

INTAKE/DISCHARGE SHEET

Please Print

Patient Information

Name _____ Date _____
Date of Birth _____ Age _____ Social Security Number _____
Phone # _____ Cell # _____
Street Address _____
City _____ State _____ Zip _____
E-Mail _____
Occupation _____
Employer _____ Business Phone _____
Sex: Male Female Height _____ Weight _____
Are you Married Single Domestic Partnership Divorced Separated Widowed
Spouses Name: _____
Health Insurance _____ ID # _____ Group # _____
Name of Attorney _____ Phone # _____
Do you have any special needs? _____

Present Health

Please Complete Duties Under Duress and Loss of Enjoyment Worksheets

What are your current health concerns? _____

What are your goals coming in today? _____

Who is your primary care provider? _____

Address _____

Phone _____

Please list any allergies you may have _____

Please list any medications you are currently taking _____

Please list any supplements you are currently taking _____

Describe your current exercise regimen _____

Medical History

Have you ever been treated by a: Chiropractor Naturopathic Doctor Reflexologist
 Massage Acupuncturist Other Alternative Practitioner

Family History

(G = Good, P = Poor)

<i>Check applicable</i>	Father	Mother	Grandparent	Sibling	Other (Specify)
Anemia	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
General Health	_____	_____	_____	_____	_____

Personal History

As a child, did you have any of the following diseases?

- Scarlet Fever Rheumatic Fever Diphtheria Mumps Measles German measles
 Other _____

List any fractures or surgeries you have had with corresponding dates:

List other injuries including falls and other traumas and when they occurred:

Have you been diagnosed with any disease or disorders and when? _____

Are there any additional health concerns or questions you have? _____

Please Circle the appropriate letter next to each item based on the following:

Y = a condition you have now N = never had

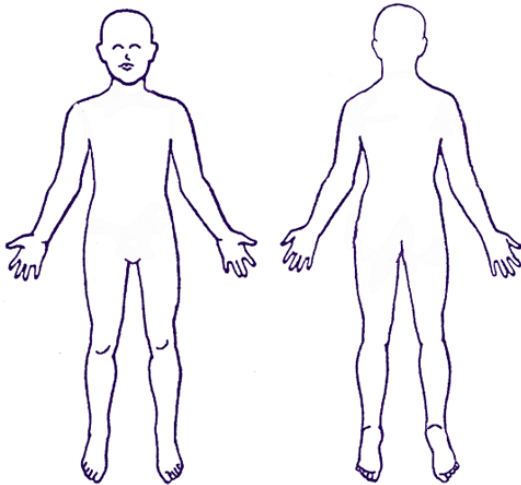
Neck Pain	Y N	R/L Leg Pain/Tingling	Y N
Mid Back Pain	Y N	R/L Foot Pain/Tingling	Y N
Lower Back Pain	Y N	R/L Foot Pain/Tingling	Y N
Extremity Pain	Y N	R/L Hand Pain/Tingling	Y N
Chest Pain	Y N	Fingers/Toes Pain/Tingling	Y N
Muscle Spasms	Y N	Dizziness	Y N
Vision Disturbance	Y N	Heart Disease	Y N
Motion Restriction	Y N	Low/High Blood Pressure	Y N

Sleep Disturbance	Y N	Nausea	Y N
Anxiety	Y N	Vomiting	Y N
Night Sweats	Y N	Liver Disease	Y N
Headaches	Y N	Abdominal Pain	Y N
Head Injury	Y N	Joint Pain/Stiffness	Y N
Impaired Vision	Y N	Arthritis	Y N
Depression	Y N	Broken Bones	Y N
Double Vision	Y N	Fainting	Y N
Ringing in Ears	Y N	Seizures	Y N
Frequent Colds	Y N	Muscle Weakness	Y N
Sinusitis	Y N	Goiter	Y N
Cough	Y N	Spit up Blood	Y N
Asthma	Y N	Bronchitis	Y N
Emphysema	Y N	Difficulty Breathing	Y N
Diabetes	Y N	Sexual Difficulties	Y N
Mood Swings	Y N	Memory Loss	Y N
Drug/Alcohol Abuse	Y N	Thyroid Problem	Y N
Pacemaker/Defibrillator	Y N		

Women Only:

Currently Pregnant Y N

Please indicate on the picture below your problem areas. Please use the following symbols provided:



= = - Numbness
OO – Pins and Needles
XX – Aching
//// - Stabbing

Pain scale: (1-10 - 1 = low, 10 = High)

Neck: _____
Mid Back: _____
Low Back: _____
Extremities: _____

Patients Signature: _____ Date: _____

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Phone: 330-786-9861
Fax: 330-786-9862**

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PHYSICIAN

Attorney, Private, Group, Accident, and Health Insurance

Date: _____

I hereby authorize and direct _____ (Insurance Carrier/Attorney)
to pay by check, made out and mailed directly to:

Gordon Family Chiropractic, LLC
1650 S. Arlington Rd., Suite 2
Akron, OH 44306

If my policy prohibits direct payment to my doctor then I hereby instruct and direct the check to be made
to me and mailed as follows so that I can make/give payment to:

Gordon Family Chiropractic, LLC
1650 S. Arlington Rd., Suite 2
Akron, OH 44306

The professional or medical expense benefits allowable and otherwise payable to me under my current
policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to
pay, in a current manner, any balance of said professional service charges if no payment was made by the
Insurance Co., Attorney, or if I have settled my claim and received all monies to me.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID
AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance carrier, adjuster, or
Attorney involved in this case.

Print Name

Date

Signature

Witness