DESIGNED 2 MOVE
SPINE & SPORT

New Patient Intake

Dr. Aaron Rickelman
Dr. Abbi Rickelman
Dr. Brady Dougherty

Patient Name: ____ **Date:** ___________

Address______________________ City_______________ State _________ Zip Code __________

H. Phone _________________W. Phone_______________ Cell Phone ________________________

Email Address: ___________________________ Height ___________ Weight _____________

Sex M F Marital Status M S D W Date of Birth_____________ Age__________

Occupation ________________________________ Employer ________________________________

Emergency Contact/Relationship and Phone#: ____

Referred by: _____________________________________

Have you ever received Chiropractic Care? Yes No If yes, when? __________________

Name of most recent Chiropractor: ____

1. Past Health History:

A. Surgeries:

Date	Type of Surgery
_________________	____
_________________	____
_________________	____
_________________	____
_________________	____

B. Previous Injury or Trauma: ____

Have you ever broken any bones? Which? _____________________________________

C. Allergies: ____

D. Cancer: Y N Type:____________________________________ In remission: Y N

2. Family Health History:

A. Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases
□ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other ______________________________________ □ None of the above

B. Deaths in immediate family:

Cause of parents' or siblings' death	Age at death
____	_______________________
____	_______________________
____	_______________________

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Patient Name: ____**Date:** ____________

____

3. **Social and Occupational History:**
   A. **Job description:** ____
   B. **Recreational activities:** ____
   C. **Lifestyle:**
      Level of Exercise: ____
      Alcohol Use: ____
      Tobacco Use: ____
      Drug Use: ____
      Diet: ____
4. **Medications:**

Medication	Reason for taking

5. **Primary Care Physician**

   Who is your primary care physician?____

   Office Address:__________________________________ Office Phone #:______________________

   Office Fax #:_______________________

   Please sign here if we have permission to release records to the above physician should the need arise:

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Patient Name: ____Date: ____________

Signature:____ Date:______________________________

Review of Systems (please indicate if you have experienced any of the following)

Pulmonary (lung-related)
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other ____________ □ None of the above

Cardiovascular (heart-related)
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other ___________ □ None of the above

Neurological (nerve-related)
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _______________ □ None of the above

Endocrine (glandular/hormonal)
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other ________________ □ None of the above

Renal (kidney-related)
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other ______________________ □ None of the above

Gastroenterological (stomach-related)
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _________ □ None of the above

Hematological (blood-related)
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other _______________ □ None of the above

Dermatological (skin-related)
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other __________ □ None of the above

Musculoskeletal (bone/muscle-related)
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Osteoporosis □ Other ______________________ □ None of the above

Psychological
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other ____________ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? __________________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Designed 2 Move, LLC** for services performed.

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Patient Name: ____Date: _____________

Patient or Guardian Signature ________________________________
Date_________________________

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

______________________________________ __________________________

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Patient Name: ____**Date:** ____________

Signature of Patient of Representative   Date

____
Printed Name

NEW PATIENT HISTORY FORM

Symptom 1 ___________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
  - How did the symptom begin? ____
- What makes the symptom worse? (check all that apply):
  - Nothing
  - Any Movement
  - Bending neck forward
  - Bending neck backward
  - Tilting head right
  - Tilting head left
  - Turning head right
  - Turning head left
  - Laying on side
  - Bending forward at waist
  - Bending backward at waist
  - Leaning right
  - Leaning left
  - Sitting
  - Driving
  - Standing
  - Walking
  - Other______________
  - Running
  - Lifting
  - Transitional Movement
  - Chewing
  - Lying down
  - Reading
  - Working
  - Exercising
- What makes the symptom better? (check all that apply):
  - Nothing so far
  - Rest
  - Standing
  - Walking
  - Sitting
  - Pain medication
  - Chiropractic care
  - Massage
  - Stretching
  - Movement
  - Other______________
- Describe the quality of the symptom (check all that apply):
  - Sharp
  - Dull
  - Achy
  - Burning
  - Tingling
  - Throbbing
  - Tight/Stiff
  - Stabbing
  - Deep
  - Numb
  - Nagging
  - Shooting
  - Stinging
  - Fleeting
  - Other______________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? __________________________________
- Is the symptom worse at certain times of the day or night? (please circle)
  No difference   Morning   Afternoon   Evening   Night   Other ____________
- Have you received treatment for this condition prior to today's visit? (check all that apply)
  - No
  - Anti-inflammatory meds
  - Trigger point injections
  - Cortisone injections
  - Physical Therapy
  - Chiropractic

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Patient Name: ____**Date:** ____________

- Pain medication
- Surgery
- Other_______________
- Muscle relaxers
- Massage

- What activities of daily living is this limiting? ____

NEW PATIENT HISTORY FORM

Symptom 2 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)

- When did the symptom begin? ____
  - How did the symptom begin? ____

- What makes the symptom worse? (check all that apply):
  - Nothing
  - Any Movement
  - Bending neck forward
  - Bending neck backward
  - Tilting head right
  - Tilting head left
  - Turning head right
  - Turning head left
  - Laying on side
  - Bending forward at waist
  - Bending backward at waist
  - Leaning right
  - Leaning left
  - Sitting
  - Driving
  - Standing
  - Walking
  - Other________________
  - Running
  - Lifting
  - Transitional Movement
  - Chewing
  - Lying down
  - Reading
  - Working
  - Exercising

- What makes the symptom better? (check all that apply):
  - Nothing so far
  - Rest
  - Standing
  - Walking
  - Sitting
  - Pain medication
  - Chiropractic care
  - Massage
  - Stretching
  - Movement
  - Other_______________

- Describe the quality of the symptom (check all that apply):
  - Sharp
  - Dull
  - Achy
  - Burning
  - Tingling
  - Throbbing
  - Tight/Stiff
  - Stabbing
  - Deep
  - Numb
  - Nagging
  - Shooting
  - Stinging
  - Fleeting
  - Other_______________

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ____

- Is the symptom worse at certain times of the day or night? (please circle)
  No difference Morning Afternoon Evening Night Other _____________

- Have you received treatment for this condition prior to today's visit? (check all that apply)
  - No
  - Anti-inflammatory meds
  - Trigger point injections
  - Cortisone injections
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Patient Name: ____**Date:** ___________

- Pain medication
- Muscle relaxers
- Surgery
- Massage
- Other_______________

- What activities of daily living is this limiting? ____

NEW PATIENT HISTORY FORM

Symptom 3 _______________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)

- When did the symptom begin? ____
  - How did the symptom begin? ____

- What makes the symptom worse? (check all that apply):
  - Nothing
  - Any Movement
  - Bending neck forward
  - Bending neck backward
  - Tilting head right
  - Tilting head left
  - Turning head right
  - Turning head left
  - Laying on side
  - Bending forward at waist
  - Bending backward at waist
  - Leaning right
  - Leaning left
  - Sitting
  - Driving
  - Standing
  - Walking
  - Other________________
  - Running
  - Lifting
  - Transitional Movement
  - Chewing
  - Lying down
  - Reading
  - Working
  - Exercising

- What makes the symptom better? (check all that apply):
  - Nothing so far
  - Rest
  - Standing
  - Walking
  - Sitting
  - Pain medication
  - Chiropractic care
  - Massage
  - Stretching
  - Movement
  - Other_______________

- Describe the quality of the symptom (check all that apply):
  - Sharp
  - Dull
  - Achy
  - Burning
  - Tingling
  - Throbbing
  - Tight/Stiff
  - Stabbing
  - Deep
  - Numb
  - Nagging
  - Shooting
  - Stinging
  - Fleeting
  - Other_______________

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________________

- Is the symptom worse at certain times of the day or night? (please circle)
  No difference Morning Afternoon Evening Night Other _____________

- Have you received treatment for this condition prior to today's visit? (check all that apply)
  - No
  - Anti-inflammatory meds
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Patient Name: ____**Date:** ___________

- Pain medication
- Muscle relaxers
- Surgery
- Massage
- Other_____________

- What activities of daily living is this limiting? ______________________________________

NEW PATIENT HISTORY FORM

Symptom 4 _______________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)

- When did the symptom begin? ____
  - How did the symptom begin? ____________________________________

- What makes the symptom worse? (check all that apply):
  - Nothing
  - Any Movement
  - Bending neck forward
  - Bending neck backward
  - Tilting head right
  - Tilting head left
  - Turning head right
  - Turning head left
  - Laying on side
  - Bending forward at waist
  - Bending backward at waist
  - Leaning right
  - Leaning left
  - Sitting
  - Driving
  - Standing
  - Walking
  - Other_____________
  - Running
  - Lifting
  - Transitional Movement
  - Chewing
  - Lying down
  - Reading
  - Working
  - Exercising

- What makes the symptom better? (check all that apply):
  - Nothing so far
  - Rest
  - Standing
  - Walking
  - Sitting
  - Pain medication
  - Chiropractic care
  - Massage
  - Stretching
  - Movement
  - Other_____________

- Describe the quality of the symptom (check all that apply):
  - Sharp
  - Dull
  - Achy
  - Burning
  - Tingling
  - Throbbing
  - Tight/Stiff
  - Stabbing
  - Deep
  - Numb
  - Nagging
  - Shooting
  - Stinging
  - Fleeting
  - Other_____________

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________

- Is the symptom worse at certain times of the day or night? (please circle)
  No difference Morning Afternoon Evening Night Other ___________

- Have you received treatment for this condition prior to today's visit? (check all that apply)
  - No
  - Anti-inflammatory meds
  - Trigger point injections
  - Cortisone injections
  - Physical Therapy
  - Chiropractic

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Patient Name: ____**Date:** ___________

- Pain medication
- Muscle relaxers
- Surgery
- Massage
- Other_______________

- What activities of daily living is this limiting? ____

NEW PATIENT HISTORY FORM

Symptom 5 _______________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
  - How did the symptom begin? ____
- What makes the symptom worse? (check all that apply):
  - Nothing
  - Any Movement
  - Bending neck forward
  - Bending neck backward
  - Tilting head right
  - Tilting head left
  - Turning head right
  - Turning head left
  - Laying on side
  - Bending forward at waist
  - Bending backward at waist
  - Leaning right
  - Leaning left
  - Sitting
  - Driving
  - Standing
  - Walking
  - Other________________
  - Running
  - Lifting
  - Transitional Movement
  - Chewing
  - Lying down
  - Reading
  - Working
  - Exercising
- What makes the symptom better? (check all that apply):
  - Nothing so far
  - Rest
  - Standing
  - Walking
  - Sitting
  - Pain medication
  - Chiropractic care
  - Massage
  - Stretching
  - Movement
  - Other_______________
- Describe the quality of the symptom (check all that apply):
  - Sharp
  - Dull
  - Achy
  - Burning
  - Tingling
  - Throbbing
  - Tight/Stiff
  - Stabbing
  - Deep
  - Numb
  - Nagging
  - Shooting
  - Stinging
  - Fleeting
  - Other_______________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _______________________________________
- Is the symptom worse at certain times of the day or night? (please circle)
  No difference Morning Afternoon Evening Night Other _____________
- Have you received treatment for this condition prior to today's visit? (check all that apply)
  - No
  - Anti-inflammatory meds
  - Trigger point injections
  - Cortisone injections
  - Physical Therapy
  - Chiropractic

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Patient Name: ____**Date:** ____________

- Pain medication
- Muscle relaxers
- Surgery
- Massage
- Other_______________

- What activities of daily living is this limiting? ____

NEW PATIENT HISTORY FORM

Symptom 6 _______________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)

- When did the symptom begin? ____
  - How did the symptom begin? ____

- What makes the symptom worse? (check all that apply):
  - Nothing
  - Any Movement
  - Bending neck forward
  - Bending neck backward
  - Tilting head right
  - Tilting head left
  - Turning head right
  - Turning head left
  - Laying on side
  - Bending forward at waist
  - Bending backward at waist
  - Leaning right
  - Leaning left
  - Sitting
  - Driving
  - Standing
  - Walking
  - Other________________
  - Running
  - Lifting
  - Transitional Movement
  - Chewing
  - Lying down
  - Reading
  - Working
  - Exercising

- What makes the symptom better? (check all that apply):
  - Nothing so far
  - Rest
  - Standing
  - Walking
  - Sitting
  - Pain medication
  - Chiropractic care
  - Massage
  - Stretching
  - Movement
  - Other_______________

- Describe the quality of the symptom (check all that apply):
  - Sharp
  - Dull
  - Achy
  - Burning
  - Tingling
  - Throbbing
  - Tight/Stiff
  - Stabbing
  - Deep
  - Numb
  - Nagging
  - Shooting
  - Stinging
  - Fleeting
  - Other_______________

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _______________________________________

- Is the symptom worse at certain times of the day or night? (please circle)
  No difference   Morning   Afternoon   Evening   Night   Other _____________

- Have you received treatment for this condition prior to today's visit? (check all that apply)
  - No
  - Anti-inflammatory meds
  - Trigger point injections
  - Cortisone injections
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Patient Name: ____Date: ____________

- Pain medication
- Muscle relaxers
- Surgery
- Massage
- Other_______________

- What activities of daily living is this limiting? ____

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