_\_\_
- Does the problem RADIATE outward from a source? \_\_\_\_\_
- What RELIEVES the problem? \_\_\_\_\_
- What makes the problem WORSE? \_\_\_\_\_

**DIRECTIONS:** CIRCLE the area(s) on the diagram that relate to your pain/symptom(s)/issue(s):

**How would you describe the problem(s)?**

- Dull ache    Burning    Stiff/Tight
- Tingling    Radiating    Deep, boring
- Pounding    Numb    Sharp/Stabbing
- Other: \_\_\_\_\_



**PAST HISTORY**

**Has your symptom/pain/reason for seeking chiropractic care happened BEFORE?**  No  Yes

- If yes, how many times?  N/A
- What sort of treatment did you seek before?  N/A
- What were the results of your previous treatment?  N/A

**Help us identify past conditions or procedures that could be related to your main issue:**

- Past Surgeries    Childhood Diseases    Past Injuries    N/A *Explain:* \_\_\_\_\_

**Have you experienced or been diagnosed with any of the following?**  N/A

- Pain that wakes you up at night    Night Sweats    Stroke    Heart Attack    Diabetes

*Explain:* \_\_\_\_\_

## QUADRUPLE VISUAL ANALOG SCALE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### PLEASE READ CAREFULLY

DIRECTIONS: Fill in your problem(s)/concern(s) from the previous page. *Regarding these problem(s)/concern(s), please CIRCLE the number that best describes the question being asked.*

**PROBLEM/CONCERN #1:** \_\_\_\_\_

**1. What is your pain RIGHT NOW?**

No Pain \_\_\_\_\_ Worst Pain Possible  
0 1 2 3 4 5 6 7 8 9 10

**2. What is your TYPICAL or AVERAGE pain?**

No Pain \_\_\_\_\_ Worst Pain Possible  
0 1 2 3 4 5 6 7 8 9 10

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

No Pain \_\_\_\_\_ Worst Pain Possible  
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 Pain Possible  
0 1 2 3 4 5 6 7 8 9 10

**PROBLEM/CONCERN #2:**  N/A \_\_\_\_\_

**1. What is your pain RIGHT NOW?**

No Pain \_\_\_\_\_ Worst Pain Possible  
0 1 2 3 4 5 6 7 8 9 10

**2. What is your TYPICAL or AVERAGE pain?**

No Pain \_\_\_\_\_ Worst Pain Possible  
0 1 2 3 4 5 6 7 8 9 10

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

No Pain \_\_\_\_\_ Worst Pain Possible  
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 Pain Possible  
0 1 2 3 4 5 6 7 8 9 10

**OTHER COMMENTS:** \_\_\_\_\_

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**ACTIVITIES OF DAILY LIVING**

**DIRECTIONS:** Assess your ability/lack of ability to complete the following activities.

Activity	CAN COMPLETE			CANNOT COMPLETE Due to Pain	N/A
	Without Pain or Difficulty	With Minimal Pain or Difficulty	With Significant Pain or Difficulty		
Bathe/Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Groom Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brush Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress Upper Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress Lower Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily Physical Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Move from Seated to Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Go Up/Down Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get In/Out of Car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Focus/Concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepare Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household Chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carry Bag/Purse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Run/Hike	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## REVIEW OF SYSTEMS & ORGAN DYSFUNCTION

**DIRECTIONS:** Check the box(es) that apply to conditions that you or your family members currently suffer from or have suffered from in the past.

CONDITION	SELF	CHILD	SIBLING	PARENT	GRANDPARENT
Acid Reflux/Heartburn/GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Changes/Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of Legs/Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TMJ/Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Organic/System Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*Select ALL that apply:  Digestive  Gallbladder  Heart  Liver  Stomach  Pancreas  
 Reproductive  Lung/Respiratory  Urinary  Kidney  Prostate  Vision  Thyroid  
 Skin  Sexual  Other(s): \_\_\_\_\_ Explain: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## TERMS OF ACCEPTANCE

*Please read the below and if you have any questions, feel free to ask on of our team members.*

### Virtue CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

#### **PERMITTED DISCLOSURES:**

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating areas mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or imminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or inform you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.





**YOUR RIGHTS:**

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

**VIRTUE CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY (CONTINUED)**

I understand my rights as well as the practice’s duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this “Notice of Privacy Practice” at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this “Notice” is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**INFORMED CONSENT**

A practice member, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the practice member to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic doctor. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a practice member by a doctor at Virtue Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION FOR X-RAYS**

X-rays are utilized in the office to help locate and analyze vertebral subluxations. These x-rays are not to be used to investigate medical pathology. The doctor of Virtue Chiropractic does not diagnose or treat medical conditions; however if any abnormalities are found, they will be brought to your attention so that you can seek proper medical advice. By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(Women Only) Please check the box that applies to you** - To the best of my knowledge:

- I AM NOT pregnant at this time
- I AM/believe I MAY BE pregnant, therefore I DO NOT authorize Virtue Chiropractic to X-ray me at this time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I authorize Virtue Chiropractic to release all necessary information concerning my health condition to my billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize Virtue Chiropractic to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Virtue Chiropractic to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_