River Valley Chiropractic

104 Burnside Ave S Red Wing, MN

Intake Form

Name: _____ **Date:** _____

Nickname: _____ **Date of Birth:** _____ **Age:** _____ **Sex: M** ☐ **F** ☐

Address: _____

City: _____ **State:** _____ **Zip:** _____

Mobile Phone #: _____ **Home Phone #:** _____

Email Address: _____

Occupation (Current or Previous): _____ **Retired: Yes / No**

Current or Previous Work Type: Clerical – Y / N Light Labor – Y / N Moderate Labor – Y / N Heavy Labor – Y / N

Spouse's Name: _____ **Marital Status: S M D W** **# of Children:** _____

In Case of Emergency: Contact Name: _____ **Phone #:** _____

How did you hear about our office? _____

What is your main health concern / condition coming in today?

_____

Please check all that apply:

☐ Foot Pain	☐ Low Back Pain	☐ Bulging Disc	☐ High Blood Pressure	☐ Neck Pain
☐ Foot Numbness	☐ Sciatica	☐ Joint Replacement	☐ High Cholesterol	☐ Morton's Neuroma
☐ Foot Surgery	☐ Pinched Nerve	☐ Falls	☐ Diabetes	
☐ Leg Pain	☐ Herniated Disc	☐ Balance Issues	☐ Plantar Fasciitis	☐ Charley Horses
☐ Hand Pain	☐ Spinal Stenosis	☐ Poor Circulation	☐ Cancer	☐ Restless legs
☐ Hand Numbness	☐ Spinal Arthritis	☐ Poor Wound Healing	☐ Chemotherapy	☐ Restless feet
☐ Arthritis in Hands/Feet	☐ Degenerative Disc Disease	☐ Pacemaker/Defibrillator	☐ Implanted Cord / Bladder Stimulator	

When did this begin? _____

What makes it worse? _____

What makes it better? _____

On a scale of 1 – 10; how committed and serious are you about fixing your condition?

Not Serious 0 1 2 3 4 5 6 7 8 9 10 Totally Committed

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How would you describe your symptoms? *(Circle any that apply)*

| Sharp Pain | Stabbing Pain | Aching Pain | Throbbing Pain | Numbness | Tiredness |

| Heavy Feeling | Dead Feeling | Swelling | Electric Shocks | Pins & Needles | Tingling |

| Cramping | Imbalance / Falls | Burning | Hot Sensation | Cold Hands / Feet |

Are your Symptoms over time *(Please Circle)*: Worsening Staying the Same Improving

Frequency of your Pain:

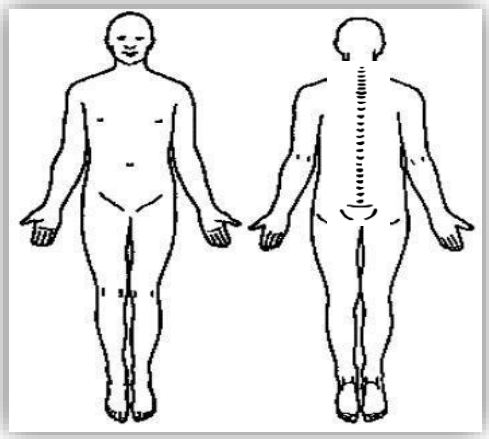
Constant (75-100%) ___ Frequent (51-75%) ___ Occasional (25-50%) ___ Intermittent (0-25%) ___

On average what level would you rate your overall pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Is this condition interfering with any of the following? *(Circle any that apply)*

| Daily Activities | Hobbies | Walking | Standing | Work | Sleep | Relationships | Sex Life |



Please indicate on this drawing the area(s) where you are currently experiencing symptom(s):

Please circle the things you have used / tried to relieve your symptoms:

| Gabapentin | Amitriptyline | Neurontin | Cymbalta | Lyrica | Opioids | Injections |

| Aleve / Naproxen | Tylenol / Acetaminophen | Advil / Ibuprofen | Motrin |

| Creams | CBD / Hemp Products | Chiropractic | Physical Therapy | Massage Therapy |

Other: _____

Were you aware that • Doctors of Chiropractic work with the nervous system? Yes No

The nervous system controls all bodily functions and systems? Yes No

Chiropractic is the largest natural healing profession in the world? Yes No

If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

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Please list any / all prescription medications you are currently taking (or you may attach a list):

Name	Dosage per Day

Please list any / all supplements (vitamins, minerals, herbs, homeopathic, etc.) you are currently taking:

Name	Dosage per Day

Do you smoke? No Yes How Much_____
Do you drink alcohol? No Yes How Much_____
Do you drink coffee? No Yes How Much_____
Do you drink pop? No Yes How Much_____
Do you exercise regularly? No Yes Strenuous Moderate Light
Are you exposed to toxic chemicals? No Yes List_____
Do you have any Air borne allergies? No Yes List_____
Do you have any food allergies? No Yes List_____
Do you wear: Heel lifts Sole lifts Inner soles Arch supports
Rate your overall health: Excellent Very good Fair Poor

On a scale of 1-10 describe your stress level (1=none / 10=extreme) Occupational_____Personal_____

Who referred you to this office? _____
Have you been adjusted by a Chiropractor before? Yes No
Reason for those visits? _____
Doctor's name_____
Approximate date of last visit _____
Has any adult in your family seen a Chiropractor? Yes No
Has any child in your family seen a Chiropractor? Yes No

- I hereby authorize release of any medical information necessary to evaluate my case to River Valley Chiropractic.
- I understand that River Valley Chiropractic cannot file the Neuropathy treatments to insurance at this time.
- River Valley Chiropractic will not enter into any dispute with your insurance company. If there is a discrepancy, it is the patients' responsibility to contact their insurance.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

Signature: _____ Date: _____

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FUNCTIONAL GOALS SURVEY

Please take several minutes to answer these questions so we can help you get better.

How many doctors have you seen for this condition? _____

What medications/supplements/therapies/treatments did they prescribe/recommend for you?

_____

_____

_____

_____

_____

Has what you've done to date for your condition helped?

☐ **Yes, a lot** ☐ **Yes, some** ☐ **No, not at all** ☐ **Indifferent**

What are 3 – 5 activities you can no longer do or are struggling to do because of this condition? *Please be specific.*

1._____
2._____
3._____
4._____
5._____

What is your honest vision of your life in the next few years if this problem continues to progress? _____

_____

_____

What would be different &/or better in your life without this problem? Please be specific.

_____

_____

_____

What is your biggest fear if this condition continues to progress? _____

_____

_____

_____

What would success mean to you in our office? _____

_____

_____

_____