ABOUT THE PATIENT

Name _____ **Today's Date** _____ **Birthdate** _____ **Age** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Cell Phone _____ **Marital Status:** _____ **Gender** __ M __ F **Significant Other's Name** _____

Have you been to a chiropractor before? __ No __ Yes **When was your last Chiropractic Appointment?** _____

Your Employer _____ **Type of Work** _____

E-Mail Address _____ **Who Referred you to us?** _____

Emergency Contact _____ **Ph #** _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize 614 Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- I understand that your health information is protected by the Health Insurance Portability and Accountability Act of 1996. If you have any questions, please talk to the front desk.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

2. _____ How long has this been an issue? _____

3. _____ How long has this been an issue? _____

4. _____ How long has this been an issue? _____

5. What makes it better? _____

6. What makes it worse? _____

7. What Doctors have you seen for this? _____

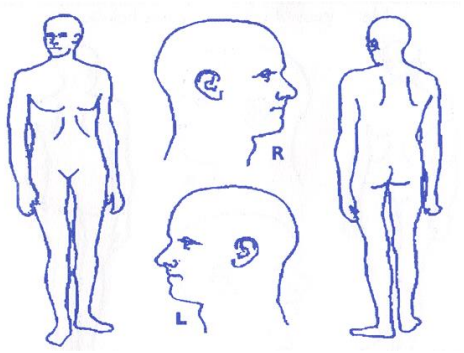
_____

NOTES: _____

_____

_____

Please mark all areas of concern.



Are you pregnant? __ Yes __ No **How far along?** _____ **Due Date:** _____

PATIENT INTAKE + BASELINE OUTCOME FORM

1. PRIMARY COMPLAINTS

Date of Injury / Onset: _____

Check all that apply: Neck Mid Back Pain

Low Back Pain Shoulder Pain Hip Pain

Radiating Pain (Specific Area): _____

Other: _____

2. PAIN SCORING

Current Pain (0-10): _____ **Worst Pain (0-10):** _____

Best Pain (0-10): _____

Pain Type: Sharp Dull Achy Burning Stiff

Radiating Intermittent Constant

3. IMPACT SCORE (ANNOYANCE / DISRUPTION)

How much does this affect your daily life? 0 = no impact 10 = completely disrupts life

Score: _____ / 10

4. FUNCTIONAL TOLERANCE (CORE METRICS)

Before symptom onset, patient could:

	Before		Now	
Sitting	_____	minutes	_____	minutes
Standing	_____	minutes	_____	minutes
Walking	_____	minutes	_____	minutes
Lifting	_____	lbs	_____	lbs
Driving	_____	hours	_____	hours

5. SLEEP QUALITY

☐ No Disruption ☐ Mild Disruption ☐ Moderate Disruption ☐ Severe Disruption

Hours slept nightly: _____

Wakes due to pain? ☐ yes ☐ no

6. ADL IMPACT (SIMPLIFIED, HIGH VALUE)

Check all affected: ☐ Work ☐ Sitting ☐ Driving ☐ Sleeping ☐ Exercise ☐ Household Tasks ☐ Self-care ☐ Recreation

Top 3 most affected ADL's:

1. _____
2. _____
3. _____

7. WORK PROFILE

Sitting hours per day: _____

Break frequency: _____

Work Impact: | None | Mild | Moderate | Severe

8. EXERCISE / PRIOR ATTEMPTS

Have you tried exercises or stretching? yes no

If yes: What specifically? _____

Duration tried: _____

Result: Helpful | Temporary | No Change | Worse

9. MEDICATION USE

Tylenol	Ibuprofen / NSAIDs	Muscle Relaxers
None	Other: _____	

Frequency: Daily | Weekly | Occasional

10. PRIOR CARE

Chiropractic	Physical Therapy	Massage
Dry Needling	None	

Outcome: | Helpful | Temporary | No Change | Worse

11. GOALS (CHECK ALL):

Pain Reduction	Sleep Improvement
Return to Exercise	Work Without Discomfort
Improve Mobility	Improve Sitting Tolerance

GENERAL HEALTH HISTORY

Mark the conditions that apply to you.

Past	Present		Past	Present	
		Headaches			Urinary Problems
		Migraines			Easy Bruising
		Shortness of Breath			Tobacco Use
		Allergies / Asthma			Dental Problems
		Medication Side Effects			Fibromyalgia
		Diabetes			Blood Thinner use
		Hands or Feet cold			HIV Positive
		Muscle aches			Cancer
		Trouble Walking			Depression
		Leg / Foot Numbness			Alcohol Use
		Fainting			___ High or ___ Low Blood Pressure
		Gall Bladder Trouble			Stroke History
		Ringing in Ears			High Cholesterol
		Ear Problems			TMJ
		Sleeping Problems			Digestive Problems
		Vision Problems			Pain all Over
		Thyroid Problems			Tension / Irritability
		Liver Disease			Chest Pains
		Kidney Problems			Heart Pacemaker
		Light Bothers Eyes			Heart Problems
		Other _____			

1. List any medications you are taking: _____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor": | No | Yes, Name _____

PAST HISTORY

4. List any past auto collisions: _____ **Was any care received?** _____

5. List any past work injuries: _____ **Was any care received?** _____

6. List any past sport, recreational, or home injuries _____

7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: __ Heart Disease | __ Cancer | __ Diabetes | __ Heavy Medication use | __ Arthritis | __ Other _____

Mother's side: __ Heart Disease | __ Cancer | __ Diabetes | __ Heavy Medication use | __ Arthritis | __ Other _____

Is there any other family history you want us to know? _____

_____

Informed Consent

Section 1: Informed Consent for Chiropractic Care

We are committed to providing you with safe, effective, and natural chiropractic care. Please read this form carefully.

What is Chiropractic Care? Chiropractic care at our office, provided by Dr. Nicholas Esser, focuses on gentle, specific adjustments to the spine and other joints to improve alignment, movement, and overall function.

What to Expect During Your Care:

- Thorough health history and physical exam (posture, movement, muscle strength, etc.).
- X-rays may be recommended.
- Personalized care plan that may include adjustments, soft tissue therapies, exercises, or referrals if needed.

Benefits of Chiropractic Care:

- Reduced pain or discomfort in back, neck, or joints
- Improved mobility, flexibility, and posture
- Enhanced overall wellness, energy, and physical performance

Understanding Rare Risks: Chiropractic care is very safe, but like any healthcare approach, there are rare risks:

- Temporary soreness or discomfort after adjustments
- In very rare cases, minor muscle or ligament strain
- Extremely rare risks involving neck adjustments (estimated at less than 1 in 1 million)

What Happens if You Choose Not to Pursue Care? You may continue to experience discomfort, limited mobility, or other symptoms. Untreated issues could worsen over time.

Other Care Options: Rest, over-the-counter pain relievers, physical therapy, medications, injections, or surgery.

Your Rights and Responsibilities:

Your Right to Choose: You can stop or modify your care plan at any time. Just let us know what you're comfortable with.

Your Responsibility: Please share all relevant health information (e.g., past injuries, medical conditions, or medications) to help us provide the safest and most effective care.

Section 2: SoftWave (ESWT) Suitability Questions

Please answer the following to help us determine if SoftWave Tissue Regeneration is appropriate for you:

- Have you been injected with cortisone this month? Yes / No
- Have you been diagnosed with cancer/tumor within the last 12 months? Yes / No
- Have you been diagnosed with a skin infection in the last 12 months? __ Yes / __ No
- Are you pregnant or do you suspect you may be pregnant? Yes / No
- Are you under 16 years of age? Yes / No

Our Commitment to You We adhere to the highest professional standards to ensure your care is safe and effective. Our goal is to support your health naturally and respectfully.

Section 3: Decompression Suitability

Please circle any that apply to you:

Pregnant | Metal implants in spine | Advanced Osteoporosis | Hernia | Blood Thinners | Spinal Fusion | Fractured or Broken Vertebra | Failed Back Surgery | Tumor | Cardiac or Pulmonary Disease | Abdominal Aortic Aneurysm

Other (related to today's treatment): _____

Photos and Text Reminders: By signing this form, you also agree to the following (please cross out any that you want to opt out of):

- **Photos for Social Media:** I allow my image to be shared on 614 Chiropractic LLC's social media or website for positive, professional purposes (e.g., celebrating patient milestones). I understand I may request removal of my photo at any time. — Opt out of photos for social media
- **Text Appointment Reminders:** I agree to receive text reminders for my appointments to help me stay on track. — Opt out of text appointment reminders

Your Consent: By signing below, I confirm that:

- I have read and understood this form, and my questions have been answered to my satisfaction.
- I understand the benefits, rare risks, and alternatives to chiropractic care.
- I consent to the recommended care plan for my current condition and any future conditions I seek treatment for at 614 Chiropractic LLC.
- I understand I can stop or change my care plan at any time.

Patient Name (Printed):	Patient Signature:	Date:
Parent/Guardian Name (if applicable):	Parent/Guardian Signature:	Date:

Paying for your care is easy here!

Initial which one is you:

No Insurance:

- Easy! Our Chiropractic, Decompression Care Plans and simple payment arrangements have helped over 2500 people and will work great for you too!
- Insurance pays very little and maybe not at all for necessary services like LASIK, or necessary cosmetic surgery or our incredible Decompression & SoftWave Tissue Regeneration protocols.

Initial _____

Health Insurance:

- These days, insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!
- We will verify any benefits you may have and send your claims in to your insurance for you.
- If they pay anything after your deductible is met, we will accept payment directly from them.
- You are responsible for any deductible, co-insurance, co-pays and unpaid visits.
- Of course you can use your HSA, HRA and Flex dollars here!
- For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

Initial _____

Auto Injury

- Auto injuries: if you were not the at-fault driver, your care is typically covered by the at-fault driver's insurance.
- All we need is your claim number and insurance information.

Initial _____

Medicare

- Medicare pays for much of your care making it quite easy.
- We simply need a copy of your Medicare card.
- Medicare supplements normally don't pay anything.

Initial _____

You have made a great decision to get care here!
Our goal is to be your family chiropractor for life!