

Intake Form – Dr. David Byers, Chiropractor

BOX 1

CHIEF COMPLAINT

DATE: _____

Name _____ Home Phone _____ Cell _____

Is this appointment for yourself or the whole family? Self [] Family []

Primary reason for consulting this office: general wellness care, or specific problem (please describe)?

Any other associated complaints? _____

How long has this been going on? Days: _____ Months: _____ Years: _____

Any previous incidents in your life? _____

BOX 2

GENERAL INFORMATION

CASE # _____

Address: _____ City: _____ State: _____

Zip: _____ Age: ____ DOB: ____/____/____ M F Marital Status: S M W # of Children: ____

SS#: _____ e-mail: _____ Work Phone: _____

Employer: _____ Occupation: _____

Insurance Name: _____ ID# _____ Group# _____

Seen any other chiropractors? N Y Who? _____ # of Visits: _____

Spine X-Rayed in last 2 years? N Y Area X-Rayed: _____

Location of X-Rays: _____

Name of MD: _____ or others seen for this condition: _____

Who may we thank for referring you to our office? _____

BOX 3

VISITS SCHEDULED

VISIT 1 Date: _____ Time: _____ VISIT 2 Date: _____ Time: _____

VISIT 3 Date: _____ Time: _____ (Wellness Seminar)

BOX 4

AGREEMENTS

Office Fees

Exam \$30 - \$180 Adjustments \$38 - \$80 X-Rays – \$40 - \$150

INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures and, if necessary, diagnostic X-Rays on me by the Doctor of Chiropractic named above and/or anyone authorized by same. I further understand and am informed that, as in all health care, there are some slight risks to treatment, and do not expect the doctor to be able to anticipate or explain all risks and combinations. I understand that some treatments are considered experimental in the state of Colorado, and wish to rely upon 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 interest. I have read this Consent and intend this Consent form to cover the entire course of my care for this condition and any care in the future.

Signature: _____ Printed Name: _____

Witness: _____ Date: _____

BOX 5

(to be filled out by doctor)

Quality of Life Issue: _____

Level of Challenge: 1 _____ 5 _____ 10 _____

Short Term Goal (2-3 months): _____ Long Term Goal (1 year): _____

Family Health Attitudes – Dr. David Byers, Chiropractor

BOX 1

BEGIN HERE

NAME _____

CASE # _____

FAMILY HISTORY

Health challenges always involve lifestyle choices. Most challenges begin early in life (sometimes before birth) and accumulate without any signs or symptoms until permanent damage has been done. This history is divided into 4 parts. (In each section, check as applicable)

1. Your personal history
2. Your spouse's history
3. Your children's history
4. Your family's current health attitudes

BOX 2

YOUR PERSONAL FAMILY HISTORY (Blood Relatives Only)

In your family, any history of: Cancer TB Nervous Disorders Diabetes
Stroke High Blood Pressure Scoliosis Heart Problems Osteoporosis

YOUR PERSONAL HEALTH PROFILE

Loss of Energy Recurrent Complaints Misses Work Takes Medicines
Plays Sports Overweight Underweight Irritable Mood Swings
Headaches Loss of Sleep Under Stress Any Accidents Surgery

Other Challenges or Medications:

BOX 3

YOUR SPOUSE'S PERSONAL FAMILY HISTORY

In spouse's family, any history of: Cancer TB Nervous Disorders Diabetes
Stroke High Blood Pressure Scoliosis Heart Problems Osteoporosis

SPOUSE'S PERSONAL HEALTH PROFILE

Loss of Energy Recurrent Complaints Misses Work Takes Medicines
Plays Sports Overweight Underweight Irritable Mood Swings
Headaches Loss of Sleep Under Stress Any Accidents Surgery

Other Challenges or Medications:

BOX 4

CHILDREN'S HISTORY

Overactive On Ritalin Fatigued Falls Misses School Asthma
Ear Infections Under Stress Recurrent Infections Plays Sports Irritable
Underweight Overweight Surgery Allergies

Other Challenges or Medications:

BOX 5

YOUR FAMILY HEALTH ATTITUDES

Do you now buy or have you ever bought:

Bottled Water? YES NO Vitamins? YES NO Supplements? YES NO
Health Magazines? YES NO Health Club Membership? YES NO

Have you ever:

Had your children checked for scoliosis? YES NO
Had your nervous system checked for function? YES NO
Had your teeth checked regularly? YES NO Been a runner? YES NO
Had a massage? YES NO Been concerned about your diet? YES NO

DR. DAVID BYERS