

## Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

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

Insurance: \_\_\_\_\_ (dd/mm/yr)

Date of Birth: \_\_\_\_\_  male  female

Address: \_\_\_\_\_

Marital status

S  M  W  D  SEP

Phone #: home: \_\_\_\_\_ work: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Mark (c) for current problems, check  and indicate the age when you had any of the following:

### General

- Allergies
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Headaches
- Loss of sleep
- Mental illness
- Nervousness
- Tremors
- Weight loss / gain

### Muscle / Joint

- Arthritis / rheumatism
- Bursitis
- Foot trouble
- Muscle weakness
- Low back pain
- Neck pain
- Mid back pain
- Joint pain

### Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergies
- Itching
- Rash
- Varicose veins

### Eye, Ear, Nose & Throat

- Colds
- Deafness
- Ear ache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Ringing of the ears
- Sinus infection
- Sore throat
- Tonsillitis
- Vision problems

### Gastrointestinal

- Abdominal pain
- Bloody or tarry stool
- Colitis / Crohn's
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Diverticulosis
- Bloating abdomen
- Excessive hunger
- Gallbladder trouble
- Hernia
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Painful defecation
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

### Genitourinary

- Bed-wetting
  - Bladder infection
  - Blood in urine
  - Kidney infection
  - Kidney stones
  - Prostate trouble
  - Pus in urine
  - Stress incontinence
- Urination
- Overnight more than twice
  - More than 8x in 24hrs
  - Decreased flow/force
  - Painful urination
  - Urgency to urinate

### Cardiovascular

- High blood pressure
- Low blood pressure
- Hardening of the arteries
- Irregular pulse
- Pain over heart
- Palpitation
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

### Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever
- Shortness of breath
- Spitting up phlegm / blood
- Wheezing

### Women only

- Congested breasts
- Hot flashes
- Lumps in breast
- Menopause
- Vaginal discharge

### Menstrual flow

- Reg.  Irreg.  Pain / cramps

Days of flow: \_\_\_\_\_ Length of cycle: \_\_\_\_\_

Date - 1<sup>st</sup> day last period: \_\_\_\_\_

Are you pregnant?  yes,  no

If yes, how many months? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Birth control method: \_\_\_\_\_

Date of last PAP test: \_\_\_\_\_

normal,  abnormal

Date of last mamogram: \_\_\_\_\_

normal,  abnormal

Check any of the conditions you have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chicken pox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart burn
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV/AIDS
- Influenza
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness/tingling
- Pace maker
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

Please list any medication you are currently taking and why:

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**Patient Intake Form** (side 2)

Give a brief detailed description of the problem you are currently experiencing: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

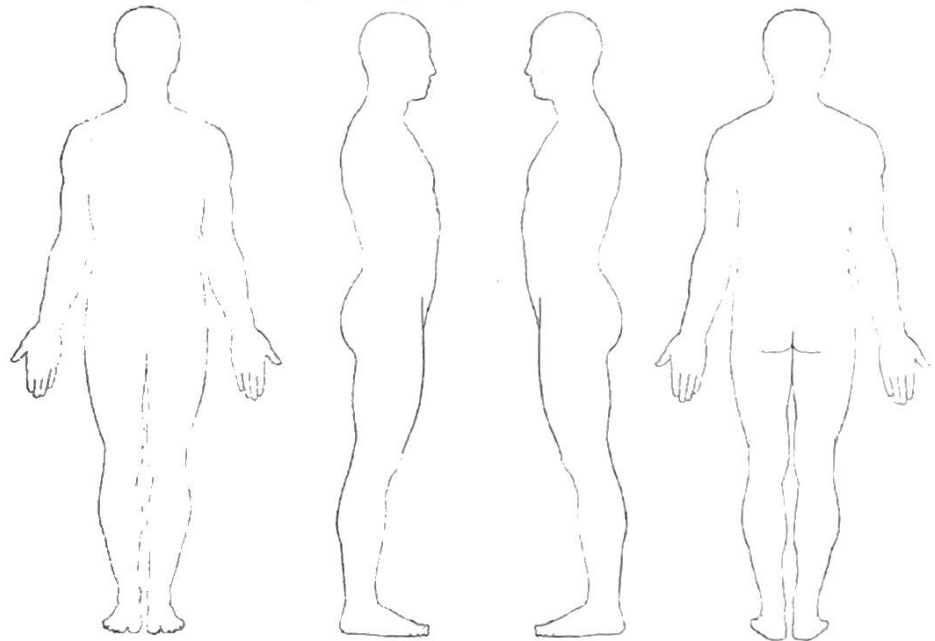
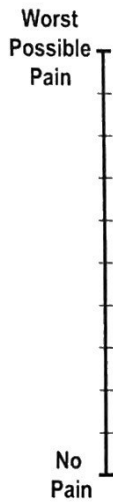
How long have you had this condition? \_\_\_\_\_ Is it getting worse?  yes,  no \_\_\_\_\_

Does it bother you (check appropriate box):  work,  sleep,  other: \_\_\_\_\_

What seemed to be the initial cause: \_\_\_\_\_

*Please mark you area(s) of pain on the figure below*

*Please place a mark at the level of your pain on the scale below:*



**Past health history**

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... ever used orthotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How is most of your day spent?	<input type="checkbox"/> standing, <input type="checkbox"/> sitting, <input type="checkbox"/> other: _____		
How old is your mattress?	_____		
When was your last physical exam?	_____		

Habits	none	light	mod.	heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<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"/>
Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Family history** *If any blood relative has had any of the following conditions, please check and indicate which relative(s)*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cancer        | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> High cholesterol    |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Multiple sclerosis  |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Bleed easily     | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease     |

Do you have any other health issues or concerns that our staff should be made aware of? \_\_\_\_\_

**Chris J. Muller, D.C., P.C.**

3083 William Street  
Cheektowaga, New York 14227  
Telephone: (716) 894-2959  
Fax: (716) 894-2951

A policy has been enacted in my office with regards to missed appointments.

There will be a fee for missed appointments. This applies to no call no shows. Our office has been very lenient in the past and we will accept an appointment change up to the time of the appointment. This includes a cancellation.

**No call no shows can no longer be tolerated.**

A fee of \$15.00 will be assessed and mailed. No future visits can be made until this fee has been received.

I, Print name \_\_\_\_\_  
Sign name, \_\_\_\_\_ . As a patient of  
Dr Muller, I agree to the above policy and will adhere to it in the  
future.

Sincerely,

Chris J. Muller

## CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

- a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;
- b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

- a. The condition that the treatment is to address;
- b. The nature of the treatment;
- c. The risks and benefits of that treatment; and
- d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with \_\_\_\_\_ (health care providers name).

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_

\_\_\_\_\_  
Patient signature (or Legal Guardian)  
Print Name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness  
Print Name: \_\_\_\_\_