BURTIS CHIROPRACTIC CENTER
PERSONAL INJURY WAIVER

TODAY'S DATE: _______________

First Name: _______________________ **Middle Name:**_________________ **Last Name:**___________________________

Address:____

City: ____ **State:**______________ **Zip:**___________________________

Home Phone: ______________________________________ **Cell Phone:** ____________________________________

Email: ____

Date of Birth: _______/__________/_______ **Social Security #:** _________-________-_____________

Gender: [male] or [female]

MARITAL STATUS: Single / Married / Divorced / Widowed / Other **MAIDEN NAME**: _____________________

Spouse's Name: ____________________________ Number of Children: ________________

I give my consent to receive appointment reminders by Email and Text Message: YES [ ] NO [ ]

EMERGENCY CONTACT

Name: _____________________________

Relationship: _________________________

Phone: _____________________________

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

Did someone refer you here? [YES] or [NO]

If yes, name: ____

Did you hear or see us in an Advertisement? [YES] or [NO]

If yes, where: ____

EMPLOYMENT (or parent's employment for minors)

Regular Work Status: (*circle one*)

EMPLOYED / PART-TIME EMPLOYED / RETIRED / UNEMPLOYED / FULL-TIME STUDENT / PART-TIME STUDENT

Employer/School Name: ____

Employer City and State: ____

Occupation: __________________________________ Employer Phone #:_________________________

PREVIOUS CHIROPRACTIC CARE EXPERIENCE

Have you had previous Chiropractic Care? [YES] or [NO]

If yes, reason for visit: ____ ____________________________

Doctor's name: _____________________________ Date of last chiropractic visit: _______________________________

CURRENT SYMPTOMS

Purpose of visit today: [ ] Wellness [ ] Complaint [ ] Injury [ ] Other: ___________________________

If an injury, where did the injury occur? [ ] Automobile [ ] Work [ ] 3rd Party Premise [ ] Other

Date of Injury: ______________________________

Location of Accident: ____

Were you the: [ ] DRIVER OR [ ] PASSENGER

Was anyone else with you in the vehicle: __________ Do you have insurance on your vehicle?__________

POLICY HOLDER: ________________________________ POLICY #: ______________________________

INSURANCE COMPANY: ____

ADDRESS: ____

CLAIM #: ____

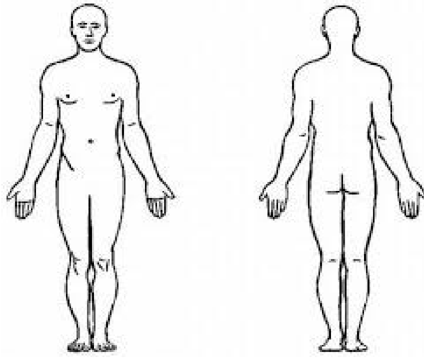
HAVE YOU RECEIVED CARE ANYWHERE ELSE? _________ YES _________ NO
IF YES – WHERE: _______________________ WERE X-RAYS TAKEN? _________ YES _________ NO

Describe how the injury happened: ____
____

____

Rate your pain on a scale of 1-10: (1 being the least pain and 10 is the maximum pain)
At its best: _____________ At its worse: ____________ Current level: ________________

Please indicate the areas affected by the injury:



Describe the pain/discomfort you are feeling and where: (i.e. numbness in right arm, shooting pains from hip down left leg, back pain more on left or right side)

____

____

____

Indicate the areas of your life it has impacted:
[ ] Work [ ] Daily Activities [ ] Sleep [ ] Appetite [ ] Other
Please describe: ____

Frequency you are experiencing pain from this condition?
[ ] Always [ ] Hourly [ ] Daily [ ] Occasionally

Has this concern:
[ ] Gotten Worse [ ] Stayed Constant [ ] Come and Gone

Have you reduced or limited your work hours because of this condition? [YES] or [NO]

If yes, explain: ____

Is your pain/discomfort worse at certain times of the day? [YES] or [NO]
If yes, when: ____

List anything that aggravates your condition: ____

____

List anything that relieves or improves your condition: ____

____

Have you seen any other doctors for this concern? [YES] or [NO]
If yes: Doctor's name: ______________________________ Where: ____
Type of Treatment: __________________________ X-rays/MRI taken? [YES] or [NO]
Results: [GOOD] [BAD] OR [INDIFFERENCE]

PERSONAL INCIDENT HISTORY

Broken any bones? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]
Briefly explain: ____

Had any major sprains or strains? [YES] or [NO]
If yes, did you get professional treatment? [YES] or [NO]
Briefly explain: ____

Been hospitalized? [YES] or [NO]
Briefly explain: ____

Had surgery? [YES] or [NO]
Briefly explain: ____

Been in a previous Auto Accident? [YES] or [NO]
If yes, did you get professional treatment? [YES] or [NO]
Briefly explain: ____

Been Struck Unconscious? [YES] or [NO]
If yes, did you get professional treatment? [YES] or [NO]
Briefly explain: ____

Been diagnosed with an eating disorder? [YES] or [NO]
Briefly explain: ____

Had a stroke? [YES] or [NO]
Briefly explain: ____

FAMILY HEALTH HISTORY

List diagnosed health conditions and untimely deaths of your blood-related family members:

(*Condition and relationship to you*) (ex: arthritis, cancer, diabetes, heart disease, high blood pressure)

____

____

SOCIAL HISTORY AND LIFE CHOICES

Alcohol:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Diet Food Products:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Energy Products & Over-the-Counter Stimulants:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Caffeine Drinks & Products:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Soft Drinks:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Water:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Fresh & Homemade Foods:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Preprocessed, Packaged, & Restaurant Food:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Exercise:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Tobacco:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never

HEALTH PROBLEMS AND CONCERNS

Please check all that you have had or currently have.

[ ] Allergies
[ ] Alcoholism
[ ] Anemia
[ ] Arteriosclerosis
[ ] Arthritis
[ ] Asthma
[ ] Autoimmune Disease
[ ] Back Pain
[ ] Bleeding Disorders
[ ] Breast Lump
[ ] Bronchitis
[ ] Bruise Easily
[ ] Cancer
[ ] Cataracts
[ ] Chest Pain
[ ] CHF (congestive heart disease)
[ ] Cold Extremities
[ ] Constipation
[ ] COPD/emphysema
[ ] CVA (stroke/TIA)

[ ] Cramps
[ ] Dementia/Alzheimer's
[ ] Depression
[ ] Diabetes
[ ] Digestion Problems
[ ] Diagnosed emotional/ mental disorders
[ ] Dizziness
[ ] Epilepsy
[ ] Excessive Menstruation
[ ] Eye Pain or Difficulties
[ ] Fatigue
[ ] Frequent Urination
[ ] Gallbladder disease/ stones
[ ] Glaucoma
[ ] Gout
[ ] Headache
[ ] Hemorrhoids
[ ] High Blood Pressure

[ ] Hot Flashes
[ ] Irregular Heart Beat
[ ] Irregular Menstrual Cycle
[ ] Kidney Infection
[ ] Kidney Stones
[ ] Liver disease/cirrhosis
[ ] Loss of Memory
[ ] Loss of Balance
[ ] Loss of Smell
[ ] Loss of Taste
[ ] Lung disease
[ ] Macular Degeneration
[ ] Migraines
[ ] Nosebleeds
[ ] Pacemaker
[ ] Parkinson's
[ ] Polio
[ ] Poor Posture
[ ] Prostate Trouble
[ ] Retinal Disease

[ ] Sciatica
[ ] Seizures
[ ] Shortness of Breath
[ ] Sinus Infection
[ ] Sleep Problems/Insomnia
[ ] Skin Sensitivity
[ ] Spinal Curvatures
[ ] Stroke
[ ] Swelling of Ankles
[ ] Swollen Joints
[ ] Thyroid Condition
[ ] Tuberculosis
[ ] Ulcers
[ ] Varicose Veins
[ ] Venereal Disease(STD)
[ ] Other:
____
____
____

AUTHORIZATION

I certify that I'm the patient or legal guardian listed below. I understand the information given on this intake form is true and accurate to the best of my knowledge. I consent to the collection and use of that information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand that if my account is inactive for 18 months any credit balance under the amount of $20.00 will not be reimbursed.

☐ I agree with this statement of authorization.

Name **(Please Print)**: ____

Patient's Signature: ____ **Date:** ______________