INTAKE/DISCHARGE SHEET

Please Print

Patient Information

Name_____ Date_____
Date of Birth _____ Age _____ Social Security Number _____
Phone # _____ Cell # _____
Street Address _____
City _____ State _____ Zip _____
E-Mail _____
Occupation_____
Employer _____ Business Phone _____
Sex: □ Male □ Female Height _____ Weight _____
Are you □ Married □ Single □ Domestic Partnership □ Divorced □ Separated □ Widowed
Spouses Name: _____
Your Auto Insurance Carrier _____ Claim # _____
Other Party's Auto Insurance Carrier _____Claim # _____
Health Insurance_____ ID # _____ Group # _____
Name of Attorney _____ Phone # _____
Do you have any special needs? _____

Present Health

Please Complete Duties Under Duress and Loss of Enjoyment Worksheets

What are your current health concerns? _____
_____
What are your goals coming in today? _____
_____
Who is your primary care provider? _____
Address _____
Phone _____
Please list any allergies you may have _____
Please list any medications you are currently taking
_____
Please list any supplements you are currently taking
_____
Describe your current exercise regimen _____
Did you strike your head or any other part of your body in this accident? _____
_____

Medical History

Have you ever been treated by a: □ Chiropractor □ Naturoprathic Doctor □ Reflexologist □ Massage □Acupuncturist □ Other Alternative Practitioner

Family History

(G = Good, P = Poor)

Check applicable	Father	Mother	Grandparent	Sibling	Other (Specify)
Anemia	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
General Health	_____	_____	_____	_____	_____

Personal History

As a child, did you have any of the following diseases?
□ Scarlet Fever □ Rheumatic Fever □ Diphtheria □ Mumps □ Measles □ German measles □ Other _____

List any fractures or surgeries you have had with corresponding dates:
_____

Have you ever been in an auto accident? _____ When? _____

List other injuries including falls and other traumas and when they occurred:
_____

Have you been diagnosed with any disease or disorders and when? _____
_____

Are there any additional health concerns or questions you have? _____
_____
_____

<u>Please Circle the appropriate letter next to each item based on the following:</u>
Y = a condition you have now **N** = never had

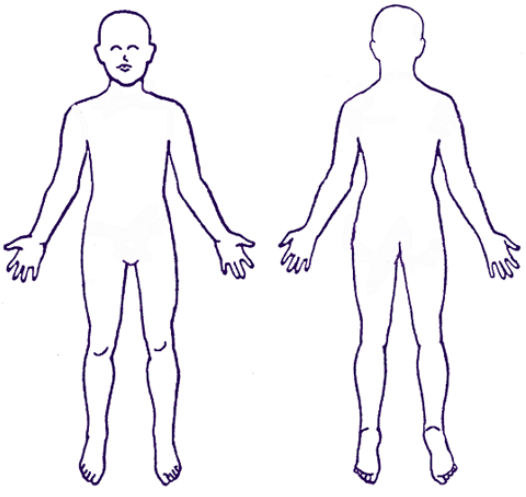
Neck Pain	Y N	R/L Leg Pain/Tingling	Y N
Mid Back Pain	Y N	R/L Foot Pain/Tingling	Y N
Lower Back Pain	Y N	R/L Foot Pain/Tingling	Y N
Extremity Pain	Y N	R/L Hand Pain/Tingling	Y N
Chest Pain	Y N	Fingers/Toes Pain/Tingling	Y N

Muscle Spasms	Y N	Dizziness	Y N
Vision Disturbance	Y N	Heart Disease	Y N
Motion Restriction	Y N	Low/High Blood Pressure	Y N
Sleep Disturbance	Y N	Nausea	Y N
Anxiety	Y N	Vomiting	Y N
Night Sweats	Y N	Liver Disease	Y N
Headaches	Y N	Abdominal Pain	Y N
Head Injury	Y N	Joint Pain/Stiffness	Y N
Impaired Vision	Y N	Arthritis	Y N
Depression	Y N	Broken Bones	Y N
Double Vision	Y N	Fainting	Y N
Ringing in Ears	Y N	Seizures	Y N
Frequent Colds	Y N	Muscle Weakness	Y N
Sinusitis	Y N	Goiter	Y N
Cough	Y N	Spit up Blood	Y N
Asthma	Y N	Bronchitis	Y N
Emphysema	Y N	Difficulty Breathing	Y N
Diabetes	Y N	Sexual Difficulties	Y N
Mood Swings	Y N	Memory Loss	Y N
Drug/Alcohol Abuse	Y N	Thyroid Problem	Y N
Pacemaker/Defibrillator	Y N		

Women Only:

Currently Pregnant Y N

Please indicate on the picture below your problem areas. Please use the following symbols provided:



= = - Numbness
OO – Pins and Needles
XX – Aching
//// - Stabbing

Pain scale: (1-10 - 1 = low, 10 = High)

Neck: _____
Mid Back: _____
Low Back: _____
Extremities: _____

Patients Signature: _____ Date: _____

Gordon Family Chiropractic, LLC
Chiropractic Rehab Center
1650 S. Arlington Rd., Suite 2
Akron, OH 44306
Phone: 330-786-9861
Fax: 330-786-9862

Personal Injury Description

Name: _____
Today's Date: _____ Date of Injury: _____

Auto Accidents:

1. Where were you seated in the vehicle? _____
2. Were you wearing your seatbelt? _____
3. Describe the Auto Accident:
   _____
   _____
   _____
   _____
4. Did any part of your body strike the vehicle? If so, which?
   _____
5. Did the police arrive at the scene? Any Citations given?
   _____
6. Estimated damage to your vehicle: _____

Other Type of Injury:

1. Describe what happened: (Slip/Fall, Premises Injury, Etc.)
   _____
   _____
   _____
   _____

Treatment questions:

1. Did you lose consciousness? _____
2. Did you receive any cuts/bruises? Where? _____
3. Were you taken to hospital? If so, which one? _____
   _____
4. Were x-rays taken? If so, which? _____
5. Have you done anything to relieve pain?
   _____

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PHYSICIAN

Attorney, Private, Group, Accident, and Health Insurance

Date: _____

I hereby authorize and direct _____ (Insurance Carrier/Attorney) to pay by check, made out and mailed directly to:

Gordon Family Chiropractic, LLC
1650 S. Arlington Rd., Suite 2
Akron, OH 44306

If my policy prohibits direct payment to my doctor then I hereby instruct and direct the check to be made to me and mailed as follows so that I can make/give payment to:

Gordon Family Chiropractic, LLC
1650 S. Arlington Rd., Suite 2
Akron, OH 44306

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges if no payment was made by the Insurance Co., Attorney, or if I have settled my claim and received all monies to me.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORGINAL.

I also authorize the release of any information pertinent to my case to any insurance carrier, adjuster, or Attorney involved in this case.

_____ _____
Print Name Date

_____ _____
Signature Witness