Patient Name:_____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cellular Phone: (_____) _____-_____

Social Security #: _____/_____/_____ ☐ Male ☐ Female Date of Birth: ____/____/_____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____

Employer Name: _____Work Phone: (_____) _____-_____

Employer Address: _____City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: (____) _____-_____

Who can we thank for referring you to us? _____

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of therapeutic exercise, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is

with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name: _____

Signature:_____

Date:_____

I understand I have a right to a copy of the HIPAA privacy practice documentation from Endurance Chiropractic and Sports Therapy, I choose not to receive this paperwork at this time. Please check here if you want a copy of this documentation ◯

Signature: _____ Date: _____

Patient Intake Form

Patients Name:_____**Date:** ____ / ____ /____

1) Please choose the location(s) of your problem(s):

Headaches	Shoulder	Hand	Legs
Jaw	Arm	Mid back	Knee
Neck	Elbow	Low back	Ankle
Upper back	Wrist	Hip	Foot

Other:_____

2) What is your height? _____ ft. _____ in.

3) How much do you weight? _____ lbs.

4) DOB _____ / _____ /_____

5) Occupation:

Trader	Professional/Executive	White Collar	Tradesperson	Retired
Laborer	Homemaker	Truck driver	Student	Unemployed

Other:_____

6) In general, how do you rate your overall health?

Excellent	Very good	Good	Fair	Poor

7) What kind of exercise do you perform?

Strenuous	Moderate	Light	None

8) Do you have an immediate family member with any of the following?

Rheumatoid arthritis	Heart problems	Diabetes
Cancer	Lupus	ALS

Other:_____

9) Please check all that apply to you in the appropriate column:

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

10) Please list all prescription medications you are currently taking:

_____

11) Please list all supplements you are currently taking:

_____

12) Please list all surgical procedures you have had:

_____

13) What do you do at work?

Sits most of the day	Sits about half the day	Sits a little of the day
Stands most of the day	Stands about half the day	Stands a little of the day
Computer most of the day	Computer about half the day	Computer a little of the day
On the phone most of the day	On the phone about half the day	On the phone a little of the day
Drives most of the day	Drives about half the day	Drives a little of the day
Performs manual labor most of the day	Reads a lot about half the day	Travels frequently a little of the day
None		

Other: _____

14) What do you do outside of work?

Aerobics	Skiing	Basketball	Soccer	Baseball	Softball
Bicycling	Swimming	Football	Tennis	Golf	Triathlons
Hiking	Volleyball	Ice hockey	Walking	Inline skating	Weight lifting
Jogging	Working out	Martial arts	Yoga	Rock climbing	Other

15) Have you had any hospitalizations?

Yes	No	Previously mentioned

16) Have you seen a chiropractor before?

Yes	No

17) Have you had any significant past trauma?

Yes	No

18) Is there anything else you think I should know?

Yes	No

20) What did the patient score on the revised neck oswestry index? _____

21) What did the patient score on the revised lower back oswestry index? _____