Pain Free Chiro Clinic
Arash Fatemi, DC | 237 NE Chkalov Dr, Suite 116, Vancouver, WA 98684 | Phone:360-909-1800

NEW PATIENT INTAKE FORM

NAME_____ DOB___/___/___ TODAY'S DATE ___/___/___

PHONE (HOME) ___-___-_____ (CELL) ___-___-____ (WORK) ___-___-_____

ADDRESS_____ CITY _____ STATE ____ ZIP_____

AGE____ EMAIL_____ PRIMARY PHYSICIAN_____

EMERGENCY CONTACT_____ RELATION_____ PHONE_____

I would like to receive appointment reminders via: EMAIL PHONE TEXT NONE

EMPLOYER_____ OCCUPATION_____

Reason for today's visit and current symptoms:
_____

Date of injury/onset of symptoms:
_____

Describe how the condition started:
_____

Has this happened before? YES / NO
Has your condition been treated before? YES / NO
Have you received any diagnostic testing? (MRI, X-Ray, lab work, etc.)
_____

What has worked in the past? (Medications, therapy, etc.)
_____

List any medications/herbs you are currently taking:
_____

Have you had any spinal surgeries? YES / NO
If YES, list all and years:
_____

Do you suffer from headaches? YES / NO
Location: _____
How long do they last? _____
How many times per week/month? _____

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Are you currently pregnant? YES / NO
If YES, how far along? _____

Conditions you have been diagnosed as having:
Anxiety | Diabetes | Depression | Acid reflux | Bleeding disorder | Arthritis | Stroke | Numbness/tingling | Asthma | Cancer | High blood pressure | High cholesterol | Memory loss | Heart attack | Kidney stones | Scoliosis | Ringing in ears | Anemia | Thyroid disease | Dizziness

Other:
_____

Fractures (describe):
_____

Is there anything else we may be able to help you with?
_____

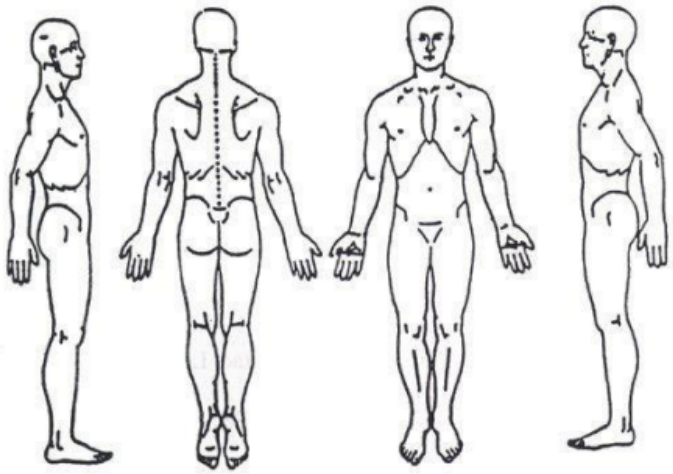
Who can we thank for referring you?
_____

PAIN DRAWING

Have you been treated by a chiropractor before?
YES / NO

Please mark the area(s) on your body where you feel the described sensation(s).

Numbness	----------
Pins & Needles	**ooooooo**
Burning Pain	**xxxxxxx**
Stabbing Pain	/////////
Aching Pain	**(((((((((**



Pain Scale: Below, circle the pain level that most accurately represents your pain. 0 is low, 10 is high

A. Right now:	0 1 2 3 4 5 6 7 8 9 10
B. Average pain:	0 1 2 3 4 5 6 7 8 9 10
C. At best:	0 1 2 3 4 5 6 7 8 9 10
D. At worst:	0 1 2 3 4 5 6 7 8 9 10

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Informed Consent for Chiropractic Care

When you choose to receive chiropractic services at this clinic and we agree to provide care, it is important that both you and your doctor share a clear understanding of the goals and methods of treatment. This mutual understanding helps avoid confusion or unmet expectations.

As a patient, you have the right to receive information about your health condition and the care that is recommended, including expected benefits, potential risks, and reasonable alternatives, so that you can make an informed decision about proceeding with chiropractic treatment.

Chiropractic care focuses on the relationship between the structure of the body—primarily the spine— and the function of the nervous system and how this relationship affects overall health.

Subluxations are corrected through specific spinal adjustments. Adjustments are typically performed by hand but may also involve specialized instruments. Supportive therapies such as physiotherapy or rehabilitative exercises may also be recommended.

If findings arise during care that fall outside the scope of chiropractic practice, you will be informed and referred to an appropriate healthcare provider.

By signing below, you acknowledge that you have been informed of and understand the potential benefits, risks, and alternatives associated with chiropractic care, and you voluntarily consent to receive treatment.

Print Name: _____

Signature: _____

Date: _____

Consent to Evaluate and Adjust a Minor Child

I, _____ being the parent or legal guardian of _____ have read and understand the informed consent above and grant permission for my child to receive chiropractic care.

Notice of Privacy

We maintain records of the healthcare services provided to you. You may request to review or receive a copy of your record and request corrections if necessary. This information will not be shared without your authorization except as required by law.

Your signature below signifies that you have read and understand the Privacy Notice provided.

Print Name: _____

Signature: _____

Date: _____