Initials _____

Dr. Bridget Farrar - Dr. Vincent Farrar
(904)718-6330
2370 3rd Street South Jacksonville Beach, FL 32250
info@slaintechiropractic.com

Sláinte CHIROPRACTIC
ADJUST • ALIGN • ABIDE

ADULT INTAKE PAPERWORK

Discover Your True Health Potential

Welcome to Sláinte Chiropractic!

- Initial the top right corner of each page.
- Complete all questions. (For any question that does not apply to you, respond "N/A" for Not Applicable.)

1. **Today's Date:** _____
2. **Have you ever received chiropractic care?** ☐ No ☐ Yes, **(As an):** ☐ Infant ☐ Child ☐ Adolescent ☐ Adult
   Approximate length of your care: _____Years _____Months _____Weeks _____Days
   Were x-rays taken? ☐ No ☐ Yes, **(Year taken):** _____
   Include the doctor's name: _____
3. **Who may we thank for referring you to our office?** _____

PERSONAL INFORMATION

4. **Full Name:** _____ **Preferred Name:** _____
5. **Date of Birth:** _____ **Age:** _____ **Gender:** ☐ Male ☐ Female
6. **Street Address:** _____
7. **City:** _____ **State:** _____ **Zip:** _____
8. **Cell Phone:** _____ **Cell Phone Provider:** _____
9. **Home Phone:** _____ **Work Phone:** _____
10. **Email:** _____
11. **Occupation:** _____ **Employer:** _____
12. **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____
13. **Full Name of Spouse:** _____ **Phone:** _____
14. **Spouse's Occupation:** _____ **Spouse's Employer:** _____
15. **Name of Emergency Contact** ☐ My Spouse ☐ Other: _____
    His or Her relationship to you: _____ **Phone:** _____
16. **Who is responsible for your finances?** ☐ Myself ☐ Both Myself & My Spouse ☐ My Spouse
    ☐ My Parent(s) / Guardian(s) ☐ Other: _____ **Phone:** _____
17. **Name(s) & age(s) of your children:** _____
    _____

INSURANCE INFORMATION

18. **Select which is true for you:** ☐ Self Pay ☐ Insured with Medicare, **(Record your Medicare insurance information):**

Primary Insurance: _____	Secondary Insurance: _____
Member ID #: _____	Member ID #: _____
Policy Holder's Name: _____	Policy Holder's Name: _____
Policy Holder's Date of Birth: _____	Policy Holder's Date of Birth: _____

HEALTH GOALS

19. **Select all of your current health and lifestyle goals:**

☐ Relieve Pain / Discomfort
☐ Relieve Muscle Tension
☐ Improve Mobility / Flexibility
☐ Improve Posture
☐ Restore Proper Function
☐ Strengthen Immune System
☐ Restore Emotional Health
☐ Increase Self Confidence
☐ Improve Focus / Concentration
☐ Improve Mood / Temperament
☐ Increase Energy
☐ Increase Exercise
☐ Get Adequate Sleep
☐ Drink More Water
☐ Improve Diet / Nutrition
☐ Maintain Healthy Body Weight
☐ Improve Athletic Performance
☐ Reduce Medication(s)
☐ Fertility Support
☐ Pregnancy Care
☐ Return to work
☐ Financial Stability
☐ Treat Injury: _____
☐ Treat Illness: _____
☐ Quit Unhealthy Habit: _____
☐ Other: _____

Initials _____

CASE HISTORY & LIFESTYLE

20. Do you have any genetic disorders or disabilities? ☐ No ☐ Yes, **(Explain):** _____

_____

21. Have you ever had a serious illness, operation, or health emergency?
☐ No ☐ Yes, **(List all and include the year):** _____

_____

_____

22. Have you ever been in an auto accident? ☐ No ☐ Yes, **(Include the year):** _____

23. Have you ever been unconscious as a result of an injury, illness, or bodily dysfunction?
☐ No ☐ Yes, **(Explain):** _____

24. Have you ever fractured a bone? ☐ No ☐ Yes, **(Explain):** _____

_____

25. Do you have any allergies? ☐ No ☐ Yes, **(Explain):** _____

26. How often do you smoke? ☐ Never ☐ In The Past ☐ Occasionally ☐ _____times per week ☐ Daily

27. Are you regularly exposed to secondhand smoke? ☐ No ☐ Yes, **(Explain):** _____

28. How often do you drink alcohol? ☐ Never ☐ In The Past ☐ Occasionally ☐ _____times per week ☐ Daily

29. Have you ever taken an antibiotic drug? ☐ No ☐ Yes, **(Approximate date last taken):** _____

30. Have you received any vaccines? ☐ No ☐ Yes, **(Check all that apply):** ☐ During childhood ☐ During adulthood

31. Are you taking any over-the-counter / prescription drug, vitamin / supplement, or natural remedy?
☐ No ☐ Yes, **(List the name & reason for taking):** _____

_____

_____

32. Do you experience any social, behavioral, or emotional issues? ☐ No ☐ Yes, **(Explain):** _____

_____

33. Do you have any trouble sleeping? ☐ No ☐ Yes, **(Explain):** _____

_____

34. Have you served in the US Military? ☐ No ☐ Yes
(Check all branches of service that apply): ☐ Army ☐ Marine Corps ☐ Navy ☐ Air Force ☐ Coast Guard
(Check your current status): ☐ Active Duty ☐ Reserve ☐ National Guard ☐ Retired ☐ Veteran ☐ Student

35. Select all electronic devices that you use on a daily basis, (Include your typical length of use):
☐ Computer:_____ hour(s) ☐ Smart Phone:_____ hour(s) ☐ Tablet:_____ hour(s) ☐ Television:_____hour(s)

36. What is your typical daily work activity? (Check all that apply): ☐ Working At A Computer: _____Hours
☐ Excessive Sitting: _____Hours ☐ Excessive Standing: _____Hours ☐ Excessive Driving: _____Hours
☐ Light Lifting: _____lbs. ☐ Heavy Lifting: _____lbs. ☐ Low Stress ☐ Moderate Stress ☐ High Stress
☐ Manual Labor, **(Explain):** _____
☐ Operating Machines / Equipment, **(Explain):** _____
☐ Physical Repetition, **(Explain):** _____
☐ High Volume Social Interactions, **(Explain):** _____
☐ Other, **(Explain):** _____

37. Do you have any digestive issues? ☐ No ☐ Yes, **(Check all that apply):**

☐ Abdominal Pain / Cramps	☐ Constipation	☐ Heartburn / GERD
☐ Acid Reflux	☐ Diarrhea	☐ Nausea / Vomiting
☐ Bad Breath	☐ Foul-Smelling Stool	☐ Painful Bowel Movements
☐ Bloating	☐ Gas	☐ Selective / Picky Eater
☐ A Sensitivity To:_____	☐ A Digestive Disease / Disorder:_____	

38. How many days per week do you typically eat the following types of food?

_____ Leafy Green Vegetables	_____ Soy	_____ Fats / Oils
_____ Starchy Vegetables	_____ Eggs	_____ Fried Foods
_____ Fresh Fruits	_____ Dairy	_____ Processed Foods
_____ Dried Fruits	_____ Bread / Grains	_____ Caffeinated Beverages
_____ Meat / Poultry	_____ Beans / Legumes	_____ Juices / Sugared Beverages
_____ Seafood	_____ Nuts / Seeds	_____ Artificial Sweeteners / Added Sugars

39. Record your current weight & height. Weight: _____lbs. **Height:** _____ft. _____in.

40. How often do you exercise? ☐ Never ☐ In The Past ☐ Occasionally ☐ _____times per week ☐ Daily

41. List your regular physical activities: _____

42. List your hobbies & interests: _____

Initials _____

CURRENT SYMPTOMS

43. Review the symptoms / conditions listed below and select all those that you currently experience.

- ☐ Acid Reflux
- ☐ ADHD / ADD
- ☐ Allergies
- ☐ Ankle / Foot Pain
- ☐ Anxiety
- ☐ Arm Pain
- ☐ Arthritis / Joint Pain
- ☐ Asthma
- ☐ Athletic Injury
- ☐ Autism Spectrum
- ☐ Auto Accident
- ☐ Cancer
- ☐ Carpal Tunnel
- ☐ Chest Pain
- ☐ Chronic Cold / Flu
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Digestive Problems
- ☐ Disc Problems
- ☐ Dizziness
- ☐ Ear Pain
- ☐ Elbow Pain
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gallbladder Problems
- ☐ Headaches / Migraines
- ☐ Hearing Problems
- ☐ Heart Problems
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ Infertility
- ☐ Irritable Bowel
- ☐ Kidney Problems
- ☐ Knee Pain
- ☐ Leg Pain / Cramp
- ☐ Liver Problems
- ☐ Low Back Pain
- ☐ Low Blood Pressure
- ☐ Lung / Respiratory Problems
- ☐ Menstrual Problems
- ☐ Mid Back Pain
- ☐ Muscle Spasm
- ☐ Nausea
- ☐ Neck Pain
- ☐ Nosebleeds
- ☐ Numbness / Tingling
- ☐ Pancreas Problems
- ☐ Poor Posture
- ☐ Reproductive Problems
- ☐ Restless Sleep
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shallow Breathing
- ☐ Shoulder Pain
- ☐ Sinus Problems
- ☐ Skin Problems
- ☐ Sports Injury
- ☐ Stiffness
- ☐ Stomach Problems
- ☐ Stress
- ☐ Swelling Legs / Feet
- ☐ Thyroid Problems
- ☐ Tight Muscles
- ☐ TMJ (Jaw Pain)
- ☐ Ulcers
- ☐ Upper Back Pain
- ☐ Urinary Problems
- ☐ Vertigo
- ☐ Vision Problems
- ☐ Wrist / Hand Pain
- ☐ Other: _____ _____

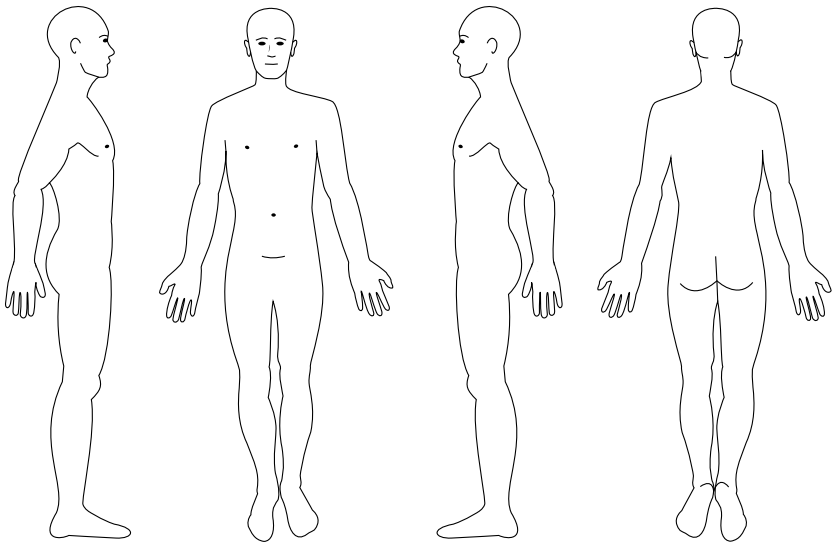
☐ I **DO NOT** have any of the symptoms / conditions listed above. **(If selected, skip ahead to page 4.)**

44. Based on your answer to the question above, list the three symptoms / conditions that you experience most. 1st: _____ **2nd:** _____ **3rd:** _____

45. In the diagram below, use the symbols provided to mark the figures in relation to where you experience symptoms on your body.

SYMBOLS

- A = Dull Ache
- B = Burning
- D = Deep Boring Pain
- E = Sensitive / Tender
- F = Stiff / Tight
- N = Numb
- P = Pressure
- R = Radiating
- S = Sharp / Stabbing
- T = Tingling
- U = Pounding
- X = Excruciating Pain
- O = Other: _____



46. When did your symptom(s) begin? _____Years Ago _____Months Ago _____Weeks Ago _____Days Ago

47. Did your symptom(s) begin as a result of an injury? ☐ No ☐ Yes, **(Explain):** _____

_____

48. Since first noticing the symptom(s), is it: ☐ Getting Better ☐ Staying The Same ☐ Getting Worse

49. When do you experience your symptom(s): ☐ Morning ☐ Afternoon ☐ Night ☐ Constant All Day

☐ Comes & Goes During The Day ☐ Increases During The Day ☐ Decreases During The Day ☐ During Sleep

☐ Only During Specific Activities, **(Explain):** _____

50. Does your symptom(s) move or travel from one area of your body to another? ☐ No ☐ Yes, **(Explain):**

_____

51. What have you already tried that HAS NOT helped to relieve your symptom(s)? _____

_____

52. What have you already tried that HAS helped to relieve your symptom(s)? _____

_____

Initials _____

INITIAL ASSESSMENT

53. NAME: _____ **DATE:** _____

54. Select all emotional, physical, and chemical stress that you have experienced in the past 3 months.

☐ Lack of Sleep	☐ Increase In Exercise	☐ Anxiety	☐ Social / Relational Stress
☐ Poor Diet / Nutrition	☐ Decrease In Exercise	☐ Depression	☐ Death of A Loved One
☐ Poor Water Intake	☐ Lack Of Energy	☐ Overwhelmed	☐ Hospitalization
☐ Slip / Fall	☐ Excessive Sitting	☐ Financial Stress	☐ Surgery / Operation
☐ Sports Injury	☐ Excessive Standing	☐ Occupational Stress	☐ Increase In Medication
☐ Pregnancy / Labor	☐ 12+ Hour Work Days	☐ Academic Stress	☐ Decrease In Medication

☐ Other: _____

55. Use the following 0 -10 scale of discomfort to answer the remaining questions on this page.

NONE	MILD			MODERATE			LIMITING			SEVERE
0	1	2	3	4	5	6	7	8	9	10
										
I am free from any symptom. I can do all my daily activities. My quality of life is great.	I barely notice the symptom, but when I do, it causes me some discomfort. I can do most of my daily activities. My quality of life is good.			I notice the symptom and it causes me discomfort. I can only ignore the symptom for a short period of time. I can do some of my daily activities. My quality of life is okay.			I am in constant distress from the symptom. It disrupts my ability to think, work, and maintain social relationships. I can not do many of my daily activities. My quality of life is poor.			I am in excruciating pain from the symptom and it causes me agony. I am ill, delirious, and / or bedridden. I can not do any of my daily activities. My quality of life is miserable.

56. Select which statement is true for you.

☐ I **DO** experience symptoms. **(If selected, complete the remaining questions on this page.)**

☐ I **DO NOT** experience symptoms. **(If selected, skip ahead to page 5.)**

57. Write your 1st symptom here:

Place an "X" in the box to rate your answer to each question below.	0	1	2	3	4	5	6	7	8	9	10
Rate your discomfort from the symptom RIGHT NOW.											
Rate your discomfort from the symptom ON AVERAGE.											
Rate how close to "0" your discomfort gets AT BEST.											
Rate how close to "10" your discomfort gets AT WORST.											

58. If you have a 2nd symptom write it here:

Place an "X" in the box to rate your answer to each question below.	0	1	2	3	4	5	6	7	8	9	10
Rate your discomfort from the symptom RIGHT NOW.											
Rate your discomfort from the symptom ON AVERAGE.											
Rate how close to "0" your discomfort gets AT BEST.											
Rate how close to "10" your discomfort gets AT WORST.											

59. If you have a 3rd symptom write it here:

Place an "X" in the box to rate your answer to each question below.	0	1	2	3	4	5	6	7	8	9	10
Rate your discomfort from the symptom RIGHT NOW.											
Rate your discomfort from the symptom ON AVERAGE.											
Rate how close to "0" your discomfort gets AT BEST.											
Rate how close to "10" your discomfort gets AT WORST.											

*** If you have more symptoms, simply ask a team member at the office for another form.**

Initials _____

ACTIVITIES OF DAILY LIVING

60. Use the 0 -10 scale to rate your level of discomfort when doing the activities listed below.

- Place an "X" in the box to mark your rating. (Mark the "N/A" box for any activity Not Applicable to you.)

NONE	MILD			MODERATE			LIMITING			SEVERE
0	1	2	3	4	5	6	7	8	9	10
										

PERSONAL HYGIENE & DAILY CARE

ACTIVITY	RATING											ADDITIONAL NOTES:
	0	1	2	3	4	5	6	7	8	9	10	N/A	
Bathing / Showering													
Grooming Hair													
Brushing Teeth													
Using The Toilet													
Dressing The Upper Body													
Dressing The Lower Body													

DAILY PHYSICAL ACTIVITIES

ACTIVITY	RATING											ADDITIONAL NOTES:
	0	1	2	3	4	5	6	7	8	9	10	N/A	
Standing													
Walking													
Sitting													
Squatting													
Kneeling													
Reaching Overhead													
Bending Forward													
Turning Left													
Turning Right													
Move From Lying To Sitting													
Move From Sitting To Standing													
Move From Standing To Sitting													

FUNCTIONAL ACTIVITIES

ACTIVITY	RATING											ADDITIONAL NOTES:
	0	1	2	3	4	5	6	7	8	9	10	N/A	
Sleeping													
Eating													
Going Up & Down Stairs													
Getting In & Out Of Car													
Driving													
Using A Computer													
Focusing / Concentrating													
Preparing Food													
Household Chores													
Lifting Children													
Carrying Bag / Purse													

SOCIAL, RECREATIONAL, & OTHER ACTIVITIES

ACTIVITY												ADDITIONAL NOTES:
	0	1	2	3	4	5	6	7	8	9	10	N/A	
Running / Hiking													
Sexual Activity													
Hobbies / Other													

Initials _____

FAMILY HEALTH HISTORY

61. Place an "X" in the box below to show if you or your family members have ever had the following conditions.

- **If there is more than one family member per category, use an "X" to represent each individual.**
- **If you are helping someone fill out this form, use "SELF" to represent his or her conditions.**

62. Are you adopted? ☐ No ☐ Yes, **(Complete the "SELF" column below and any other column if applicable.)**

CONDITION	SELF	SPOUSE	SON(S)	DAUGHTER(S)	FATHER	MOTHER	SIBLING(S)
Acid Reflux / Heartburn / GERD							
ADD / ADHD							
Allergies							
Anxiety							
Arthritis / Joint Pain							
Asthma / Difficulty Breathing							
Bed Wetting							
Birth Defect							
Cancer							
Colic							
Convulsions / Epilepsy							
Depression							
Diabetes							
Digestive Problems							
Disc Problems							
Ear Problems / Hearing Loss							
Family Member Is Deceased							
Fibromyalgia / Muscle Pain							
Frequent Cold / Flu							
Gall Bladder Problems							
Headache / Migraines							
Heart Problems							
High / Low Blood Pressure							
HIV / AIDS							
Impotence / Sexual Dysfunction							
Kidney Problems							
Learning Disability							
Liver Problems							
Menstrual Dysfunction							
Mood Changes / Irritable							
Neck Pain / Back Pain							
Prostate Problems							
Sciatica							
Scoliosis							
Sinus / Drainage Problems							
Skin Problems							
Sleep Problems							
Thyroid Problems							
Tremors							
Vertigo / Dizziness							
Vision Problems							
Other:							

Initials _____

TERMS OF ACCEPTANCE

At Sláinte Chiropractic we refer to you as a "Practice Member" instead of a "patient". The term "patient" refers to a sick person who is suffering from illness or injury. The term "Practice Member" refers to an active participant who is seeking health and wellness. As a Practice Member, you are invited to ask questions and to communicate any concerns. Please complete your intake paperwork in-full to provide us with your health history. A complete analysis of your spine will take place to detect the presence of nerve interference. Your doctor will provide you with a care plan to monitor and measure your progress. You can expect quality service and leadership from Sláinte Chiropractic as you regain control of your health. Please read and sign this form stating that you understand the items explained below. If anything is unclear please ask questions before you sign. If you refuse to sign this form, the doctor reserves the right to refuse care.

THE PHASES OF CHIROPRACTIC CARE:

RELIEVE	RESTORE	RENEW
Feel better. Begin the healing process. Expect a persistent visit frequency.	Live better. Stabilize the healing process. Expect a consistent Visit Frequency.	Perform better. Maximize the healing process. Expect a maintenance visit frequency.

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby consent to give Sláinte Chiropractic permission and authority to care for me. This includes the doctor of chiropractic and anyone working within the Sláinte Chiropractic office, authorized by the doctor. Chiropractic tests, diagnosis, analysis, and adjustments are safe and beneficial and rarely cause any risks. In rare cases, underlying physical defects, deformities or pathologies may make the Practice Member prone to injury. It is the responsibility of the practice member to make it known, or to learn through health care procedures if he or she is suffering from latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the chiropractor. The doctor of chiropractic will not give any treatment or care if he or she is aware that such care should not be used for a particular condition or circumstance. Your doctor of chiropractic is a licensed primary care provider. He/she is available to work with all other types of providers. I understand that if I am accepted as a Practice Member at Sláinte Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. I understand that following the doctor's recommended care plan is essential to maximizing my healing and reaching optimal health through chiropractic. Furthermore, any questions that I have regarding chiropractic care, will be explained to me upon my request.

AUTHORIZATION FOR X-RAYS

Specific postural x-rays may be necessary for identifying the location, type, and severity of vertebral subluxation, as well as for the diagnosis and identification of latent or dangerous conditions requiring medical attention. X-rays may also be used to show progress after a period of recommended chiropractic care. At your request, you can receive a copy of your x-rays to a disc for the fee of $15.00. By signing this page below, I authorize Sláinte Chiropractic to perform diagnostic x-rays of me **EXCEPT** if I am pregnant as indicated below.

63. Females, select which statement is true for you:

☐ I **AM NOT** pregnant at this time, to the best of my knowledge.

☐ I **AM** pregnant, or believe that I may be pregnant at this time. Therefore I **DO NOT** authorize Sláinte Chiropractic to perform diagnostic x-rays of me.

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFIT

By signing below, I recognize that I am financially responsible for all services rendered to me regardless of insurance or benefit. I understand that Sláinte Chiropractic, is primarily a cash-office and that I will have to pay for the full cost for services up front. I understand that I am responsible for submitting any insurance claim to request reimbursement. I recognize that any health insurance policy is an arrangement between me and my insurance carrier. I hereby authorize Sláinte Chiropractic to release all necessary information concerning my health condition to any billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition I authorize Sláinte Chiropractic to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Sláinte Chiropractic to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

64. SIGNATURE: _____ **DATE:** _____

Initials _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to your health information and records.

Sláinte Chiropractic understands the importance of privacy and we are committed to maintaining the confidentiality of your protected health information **(PHI)** in compliance with the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)**. We have developed office policies and procedures that protect your personal and health information when used within our office and any devices used to copy or transfer this data. We assure you that your information will only be shared as required and only for the purpose of administering your case and obtaining payment for services. Be assured that without your permission, your health information will not be used for any other purpose.

The following ways are how your PHI may be used within our office to provide you the best care and services possible:

- To provide treatment, obtain payment, and conduct health care operations.
- To schedule appointments and send reminders.
- To communicate with your family, friends, emergency contact, and / or caregivers with your authorization.
- As permitted or required by the law.
- For certain activities when the law requires it.

The following describes your rights regarding your PHI. You may:

- Request to inspect any copy of your records.
- Request to amend incomplete or inaccurate information in your records.
- Receive an accounting of certain disclosures of your health information.
- Ask for additional privacy protections (although your request may be declined).
- Ask for confidential communications in a particular manner.
- Receive a paper copy of this Notice.
- File a complaint without penalty.

Sláinte Chiropractic reserves the right to change this privacy policy as allowed by law and to make the new notice apply to health information already received as well as any information received in the future. A copy of our current notice is available upon request. The notice will display the effective date.

If you believe that we have not properly respected the privacy of your PHI, you may file a complaint with our office by calling (904) 718-6330, sending a letter to our office address: 2370 3rd Street South Jacksonville Beach, FL 32250 or by emailing info@slaintechiropractic.com

By signing below, I confirm that I have received and reviewed this notice and understand how health information about me may be used and disclosed and how I can get access to my health information and records.

65. SIGNATURE: _____ **DATE:** _____

66. *Remember to initial the top right corner of each page.

SOCIAL MEDIA CONSENT

Sláinte Chiropractic celebrates and displays chiropractic testimonials in our office and on our social media outlets to educate others about the benefits of chiropractic care.

67. Do you authorize Sláinte Chiropractic to display your chiropractic testimonial?

☐ Yes, I **DO**.
☐ No, I **DO NOT**.

BELOW IS FOR OFFICE USE

VISIT NOTES		DR. INITIALS