HIGHER HEALTH CHIROPRACTIC

Patient Intake Form

Name: Date of Birth:

Address:

Phone: E-mail:

Emergency Contact Name: Emergency Contact #:

How were you referred to us?

CIRCLE ANY BENEFITS YOU ARE INTERESTED IN, NUMBER TOP 3 IN ORDER

Pain Relief	Anxiety/Depression	Weight Loss
Joint Pain /Arthritis	Sleep	Scarring/ Wound Healing
Brain Health/TBI	Energy Levels/Mood	Anti-Aging
Inflammation	Hormones	Acne/Eczema
Bone Healing/Fractures	Fibromyalgia	Skin Conditions
Neuropathy	Auto Immune	Hair Growth
Headache/Migraine	Muscle Recovery	GLP-1 Support

What are your primary health goals?

1._____

2._____

3._____

Are you Currently Experiencing:

Pregnant Nursing Active Cancer Liver Disease

(IF YOU CIRCLED ANY OF THE ABOVE IN THIS SECTION -
PLEASE SEE THE FRONT DESK)

HIGHER HEALTH

Red Light Therapy

IF YOU ARE DOING THIS FOR WEIGHT LOSS, HOW MUCH WEIGHT WOULD YOU LIKE TO LOSE OVER THE NEXT 60-90 DAYS?

☐ 5 lbs ☐ 10 lbs ☐ 15 lbs ☐ 20 lbs ☐ 25 lbs ☐ 30+ lbs

ARE YOU CURRENTLY DOING ANYTHING TO LOSE WEIGHT/INCHES?

_____

_____

_____

ANY HISTORY OF EATING DISORDERS?

☐ Yes ☐ No

1. How have you taken care of your health in the past

Medications	Emergency Room	Routine Medical
Exercise	Nutrition/Diet	Vitamins
Other _____	Holistic Care	Chiropractic

2. How have previous weight loss method(s) worked for you?

Bad Results	Nothing Changed	Still Trying
Some Results	Did not get worse	Confused
Great Results	Didn't work for long	Other:_____

3. Does your weight affect any of the following?

Job	Marriage	Freedom
Kids	Self Esteem	Time
Hobbies	Sleep	Finances

_____

_____

4. Are there health conditions you are afraid this might turn into?

Family Health Problems	Diabetes	Depression
Heart Disease	Arthritis	Chronic Fatigue
Cancer	Fibromyalgia	Need Surgery

WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However, that does not mean it's not affecting your health. Many health issues related to gut health go undiagnosed or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help.

Please circle any that apply to you:

Sub-Clinical Symptoms Including:

Headache

Migraine

Hormone Imbalance Including:

PMS

Emotional Imbalance

Gastrointestinal Issues Including:

Abdominal bloating, cramps or gas

Irritable Bowel Syndrome

Ulcerative Colitis

Respiratory Conditions Including:

Chronic Sinusitis

Asthma

Allergies

Joint Conditions Including:

Knee, Shoulder or Spine

Autoimmune Conditions Including:

Diabetes Mellitus

Lupus

Rheumatoid Arthritis

Fibromyalgia

Thyroid Conditions Including:

Hashimotos

Hypothroidism

Hyperthyroidism

Developmental and Social Concerns

Autism

ADD/ADHD

Skin Conditions Including:

Eczema

Skin rashes

Hives

Circle the number that most closely fits, then add up your results

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
food allergies, sensitivities or intolerance	0	1	2	3
sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hay fever or Allergies	0	1	2	3
Poor Memory or Mood Swings	0	1	2	3
Use of NSAIDS	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol makes you feel sick	0	1	2	3
Gluten sensitivity/Celiac's	0	1	2	3
Nausea	0	1	2	3
Weight Issues	0	1	2	3

Your Total_____

HIGHER HEALTH

Consent to Initiate Care

I have been advised that chiropractic and wellness treatments and therapies, like all forms of healthcare, hold certain risks. Treatment objectives - as well as the risks associated with chiropractic adjustments and therapies, red light therapy, electronic nerve stimulation and nutritional therapy and all other procedures provided by Higher Health Chiropractic - have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and/or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Print name: _____

Signature: _____ **Date (dd/mm/yyyy):** _____

HIGHERHEALTH
CHIROPRACTIC & REHABILITATION