Gallatin Valley Chiropractic
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Patient Registration and History

Please take a moment to complete the following intake form so we may obtain all necessary information in regard to your care if you have any questions, please ask our office staff for assistance

General Information

Date ___/___/_____

Last Name_____ First Name_____ MI _____

Preferred Name (nickname)_____ Date of Birth ___ /___ /___ Age _____ ☐ Male ☐ Female

Street Address _____ City _____ State ____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Email _____

Employer/School _____ Work Phone (_____) _____

Occupation_____

Spouse/Partner's Name _____ Phone (____) _____

Emergency Contact _____ Relation _____ Phone (____) _____

How did you find out about our office?

□ Google

□ Referred by family/friend: _____

□ Referred by a healthcare provider: _____

□ Social Media post: _____

Insurance Information

Please present all insurance cards for photocopying

Current Health Insurance Coverage: ☐Health Insurance ☐ Medicare Medicaid None
Primary Health Insurance Carrier Name of insured:

Relation to insured: Insured DOB: / / Health Savings acct? ☐ yes ☐ no

Is your current condition related to a workplace injury or auto accident? ☐ yes ☐ no

Patient Health Questionnaire - p. 1

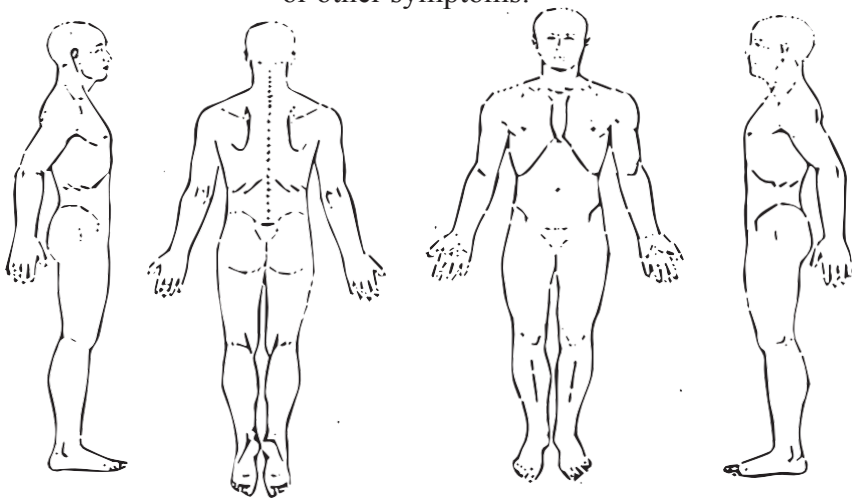
Patient Name_____ Date_____

1. When did your symptoms start: _____ Describe your symptoms and how they began:

_____

2. How often do you experience your symptoms?
   Constantly (76-100% of the day)
   Frequently (51-75% of the day)
   Occasionally (26-50% of the day)
   Intermittently (0-25% of the day)

Indicate on the diagram where you have pain or other symptoms:



3. What describes the nature of your symptoms?

□sharp	□ shooting
□dull ache	□ burning
□numb	□ tingling

4. Are your symptoms changing?
   □ getting better
   □ not changing
   □getting worse

5. How severe are your symptoms?

	none									unbearable
a. right now:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨ ⑩
a. at best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨ ⑩
a. at worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
no complaints		limiting, prevents full activity		intense, preoccupied with seeking relief		severe, no activity possible			

7. What activities make your symptoms worse: _____
8. What activities make your symptoms better: _____
9. Who have you seen for your symptoms? □ No one □ Medical Doctor □ Other_____
   □ Other Chiropractor □ Physical Therapist

   a. When and what treatment? _____

   b. What tests have you had for your symptoms and when were they performed? □X-Rays date:_____ □ CT Scan date:_____ □ MRI date:_____ □Other date:_____

10. Have you had similar symptoms in the past? □ Yes □ No
    a. if you have received treatment in the past for the same or similar symptoms, who did you see? □ Other chiropractor □ Medical Doctor □ This office □ Physical Therapist

11. What is your occupation _____
    _____
    □ Professional Executive □ Laborer □ Retired
    □ White Collar/Secretarial □ Homemaker □ Other
    □ Tradesperson □ FT Student □ Unemployed

12. What do you hope to get fro your visit/treatment? (select all that apply)
    □ Reduce Symptoms □ Explanation of condition/treatment □ How to prevent this from occurring again
    □ Resume/increase activity □ Learn how to take care of this on my own □ Other:_____

Patient Signature:_____ Date:_____

Patient Health Questionnaire - p. 2

Patient Name_____ Date _____
What type of regular exercise do you perform: □ none □ Light □ Moderate □ Strenuous

What is your height and weight? Height: ____ft._____in. Weight: _____lbs.

For each of the conditions listed below, place a check in the past column if you had the condition in the past.
If you presently have a condition listed below, place a check in the present column.

Past	Present	
□	□	Headaches
□	□	Neck pain
□	□	Upper back pain
□	□	Mid back pain
□	□	Low back pain
□	□	Shoulder pain
□	□	Elbow/upper arm pain
□	□	Wrist pain
□	□	Hand pain
□	□	Hip/upper leg pain
□	□	Knee/lower leg pain
□	□	Ankle/foot pain
□	□	Jaw pain
□	□	Joint swelling/stiffness
□	□	Arthritis
□	□	Rheumatoid arthritis
□	□	General fatigue
□	□	Muscular incoordination
□	□	Visual disturbances
□	□	Dizziness

Past	Present	
□	□	High blood pressure
□	□	Heart attack
□	□	Chest pains
□	□	Stroke
□	□	Angina
□	□	Kidney stones
□	□	Kidney disorders
□	□	Bladder infection
□	□	Painful urination
□	□	Loss of bladder control
□	□	Prostate problems
□	□	Abnormal weight gain/loss
□	□	Loss of appetite
□	□	Abdominal pain
□	□	Ulcer
□	□	Hepatitis
□	□	Liver/Gall bladder disorder
□	□	Cancer
□	□	Tumor
□	□	Asthma
□	□	Chronic sinusitis

Past	Present	
□	□	Diabetes
□	□	Excessive Thirst
□	□	Frequent Urination
□	□	Smoking/Tobacco Products
□	□	Drug/Alcohol dependence
□	□	Allergies
□	□	Depression
□	□	Systemic lupus
□	□	Epilepsy
□	□	Dermatitis/Eczema/Rash
□	□	HIV/AIDS

Females only:

□	□	Birth Control
□	□	Hormone Replacement
□	□	Pregnancy

Other health problems/issues

□ □ _____

□ □ _____

□ □ _____

Indicate if an immediate family member has had any of the following:

□Rheumatoid Arthritis □ Heart problems □ Diabetes □ Cancer □ Lupus □ _____
List all prescription and over the counter medications, and nutritional/herbal supplements you are taking

List all the surgical procedures you have had and the times you have been hospitalized:

Patient Signature:_____ Date _____

Patient Name: _____

Authorization and Release/HIPAA Acknowledgement

I authorize the release of my or my child's health information, including diagnosis, treatment, and examination records, to third-party payers and/or health practitioners. I authorize my insurance company to pay benefits directly to the doctor. I understand that insurance benefit quotes are not a payment guarantee, and I am responsible for all charges for services rendered, regardless of insurance coverage. I agree to notify the office of any insurance changes affecting claims or payments. Payment in full is due at the time of service unless other arrangements are made.

I have also received or declined the opportunity to review the notice of privacy practices.

Signature of Patient or Guardian: _____ Date: _____

Informed Consent for Chiropractic Treatment

I consent to chiropractic treatments, including adjustments, physical examinations, diagnostic testing, x-rays, and physical therapy. I understand that risks, though rare, may include soreness, soft tissue injury, dislocation, fractures, or, in extremely rare cases, arterial injuries leading to complications such as stroke. I rely on the doctor to exercise professional judgment in my best interest. I acknowledge that chiropractic care does not guarantee a cure for any condition. I have been informed of and accept these risks.

(If applicable) As the parent or legal guardian of _____, I consent to chiropractic treatments for my child.

Signature of Patient or Guardian: _____ Date: _____

Family/Spouse Records Release (optional)

If you wish to have your medical or financial information released to any person or family members(this includes spouses). You must add them here to authorize the release of your information to them. **I authorize Gallatin Valley Chiropractic LLC to release my records to the following individuals:**

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

3. _____ Relation to Patient:_____