

**PERSONAL CONTACT INFORMATION**

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Name: \_\_\_\_\_ What do you prefer to be called? \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Cell/other: \_\_\_\_\_

Email: \_\_\_\_\_ Work phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Do not contact me at work:

Date of birth: \_\_\_\_\_ Male:  Female:

Social Security #: \_\_\_\_\_

Marital status: M S D W Spouse's name: \_\_\_\_\_

No. of children: \_\_\_\_\_

Person to contact in case of an emergency: \_\_\_\_\_

Phone: \_\_\_\_\_

Primary insurance carrier: \_\_\_\_\_

Name of policyholder: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary insurance (if applicable): \_\_\_\_\_

Name of policyholder: \_\_\_\_\_ Policy #: \_\_\_\_\_

Who may I thank for referring you? \_\_\_\_\_ Relationship: \_\_\_\_\_

I certify that the above information is true and accurate. I also certify to the truth and accuracy of the information found on the *Initial Intake Form* by signing the bottom of each page. I understand that any and all information that I provide will be held in strict confidence and will not be divulged to others without my authorization.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

## INITIAL INTAKE FORM

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

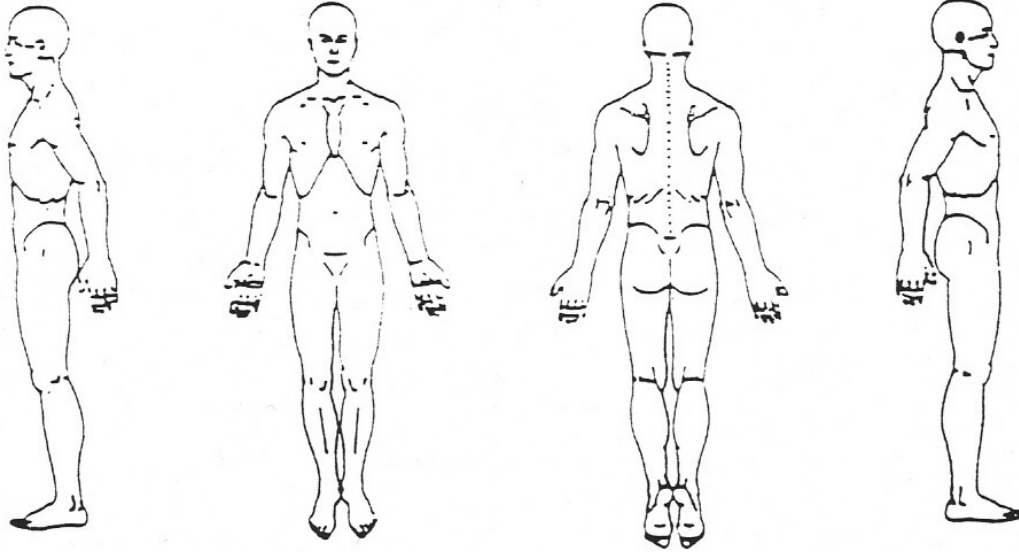
Date: \_\_\_\_\_

### PAIN DIAGRAM

Please locate and mark the quality of your pain (*if applicable*) on the body outlines below. Use the code letters as indicated in the box to the right.

#### **Pain Drawing Key**

- A = Ache
- B = Burning
- N = Numbness
- P = Pins & Needles
- S = Stabbing
- X = Other



Please mark your current level of pain:

No Pain |—————| Worst Pain

Signature: \_\_\_\_\_

**AUTHORIZATION AND PAYMENT RESPONSIBILITY**

I authorize the release of any medical or other information necessary in order to process any claims on my behalf. I also authorize the payment of any and all medical benefits for services submitted by Jason B. Richards, D.C. and/or Keystone Chiropractic, LLC, to be made directly to said submitter.

Furthermore, I understand that the office of Jason B. Richards, D.C. will submit my claims and any necessary documentation to my insurance company in a timely manner for reimbursement. However, I am ultimately responsible for payment of all services rendered regardless of insurance reimbursement or lack thereof.

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

Signed: \_\_\_\_\_

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

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**CONSENT FOR CHIROPRACTIC HEALTH CARE**

I have been informed of the nature of my disorder(s) and the nature and purpose of chiropractic procedures and related therapeutics proposed as treatment. I have also been informed of the possible consequences and risks inherent in such treatment. The availability of alternative treatment options has been explained to me. I have also been advised of the possible consequences if I decide not to receive care. I understand that there is no guarantee or warranty for any specific cure or result.

I have read the above paragraph, and I understand the information provided. This information has been explained to me, and all questions that I have asked have been answered to my satisfaction.

I, therefore, authorize chiropractic care and treatment.

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

Signed: \_\_\_\_\_

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

**When the patient is a minor or unable to consent:**

Patient is a minor of \_\_\_\_\_ years of age

Other: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Person legally authorized to sign for patient (please print name):

\_\_\_\_\_ Relationship: \_\_\_\_\_

Signature of  
authorized person: \_\_\_\_\_

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

## INITIAL INTAKE FORM

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

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

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**CHIEF COMPLAINT #1:**

Pain \_\_\_\_ / 10 Onset: \_\_\_\_\_

Character of Pain:

Since onset:    \_\_\_ increased  
                  \_\_\_ decreased  
                  \_\_\_ no change

How did it begin:

Worsens with:

Present:       \_\_\_ 75-100%  
                  \_\_\_ 50-74%  
                  \_\_\_ 25-49%  
                  \_\_\_ 0-24%

Improves with:

Affect on ADLs:

Have you seen another doctor for this?

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**CHIEF COMPLAINT #2:**

Pain \_\_\_\_ / 10 Onset: \_\_\_\_\_

Character of Pain:

Since onset:    \_\_\_ increased  
                  \_\_\_ decreased  
                  \_\_\_ no change

How did it begin:

Worsens with:

Present:       \_\_\_ 75-100%  
                  \_\_\_ 50-74%  
                  \_\_\_ 25-49%  
                  \_\_\_ 0-24%

Improves with:

Affect on ADLs:

Have you seen another doctor for this?

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**CHIEF COMPLAINT #3:**

Pain \_\_\_\_ / 10 Onset: \_\_\_\_\_

Character of Pain:

Since onset:    \_\_\_ increased  
                  \_\_\_ decreased  
                  \_\_\_ no change

How did it begin:

Worsens with:

Present:       \_\_\_ 75-100%  
                  \_\_\_ 50-74%  
                  \_\_\_ 25-49%  
                  \_\_\_ 0-24%

Improves with:

Affect on ADLs:

Have you seen another doctor for this?

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Type of work:

Exercise program:

Signature: \_\_\_\_\_

## INITIAL INTAKE FORM

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

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

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### REVIEW OF SYSTEMS (Please list any health problems that you currently have.)

Head/neck:

Liver/kidneys:

EENT:

Joints/muscles:

Digestive:

Reproductive:

Circulatory/heart:

Skin:

Respiratory:

Mental/emotional:

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### PAST MEDICAL HISTORY

1. Allergies (foods, medications, airbornes):

2. Current medications:

3. Major injuries:

4. Hospitalizations/surgeries:

5. Births:

6. Tumors (cancer, benign or malignant):

7. Other health problems:

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### FAMILY HISTORY (Please list any significant health problems in your family.)

Mom:

M Grandmother:

M Grandfather:

Dad:

P Grandmother:

P Grandfather:

Siblings:

Signature: \_\_\_\_\_