SWEETGRASS
CHIROPRACTIC
Your Family Health & Wellness Center

Today's Date: _____/_____/_____

How did you hear about our office?_____

Nickname or Preferred Name: _____ Suffix: _____

Patient's Legal Name:_____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____/_____/_____ Marital Status: Single Married Divorced Widow(ed)

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____ Email:_____

Employer: _____ Occupation: _____

Spouse Name: _____ Spouse Date of Birth: _____/_____/_____

Primary Care Physician (name & location): _____

_____

Complete below for patients under 18 years of age AND/OR covered by parents insurance:

Mother's Full Name:_____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____/_____/_____Phone:_____ Email:_____

Address (if different from child): _____

City: _____ State: _____ Zip Code: _____

Father's Full Name: _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____/_____/_____Phone:_____Email:_____

Address (if different from child): _____

City: _____ State: _____ Zip Code: _____

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All patients must complete intake forms to the best of their ability. Please fill out paperwork entirely. If you have any questions or need assistance, please let us know.

List **ALL** Surgeries and Procedures:

_____

_____

List **ALL** Health Conditions you have been diagnosed with:

_____

_____

List **ALL** Current Medications AND Supplements with dosages (if known):

_____

_____

CIRCLE your answer to the following questions:

Do you have any children? YES / NO *(if yes, how many? _____)*

Have you seen a chiropractor before? YES / NO (if yes, when was your last visit? _____)

Have you had an MRI, CT, DEXA, or X-RAYS in the last year? YES / NO

if yes, specify date and body region(s): _____

Are you interested in a FREE analysis of your current supplementation? YES / NO

Are you interested in learning more about WHOLE FOOD supplementation? YES / NO

Females Only:

Are you pregnant? YES / NO *(if yes, specify expected due date: _____)*

Is there any chance you may be pregnant? YES / NO

Are you trying to conceive? YES / NO

Are you currently taking birth control medication or utilizing other contraceptives? YES / NO

Males Only:

Do you have any past or current male reproductive conditions? YES / NO

Are you currently taking any hormone replacements (ex. testosterone)? YES / NO

SOCIAL HISTORY (Circle your answer OR Fill in the blanks):

Do you smoke or use other tobacco products? YES / NO

Do you use recreational substances? YES / NO

Do you drink alcohol? YES / NO (if yes, specify, specify amount: _____)

Do you exercise? YES / NO (if yes, specify type of exercise: _____)

Do you have any mental health or psychological disorders? YES / NO

Do you have any sleep complications? YES / NO

Do you consider yourself : HEALTHY MODERATELY HEALTHY UNHEALTHY

The worst/negative factors associated with your health?_____

The best/positive outcomes you want to see/achieve with your health care / what are your goals?

_____

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FAMILY HISTORY (Circle your answer):

Have any of your **immediate family members** been diagnosed with any of the following conditions?

CHECK all that apply:

- ☐ Heart Disease *(ex. heart attack, stroke)*
- ☐ High Blood Pressure (hypertension)
- ☐ Low Blood Pressure *(hypotension)*
- ☐ Diabetes *(type 1 or type 2)*
- ☐ Cancer - *if checked, specify:* _____
- ☐ Mental Health Disorders *(ex. Stress, Anxiety, Depression, PTSD, Personality Disorders)*
- ☐ Autoimmune Conditions *(ex. Lupus, Rheumatoid Arthritis, Hashimotos)*
- ☐ Neurological Conditions *(ex. Alzheimers, Parkinsons, Epilepsy)*
- ☐ Kidney Disease
- ☐ Asthma or other Respiratory Disorders
- ☐ Osteoporosis or Bone related Disorders
- ☐ Bleeding Disorders or Maternal Miscarriage?
- ☐ Other Hereditary Conditions - *if checked, specify:* _____

REASON FOR YOUR VISIT

What is your **PRIMARY (ONE)** complaint:

_____

_____

_____

How did it begin?_____When did it begin?_____

Have you been treated for this in the past? YES / NO

CIRCLE the following that apply to this complaint:

DESCRIBE your pain: Dull Aching Sharp Stabbing Burning Throbbing Stiffness Tingling

DURATION: Intermittent Occasional Frequent Constant Night Pain Morning Pain

PAIN: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (most severe)

AGGRAVATING FACTORS: Cough/Sneeze Lifting Sitting Standing Pushing Pulling Driving Walking Bending Lying Down Sleeping Bright Lights Noise Other:_____

RELIEVING FACTORS: Rest NSAIDS Pain Medication Ice Heat Sitting Standing Lying Down Legs Elevated Exercise Other:_____

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What is your **SECONDARY** complaint:

_____

_____

_____

How did it begin?_____When did it begin?_____

Have you been treated for this in the past? YES / NO

CIRCLE the following that apply to this complaint:

DESCRIBE your pain: Dull Aching Sharp Stabbing Burning Throbbing Stiffness Tingling

DURATION: Intermittent Occasional Frequent Constant Night Pain Morning Pain

PAIN SCALE: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (most severe)

AGGRAVATING FACTORS: Cough/Sneeze Lifting Sitting Standing Pushing Pulling Driving Walking Bending Lying Down Sleeping Bright Lights Noise Other: _____

RELIEVING FACTORS: Rest NSAIDS Pain Medication Ice Heat Sitting Standing Lying Down Legs Elevated Exercise Other: _____

What is your **THIRD** complaint, if any:

_____

_____

_____

How did it begin?_____When did it begin?_____

Have you been treated for this in the past? YES / NO

CIRCLE the following that apply to this complaint:

DESCRIBE your pain: Dull Aching Sharp Stabbing Burning Throbbing Stiffness Tingling

DURATION: Intermittent Occasional Frequent Constant Night Pain Morning Pain

PAIN SCALE: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (most severe)

AGGRAVATING FACTORS: Cough/Sneeze Lifting Sitting Standing Pushing Pulling Driving Walking Bending Lying Down Sleeping Bright Lights Noise Other: _____

RELIEVING FACTORS: Rest NSAIDS Pain Medication Ice Heat Sitting Standing Lying Down Legs Elevated Exercise Other: _____

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PHI AND HIPAA AUTHORIZATION RELEASE FORM

Please list anyone in your family, other than yourself, that we may disclose personal health information, appointment reminders, information about treatment or other health related services to:

_____	_____	_____/_____/_____
Name of Authorized Person	*Relationship*	*Date*
_____	_____	_____/_____/_____
Name of Authorized Person	*Relationship*	*Date*

The Health Professionals and staff of Sweetgrass Chiropractic are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. When the Health Professionals and staff use or disclose your "PHI" the Healthcare Professionals and staff are required to abide by the terms of this notice. Your "PHI" may be used and disclosed to provide treatment and other services to you-for example, to diagnose and treat your injury or illness. In addition, you may be contacted for appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Your "PHI" may be disclosed to other providers involved in your treatment.

HIPAA MEDICAL RELEASE AUTHORIZATION

I, the undersigned, hereby authorize Sweetgrass Health & Wellness and our licensed doctors to release and/or obtain my protected health information (PHI) as described below:

To obtain or share medical records for treatment, care coordination, and continuity of care. Medical records may include but are not limited to; medical history, diagnosis, treatment plans, diagnostic results (ex. Radiology findings, Blood labs, Urinary/stool labs, and procedure findings), progress notes and other relevant health information. This authorization will remain in effect until my treatment is completed or my relationship with Sweetgrass Health & Wellness closes.I understand that I have the right to revoke this authorization at any time by providing written notice to Sweetgrass Health & Wellness. Revocation of this authorization will not affect any action taken prior to the revocation.I understand that my health information is protected by federal law (HIPAA), and that any release of my information could potentially be subject to re-disclosure by the recipient. Once disclosed, this information may no longer be protected under HIPAA, but it will remain protected under state law. I also understand that I am not required to sign this authorization in order to receive treatment from Sweetgrass Health & Wellness.

By signing below, I authorize the release of my protected health information as described above. I have been provided with a copy of this form for my records.

Print Name of Patient: _____

Signature of Patient: _____

Date: _____/_____/_____ Phone Number: _____ Email: _____