Schillinger Chiropractic & Wellness Center
Intake Form

Dr. Mark is a long time practitioner of Functional Medicine. This means that he'll carefully consider all of your symptoms and your examination findings, so that he can diagnose the underlying problems and successfully treat your problems with a variety of approaches, if needed.

The questions on this intake form provide Dr. Mark key information about these three foundational components of optimal health:
Structural (muscle & bone) ◊ **Chemical** (endocrine & nutritional) ◊ **Psychological** (stress & happiness)

Name _____ Cell Phone _____

Email _____ Home Phone _____

Home Address _____ City _____ ST _____ Zip _____

Mailing Address _____ City _____ ST _____ Zip _____

Age _____ Birth Date _____ Social Security # _____

Marital Status: M S W D Children (indicate names & ages) _____

Occupation _____ Employer _____

Name of Spouse _____ Spouse's Occupation _____

Name of Emergency Contact _____ Phone _____

Referred to this Office by: _____

Height_____ Weight_____ Blood Pressure (if known) _____

What is the main purpose (chief complaint) of your visit today? _____

Was your condition caused by: □ Auto Accident □ Work Injury □ Other

What other structural, psychological, or chemical based symptoms do you have?

_____

Who are the other practitioners you've seen for these conditions? _____

List car accidents, injuries (including sports, work, etc.), or serious illnesses (include dates):

_____

List any hospitalizations and/or surgeries (include dates) _____

Have you ever been under chiropractic care before? Yes □ No □ Doctor's name _____

Who is your primary care physician? _____

List all current medications with reasons (Example: insulin/diabetes):_____

_____

In your opinion, how physically fit are you? Unfit □ Below average □ Average □ Above average □ Very fit □

What types of exercise do you routinely? (Example: yoga 3x/week, stretch daily, etc.)

_____

What types of exercise do you do occasionally? _____

Please check the conditions you've had in the past, or currently have:

- □ anemia
- □ arthritis
- □ asthma
- □ cancer
- □ chest pains
- □ chronic cold/flu symptoms
- □ chronic fatigue
- □ currently pregnant, # weeks __
- □ depression
- □ dizziness/fainting
- □ hemorrhoids
- □ menstrual problems
- □ osteoporosis
- □ seizures
- □ skin condition
- □ substance abuse
- □ stroke
- □ vision problems

Digestive symptoms can reveal which organ systems may be malfunctioning. This information not only helps Dr. Mark determine your chemical health, but also can serve as insight into a possible cause of your back pain, since each organ receives its electrical energy from specific nerves in your spine.

1) How would you honestly rate your diet on a scale from 1(poor) – 10(excellent) ____

2) What vitamins/minerals/herbs do you take? _____

_____

3) Do you have any food allergies, dietary restrictions, or a specific diet?
(Example: allergic to nuts, gluten free, Paleo, etc.)_____

4) CHECK any of the following that currently apply to you:

- ☐ indigestion/gas/bloating after eating
- ☐ low energy
- ☐ wake up tired in the morning
- ☐ sleepy after eating
- ☐ hungry after eating
- ☐ frequent headaches
- ☐ heartburn
- ☐ difficulty urinating
- ☐ constipation
- ☐ diarrhea
- ☐ foul smelling stools
- ☐ binge eating
- ☐ water retention
- ☐ craving certain foods
- ☐ restless, agitated, or angry frequently
- ☐ weight gain/loss
- ☐ hot flashes
- ☐ diabetes
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ hypoglycemia
- ☐ kidney problems
- ☐ liver problems
- ☐ overweight
- ☐ underweight
- ☐ thyroid condition
- ☐ prostate problems

_____

According to medical research, the #1 cause of physical pain and mental anxiety is from stress. Stress can be caused by both inner and outer adversity.

1) What are the "outer" stressors that cause you anxiety?

- ☐ work
- ☐ spouse
- ☐ children
- ☐ relatives
- ☐ finances
- ☐ friends
- ☐ moving
- ☐ traffic
- ☐ current events
- ☐ loss of family member
- ☐ loss of close friend
- ☐ living conditions
- ☐ lack of time
- ☐ chronic pain
- ☐ national security
- ☐ Other_____

2) What are the mental stressors that cause you anxiety?

- ☐ overthinking
- ☐ worrying
- ☐ beating yourself up
- ☐ upset with yourself
- ☐ doubting yourself
- ☐ grieving
- ☐ loneliness
- ☐ boredom
- ☐ procrastination
- ☐ pessimistic
- ☐ close-minded
- ☐ Other_____

3) Do you know how to consistently and quickly relax yourself, regardless of how much stress you're experiencing? Yes ☐ No ☐
If yes, what stress management techniques do you use? _____

Research on happiness clearly reveals that people who do not have a harmonious lifestyle that successfully integrates their personal, family, community and professional needs, are likely to suffer from a variety of physical and emotional symptoms.

1) Are you happy with the way your life is turning out?
Yes □ Almost Always □ Sometimes □ Mostly Not □ No □

2) What keeps you from enjoying a happier life? (check all that apply)
- □ Lack of clarity about how to move your life in the right direction
- □ You have the clarity but not the motivation
- □ You have the clarity but not the mentor or method to implement your ideas
- □ Lack of self-confidence to move in your life the right direction
- □ Lack of time for your personal growth and well-being

3) Are you able to set personal goals and accomplish them within the time-frame you want?
Consistently □ Frequently □ Intermittently □ Occasionally □ Rarely □

4) Do you engage in personal growth activities? (Example: workshops, self-help books, etc.)
Consistently □ Frequently □ Intermittently □ Occasionally □ Rarely □

ASSIGNMENT OF BENEFITS, RELEASE OF RECORDS & INFORMED CONSENT

PAYMENT/ASSIGNMENT (If we are billing insurance on your behalf)
I agree to pay for all services rendered. If I am using my insurance, I agree to pay for any and all co-pays, co-insurance and deductibles that may apply. I understand that all co-pays are due at the time of service unless other arrangements are made with the office. I hereby instruct and direct my insurance company/companies to pay by check made out and mailed directly to Mark Schillinger, DC. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to Mark Schillinger, DC. If required, I agree to pay in a current matter, any balance of professional/medical service charges over and above this insurance payment that is not covered by my policy.

RELEASE OF RECORDS
I understand that Mark Schillinger, DC will not release my personal information unless it is pertinent to my case. The release of records may include any or all of the following: physicians, insurance companies, claims adjusters or attorneys.

INFORMED CONSENT
I hereby request and consent to the treatment of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and possibly diagnostic x-rays for me, or for the patient named below, for whom I am legally responsible. I understand these treatments will be performed by either Mark Schillinger DC, licensed massage therapists or other licensed doctors of chiropractic who, in the future, may work in this office.
I understand and am informed that, as in the practice of medicine, there are risks to chiropractic treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate these risks and I wish to rely upon the doctor to exercise judgment during the course of my care which the doctor feels, based upon the facts known to him, is in my best interest.
I have read this consent and know I can ask any questions about its content with the doctor. By signing below, I agree to be treated by Mark Schillinger, DC. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment at this office.

Patient Signature _____Date_____