DR. CHRISTINE A. GRAMS, DC

ISLAND WELLNESS RESOURCES, PLLC

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PATIENT INTAKE FORM

General Information

Date: _____

Name: _____
First Middle Last

Address: _____
Street City State Zip

Phone: (Home) _____ (Work) _____ (Cell) _____

Email: _____OK to contact by email? **Y / N** OK to text appt reminders? **Y / N**

Date of Birth: _____ Age: _____

Employer: _____ Occupation: _____

Emergency Contact:_____Relation to you: _____Phone #:_____

How do you wish to be addressed in our office (e.g. nickname): _____

How did you hear about our office? _____

Any Major Complaints? _____

_____

When did this problem start? _____ Have you ever had it before? **Yes / No**

Payment Arrangements: Payment (Cash/Check/Credit Card) is expected at the time of service unless special arrangements are made in advance. I understand that I will be responsible for the full fee of the services if not covered by my insurance. I will pay for services regardless of how my insurance processes claims. Please check payment method:

[ ] Insurance billed with copay, coinsurance and deductible paid by patient
[ ] Auto accident or Personal Injury Claim
[ ] No Insurance / Visit paid for at time of service. (We accept, cash, checks or credit cards)

Cancellation/ No Show Policy: I understand that my appointment time is reserved for me. Should I need to cancel or reschedule an appointment, I must give at least 24 hours' notice to allow for that time to be given to someone else. Except for a bone fide emergency or illness, if I don't show for an appointment or have given less than 24 hours notice, I agree to pay the full rate of the scheduled treatment.

Client Signature: _____ Date:_____

Personal History

Have you ever had your spine or nervous system examined professionally? **Yes / No**

If yes, when and by whom? _____

Have you ever had X-rays, CAT Scans, or MRIs of your spine or Extremities? **Yes / No** _____ _____

Have you received chiropractic adjustments by a Doctor of Chiropractic? **Yes / No**

If yes, for how long? _____ How often did you go? _____

When was your last visit? _____ Why did you stop? _____

Were you pleased with his/her service? **Yes / No** _____

What type of adjustments, technique(s), or method(s) did he/she use (if known)? _____

Does your immediate family receive chiropractic adjustments?_____

Have you had, or do you receive, any of the following for growth and development?

Bodywork/Massage: **Yes / No** Osteopathy/Cranial work: **Yes / No** Prayer/Meditation: **Yes / No**

Psychotherapy: **Yes / No** Movement or Exercise: **Yes / No** Yoga: **Yes / No**

Pilates: **Yes / No** Other: **Yes / No**_____

Chiropractic practice is based upon the location and adjustment of vertebral subluxations. (Spinal) subluxations are caused by any stress your body can not properly perceive, adapt to or recover from. These stresses may be *physical*, *chemical*, or *emotional* in nature. The following questions will provide more clues about your unresolved stress levels.

General Physical Trauma

Take a few moments to reflect on your personal history before answering these questions, recalling any physical injuries you experienced since childhood.

Have you ever had any injuries that "took you out of commission" for a full day or more? **Yes / No**

Describe _____

Were you ever knocked unconscious? **Yes / No** Have you ever used crutches, a walker, or a cane? **Yes / No**

Have you ever broken any bones? **Yes / No** _____

Have you ever had any impacts, falls, or jolts that may have injured your head/spine? **Yes / No**

Have you had extensive dental or orthodontia work performed? **Yes / No**

Which of these describe your day? (circle all that apply) Sit Stand Walk Drive

Phone work Mechanical work Repetitive work Heavy lifting

How old is your mattress? _____ Is it comfortable? **Yes / No**

How old is your pillow? _____ Is it comfortable? **Yes / No**

What position do you sleep on? **Back / Stomach / Left Side / Right Side**

How often do you exercise? **Daily Weekly Monthly** Describe: _____

Medical Treatment

Have you ever had any of the following procedures? **Circle all that apply.**

Bone in cast / Immobilized	Chemotherapy	Traction	Transfusion X-ray treatments
Extensive diagnostic x-rays	Physical therapy	Neck collar	Corrective shoes or bars on shoes
Spinal brace	Spinal injections	Spinal tap	Heel lift

Have you ever been hospitalized? **Yes / No** When and what was done?_____

_____

Have you ever had surgery? **Yes / No** When and what was done? _____

Physical Stress

BIRTH HISTORY: (Please try to obtain this information. It is important to your care.)

Did your mother have a difficult pregnancy with you? **Yes / No**

Explain: _____

Did your mother have any falls, accidents, physical injuries, or illnesses during pregnancy? **Yes / No**

Explain: _____

Were you born at: Home / Hospital / Birthing Center. Were you Incubated or Isolated after birth? **Yes / No**

Was your delivery traumatic? (circle all that apply) Drug Induced labor Forceps or Suction C-Section

Cord around Neck Breech Prolonged Explain: _____

Were you (circle all that apply): Bottle Fed Formula Bottle Fed Mother's Milk Nursed

Food and Dietary Habits / Choices

Please indicate how often you consume the following: (**example 2x/day, 3x/week**)

Alcohol_____ Artificial Sweeteners_____ Beef_____ Butter_____ Carbonated Drinks_____

Coffee_____ (Reg or Decaf) Butter_____ Carbonated Drinks_____ Dairy (Milk Products)_____

Diet Food_____ Eggs_____ Fast Food_____ Fish_____ Fried Food_____ Fruit, Canned_____

Fruit, Fresh_____ Grains, Refined (white bread, pasta, etc)_____ Grains, Whole (pasta, bread, etc) _____

Margarine_____ Organic Foods_____ Pork_____ Poultry_____ Raw Food_____ Salt_____

Refined Sugar (Candy/Junk Food) Added_____ Seafood (Shrimp, Scallops, Etc.)_____ Tabacco_____

Vergetables, Canned/Frozen_____ Vegetables, Fresh_____ Water_____ Fasting_____

How would you rate your food habits? Excellent / Good / Fair / Poor

Are your food habits: Getting Better / About the Same / Getting Worse?

Bowel Movements (per Day / Week) _____ Urination (per Day)_____

Sports and Leisure

Were you previously active in any particular sports or hobbies? **Yes / No** Which ones? _____

_____

Are you currently active in any particular sports or hobbies? **Yes / No** Which ones? _____

_____

Have you been injured in any of these activities? **Yes / No** Comments: _____

_____

Are there activities for which you spend any length of time in a particular position(TV,reading, musician,etc)? **Yes / No**

Comments: _____ _____

Vehicular Accidents

Have you been involved in a vehicular collision/near collision, either as the driver or as a passenger, even if you do not think you were injured? **Yes / No**

Please list the approximate dates and severity **(Mild, Moderate, Extreme).**

Automobile: _____

Bus, Bicycle, Motorcycle, etc. _____

How do you rate your physical health since? **Excellent / Good / Fair / Poor**

Is it: **Getting Better / About the Same / Getting Worse**

Emotional Stress

Please circle the level of severity, and whether **P**ast (**P**) or **C**urrent (**C**), for each of the following spinal stress situations:

	Mild	Moderate	Extreme		Mild	Moderate	Extreme
Childhood Stress	**P / C**	**P / C**	**P / C**	Work Related Stress	**P / C**	**P / C**	**P / C**
School Stress	**P / C**	**P / C**	**P / C**	Stress of Commuting	**P / C**	**P / C**	**P / C**
Play or Recreation	**P / C**	**P / C**	**P / C**	Loss of Loved One	**P / C**	**P / C**	**P / C**
Family Stress	**P / C**	**P / C**	**P / C**	Change iin Lifestyle	**P / C**	**P / C**	**P / C**
Stress of Being Sick	**P / C**	**P / C**	**P / C**	Change in Vocation	**P / C**	**P / C**	**P / C**
Personal Relationships	**P / C**	**P / C**	**P / C**	Abuse (Physical, Emotional, Sexual)	**P / C**	**P / C**	**P / C**

How do you rate your Emotional/Mental Health? **Excellent / Good / Fair / Poor**

Do you feel it is getting: **Better / Worse**

Comments:_____

Patient Name / Date:_____

General Chemical Exposures / Use / Side Effects

Current smoking status? [ ] Don't smoke [ ] Current every day smoker [ ] Current some days smoker

Start Date: _____ Would you like cessation counseling / information on quitting smoking? **Yes / No**

[ ] Former smoker Start Date: _____ Quit Date: _____

[ ] Never smoked [ ] Decline to specify

Did you or do you work with any chemicals, fumes, dust, or smoke for long periods? **Yes / No**

Please list them _____

Please indicate any drugs you have taken in the **P**ast (**P**), or are **C**urrently taking (**C**):

Allergy/Cold/Flu	**P / C**	Blood Pressure Meds	**P / C**	Vaccinations	**P / C**
Antacids	**P / C**	Heart Medication	**P / C**	Other (Please List)	
Anti-Anxiety/Depression	**P / C**	Hormones	**P / C**	_____	**P / C**
Antibiotic/Antifungal	**P / C**	Laxatives	**P / C**	_____	**P / C**
Diabetic/Insulin	**P / C**	Lithium	**P / C**	_____	**P / C**
Anti-inflammatory/ Cortisone	**P / C**	Recreational	**P / C**	_____	**P / C**
Anti-parasite (Worms)	**P / C**	Relaxants/Sleeping Pills	**P / C**	_____	**P / C**
Aspirin/Tylenol/ Ibuprofen	**P / C**	Stimulants	**P / C**	_____	**P / C**
Birth Control Pills	**P / C**	Thyroid	**P / C**	_____	**P / C**
		Ulcer Medication	**P / C**		

Comments: _____

Do you have any sensitivities to scent?_____

Allergies? _____

Other

Is there anything else which may help us better understand you, which has not been covered in this form?

_____

_____

_____

_____

Name / contact info for your Primary Care Medical Provider: [ ] I do not currently have a Primary Care Doc

Name / Medical Group: _____

Address: _____

City, State: _____ Phone Number: _____

The following questions will not be disclosed unless specifically authorized by the patient with a written consent in addition to the "Notice of Patient Privacy Policy" (HIPAA consent).

Additional Social Information

Sex/Gender: [ ] Male [ ] Female [ ] Transgender [ ] Queer [ ] Decline

Relationship/Marital Status (circle): Single Married Partnered Living w/Partner Separated Divorced Widowed

Number of Children: _____ Children Ages: _____

Number of Animal Companions: _____ Specify: _____

What is your preferred speaking language? [ ] English [ ] Other (please specify):_____

What are your preferred pronouns for use in our office? (e.g. he/him, she/her, they/them, etc.): _____

Pregnancies

Number of Pregnancies _____ Number of Births _____

For each pregnancy, please complete. If you need more room, please use another sheet :

1. Your age_____ Preg outcome: Vaginal Delivery C-Section Chemically induced labor Miscarriage Preg. terminated
Any falls, accidents, injuries, illnesses, or other complications? _____

_____

2. Your age_____ Preg outcome: Vaginal Delivery C-Section Chemically induced labor Miscarriage Preg. terminated
Any falls, accidents, injuries, illnesses, or other complications? _____

_____

3. Your age_____ Preg outcome: Vaginal Delivery C-Section Chemically induced labor Miscarriage Preg. terminated
Any falls, accidents, injuries, illnesses, or other complications? _____

_____

Additional info: _____

_____

Reproductive / Hormone Medicaion Exposures

Please indicate any drugs you have taken in the **P**ast (**P**), or are **C**urrently taking (**C**):

Birth Control Pills / Devices	**P / C**	Other reproductive health medications	**P / C**
Hormones / HRT	**P / C**	Medications related to sexual function	**P / C**
Surgeries	**P / C**		

Additional info: _____

Reproductive and Gender-Related Injuries / Surgeries

Have you ever had any injuries affecting your internal or external reproductive organs? **Yes / No**
Describe:_____

Have you ever had any surgeries on your internal or external reproductive organs? **Yes / No**

Describe: _____

Additional info: _____