KIDSPACE Adaptive Play and Wellness
469 Buckland Road, Suite 102
South Windsor, CT 06074

ADULT
Intake Questionnaire

Today's Date: _____ /_____ /_____

Name: _____

Date of Birth: _____ /_____ /_____ Age: _____ Gender: _____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____

Email Address: _____

What is the best way to communicate with you regarding your care:_____

Whom may we thank for referring you: _____

Emergency Contact:

Name: _____ Relationship: _____

Telephone: (Home) ____ - ____ - ____ (Cell) ____ - ____ - ____ (Work) ____ - ____ - ____

Medical Contacts:

List the names and specialties of your medical providers.

_____
_____
_____
_____
_____
_____
_____

Permission to contact for medical records: ☐ Yes ☐ No

MEDICAL HISTORY:

Please list your health concerns in order of importance:

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

What are your current symptoms? _____

When did they begin? _____

What brought on your symptoms? _____

Have you had any treatment for these symptoms? _____

What are your goals for your care here? _____

What aggravates your symptoms?

□ Sitting	□ Rolling over in bed	□ Computer work
□ Getting up from sitting	□ Twisting	□ Driving
□ Standing	□ Bending	□ Coughing/sneezing
□ Walking	□ Lifting	□ Neck movements
□ Running	□ Reaching	□ Other:_____

What relieves your pain?

□ Sitting	□ Laying down	□ Heat
□ Standing	□ Stretching	□ Other: _____
□ Walking	□ Cold	

What activities are difficult to perform?

□ Yard work □ Household □ Other: _____

Circle the least and most amount of pain (0 is least and 10 is most):

Low back pain: 0 1 2 3 4 5 6 7 8 9 10

Neck/upper shoulder pain: 0 1 2 3 4 5 6 7 8 9 10

Arm and leg pain: 0 1 2 3 4 5 6 7 8 9 10

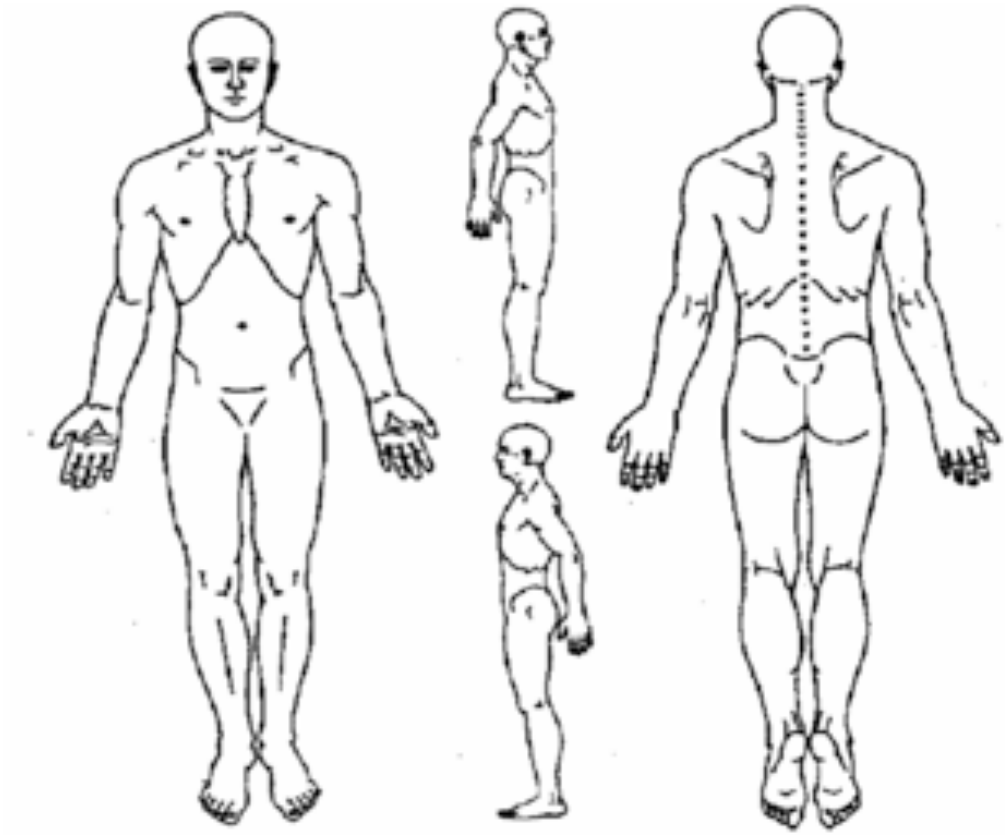
Headaches: 0 1 2 3 4 5 6 7 8 9 10

Symptoms are: □ Constant □ Intermittent

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



Please describe any major illnesses, previous diagnoses, hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc. :

Date	Description

Please list any known allergies (drugs, food, environmental, chemical etc.) and the reactions to them:

_____

_____

Please list any and all current medications (prescription and over-the counter) & supplements (vitamins, herbs, homeopathic remedies):

Name of Drug/Supplement	Date Started	Dosage/Frequency	Prescribed for

LIFESTYLE

Roles/ Relationships

Occupation: _____

Marital Status: □Single □Married □Partnership □Divorced □Widowed

Children (List name, age, and gender): _____

_____

Are you sexually active? □Y □N
Are you satisfied with your sex life? □Y □N
Do you and your partner(s) use contraception? □Y □N If yes, what type? _____

Smoking/Alcohol Intake/ Other Substances

Do you smoke cigarettes? □Y □N If yes, how many per day and for how long? _____
Previous smoking: How many years? _____ Packs per day? _____
Are you exposed to second hand smoke? □Y □N

How many alcoholic drinks per week? 1 drink = 5 oz. wine, 12 oz. beer, 1.5 oz spirits
□None □ 1-3 □ 4-6 □ 7-10 □ >10
Have you ever been treated for alcoholism? □Y □N

Do you use recreational drugs? □Y □N If yes, what and how often? _____
Have you been treated for drug dependence? □Y □N

`Exercise

Do you exercise? □Y □N

List the type of activity, number of sessions per week, and duration: _____

_____

List any problems that limit activity _____

Sleep

How many hours per night? _____

Please check all that apply:

□ Take naps
□ Nightmares
□ Restlessness
□ Snore
□ Trouble falling asleep
□ Grinds Teeth
□ Insomnia
□ Wake at night How many times? _____
□ Talk/Walk in sleep

Energy

How would you describe your energy level? □ Excellent □ Good □ Fair □ Poor

What time of day is your energy the best? _____ the worst? _____

Stress:

Rate your stress level between 1-10 (1 = lowest stress level, 10 = highest stress level) _____

Please list your biggest stressors _____

_____

Who is in your support network? _____

Diet:

How many ounces of water do you consume on a daily basis? _____ oz

Do you consume caffeinated beverages? □Y □N

If yes, what kind and how much? _____

Are you satisfied with your current diet? □Y □N If no, please explain _____

What is your current weight? _____ Height? _____

What is your ideal weight? _____

FAMILY MEDICAL HISTORY Please specify maternal vs paternal grandparents.

	Mother	Father	Brothers	Sisters	Maternal/Paternal Grandparents
Check if applicable					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Epilepsy					
Mental Illness					
Asthma					
Kidney Disease					
Autoimmune Disease					
Other					

REVIEW OF SYSTEMS

For the following section please indicate: **Y =** current**, P=** past**, N=** Never had

MENTAL/EMOTIONAL

Depression	□Y □P □N
Mood swings	□Y □P □N
Anxiety	□Y □P □N
Suicidal	□Y □P □N
Tension	□Y □P □N
Memory Issues	□Y □P □N
Poor concentration	□Y □P □N
Seasonal Depression	□Y □P □N

ENDOCRINE:

Hypothyroid	□Y □P □N
Hypoglycemia	□Y □P □N
Excessive Thirst	□Y □P □N
Fatigue	□Y □P □N
Heat/Cold Intolerance	□Y □P □N
Diabetes	□Y □P □N
Excessive Hunger	□Y □P □N

IMMUNE

Reactions to vaccines	□Y □P □N
Chronic Infections	□Y □P □N
Slow wound healing	□Y □P □N
Chronic fatigue syndrome	□Y □P □N
Chronic swollen glands	□Y □P □N

NEUROLOGIC

Seizures	□Y □P □N
Muscle weakness	□Y □P □N
Paralysis	□Y □P □N
Numbness/tingling	□Y □P □N
Loss of memory	□Y □P □N
Vertigo/dizziness	□Y □P □N
Easily stressed	□Y □P □N
Loss of balance	□Y □P □N

SKIN

Rashes	□Y □P □N
Acne/boils	□Y □P □N
Color change	□Y □P □N
Lumps	□Y □P □N
Eczema/hives	□Y □P □N
Itching	□Y □P □N
Perpetual hair loss	□Y □P □N
Night sweats	□Y □P □N

HEAD

Headaches	□Y □P □N
Migraines	□Y □P □N
Head Injury	□Y □P □N

EYES

Impaired vision	□Y □P □N
Visual floaters	□Y □P □N
Blurriness	□Y □P □N
Color Blindness	□Y □P □N
Double vision	□Y □P □N
Cataracts	□Y □P □N
Glasses/contacts	□Y □P □N
Eye pain/strain	□Y □P □N
Tearing/dryness	□Y □P □N
Glaucoma	□Y □P □N

EARS

Impaired hearing	□Y □P □N
Earaches	□Y □P □N
Ringing	□Y □P □N
Dizziness	□Y □P □N

NOSE

Frequent colds	□Y □P □N
Congestions	□Y □P □N
Sinus issues	□Y □P □N
Nose bleeds	□Y □P □N
Hay fever	□Y □P □N
Loss of smell	□Y □P □N

MOUTH/THROAT

Frequent sore throat	□Y □P □N
Teeth grinding	□Y □P □N
Gum problems	□Y □P □N
Dental cavities	□Y □P □N
Copious saliva	□Y □P □N
Sore tongue/lips	□Y □P □N
Hoarseness	□Y □P □N
Jaw/TMJ pain	□Y □P □N
Bad breath	□Y □P □N

NECK

Lumps	□Y □P □N
Goiter	□Y □P □N
Swollen glands	□Y □P □N
Pain/Stiffness	□Y □P □N

RESPIRATORY

Cough	□Y □P □N
Asthma	□Y □P □N
Pneumonia/bronchitis	□Y □P □N
Shortness of Breath	□Y □P □N
Tuberculosis	□Y □P □N

CARDIOVASCULAR

Heart disease	□Y □P □N
High/low blood pressure	□Y □P □N
Blood clots	□Y □P □N
Rheumatic fever	□Y □P □N
Swelling of ankles	□Y □P □N
Angina	□Y □P □N
Murmurs	□Y □P □N
Palpitations	□Y □P □N
Chest pain	□Y □P □N

GASTROINTESTINAL

Trouble swallowing	□Y □P □N
Change in thirst	□Y □P □N
Nausea	□Y □P □N
Vomiting blood	□Y □P □N
Blood in stool	□Y □P □N
Pain/cramps	□Y □P □N
Belching/passing gas	□Y □P □N
Black stools	□Y □P □N
Jaundice (yellow skin)	□Y □P □N
Liver Disease	□Y □P □N
Heart burn	□Y □P □N
Change in appetite	□Y □P □N
Vomiting	□Y □P □N
Constipation	□Y □P □N
Diarrhea	□Y □P □N
Gallbladder disease	□Y □P □N
Ulcer	□Y □P □N
Hemorrhoids	□Y □P □N

URINARY

Pain with urination	□Y □P □N
Frequency at night	□Y □P □N
Frequent infections	□Y □P □N
Increased frequency	□Y □P □N
Inability to hold urine	□Y □P □N
Kidney stones	□Y □P □N
Change in urine odor	□Y □P □N

BLOOD/VASCULAR

Easy bleeding/bruising	□Y □P □N
Deep leg pain	□Y □P □N
Varicose veins	□Y □P □N
Anemia	□Y □P □N
Cold hands/feet	□Y □P □N
Thrombophelbitis	□Y □P □N

FEMALES

Dates of last:
Menstrual period _____
PAP smear _____
Mammogram _____
Thermogram _____

Age of first menses: _____
Age of last menses: _____

Are your cycles regular □Y □N
Length of cycle: _____ Duration of menses: _____
Do you do self breast exams □Y □N

Are you currently pregnant □Y □N
Number of pregnancies: _____
Number of miscarriages: _____
Number of live births: _____
Number of abortions: _____

Bleeding between cycles	□Y □P □N
Heavy/excessive flow	□Y □P □N
Painful menses	□Y □P □N
PMS	□Y □P □N
Pain during intercourse	□Y □P □N
Clotting	□Y □P □N
Discharge	□Y □P □N
Endometriosis	□Y □P □N
Ovarian cysts	□Y □P □N
Breast lumps	□Y □P □N
Nipple discharge	□Y □P □N
Breast tenderness/pain	□Y □P □N
Cervical dysplasia	□Y □P □N
Abnormal PAP	□Y □P □N
Sexual difficulties	□Y □P □N
Gonorrhea	□Y □P □N
Chlamydia	□Y □P □N
Herpes	□Y □P □N
Syphilis	□Y □P □N

MALES

Dates of last:
Prostate exam _____

Hernias	□Y □P □N
Testicular Pain	□Y □P □N
Testicular Masses	□Y □P □N
Prostate Disease	□Y □P □N
Discharge/sores	□Y □P □N
Veneral Disease	□Y □P □N
Gonorrhea	□Y □P □N
Chlamydia	□Y □P □N
Herpes	□Y □P □N
Syphilis	□Y □P □N
Ejaculation problems	□Y □P □N
Difficulty with erections	□Y □P □N
Pain with intercourse	□Y □P □N
Breast lumps	□Y □P □N

CONSENT FOR TREATMENT
It has been determined that your condition would benefit from one or more of the following evaluation and treatments modalities.

___**Acupuncture:** The insertion of thin, sterilized, disposable needles into clinically applicable areas on the body.
___**Chiropractic manipulation:** A high velocity and low amplitude technique designed to mobilize restricted joints in the spine and extremities. Please identify any areas you do not want manipulated.
___**Muscle energy technique/mobilization:** Gentle mobilizations for restricted joints.
___**Soft Tissue work:** Gentle massage to release tight muscles, fascia, and trigger points.
___**CranioSacral therapy:** Gentle hands-on therapy to relieve deep body tension, pain, and dysfunction.
___**Stretching:** Used to elongate tight muscles.
___**Exercises:** Palliative or strengthening exercises demonstrated in office for home use.
___**Nutrition:** Nutritional counseling and therapeutic diets.
___**Homeopathic Medicine:** Diluted quantities of plant, mineral, or animal substances that strengthen the internal defense system to improve general health.
___ **Nutraceuticals:** Vitamin and mineral supplementation
___**Lifestyle Counseling:** Recommendations in improve health and well-being including: sleep, stress reduction techniques, etc.

Potential Benefits: Restoration of health and body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, return to activity and prevention of disease progression.
Potential Risks: As with any health care procedure, adverse reactions may occur including: reactions to prescribed supplements, inconvenience of lifestyle changes, short-term aggravation of symptoms of muscle and ligament pain. Acupuncture may have some side effects, including bruising, numbness or tingling near the needling sites, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax) or infection. Although uncommon, rib fractures have been known to occur following manual therapy. There are reported cases of stroke associated with visits to chiropractors and primary care doctors. The most current research indicates a temporal relationship between the occurrence of a stroke and a preceding visit to either a chiropractor or a primary care physician. You are being informed of this reported association because strokes can result in serious neurological impairment or death. The incidence of stroke associated with cervical manipulation is exceedingly rare and are estimated to occur between one in 1 million and one in 5 million adjustments. When nutritional, lifestyle, or any ancillary recommendations are suggested by your health care provider to enhance the healing process, material risks will be discussed on an individual basis.
Alternatives to treatment: There are other treatment options that may benefit your condition.
Notice to Pregnant Women: all female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present a risk to the pregnancy and fetus.

You are responsible for informing our providers of any relevant information or changes that affect your health. Should privileged information be shared via text message or email, your provider will make every effort to maintain privacy but text messaging and emailing are not encrypted or HIPAA-approved means of communication.

I recognize that even the gentlest therapies may potentially have complications in the elderly, or in those on multiple medications. Hence, the information I have provided my health care providers is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs I may be taking. With this knowledge, I voluntarily consent to the above procedures. I acknowledge that no guarantees of cure or improvement of my condition have been made. I understand that I am free to withdraw my consent and to discontinue treatment at any time. I understand that a record will be kept of health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted by law. I have read and understood the above explanation examination and treatment procedures. I have discussed it with Sharon A. Vallone, DC FICCP, Faraneh Carnegie-Hargreaves, DC and Karen Peck, CST and have had my questions answered to my satisfaction. I hereby give my written consent for evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

_____ _____ _____
Printed Name Signature Date

PATIENT RESPONSIBILITIES

We agree to be financially responsible for all charges incurred at this office. We will make payment as required at the time of service. Should collection efforts be necessary to collect money owed, ***a 15% interest charge will be added to the balance due.*** We are liable for any cost incurred by the office in collection efforts.

CANCELLATION POLICY

If you are unable to make your appointment, please provide at least 24-hour notice of cancellation. ***A cancellation fee of $50 will apply for appointments cancelled with less than 24-hour notice.***

_____

Signature Date

Our office requires a credit card to be kept on file for any charges incurred.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will use and disclose your health information in order help you obtain payment for our services by allowing insurance companies to process insurance claims for services rendered to you by us or by other health care providers. Finally, we may disclose your health information for certain limited operational activities such as assessment, licensing, accreditation, and training of students.

Uses and disclosures based on your authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information, social security numbers or other financial information without your written authorization.

Uses and disclosures not requiring your authorization. In the following circumstances, we may disclose your health information without your written authorization. To family members or close friends who are involved in your health care. For certain limited research purposes. For purposes of public health and safety. To government agencies for purposes of their audits, investigations and other oversight activities. To government authorities to prevent child abuse or domestic violence. To the FDA to report product defects or incidents. To the law enforcement authorities to protect public safety or to assist in apprehending criminal offenders. When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights. As our patients you have the following rights: To have access to and/or a copy of your health information. To receive an accounting of certain disclosures we have made of your health information. To request that we communicate with you in confidence. To request that we amend your health information. To receive a notice of our privacy practices.

A COPY OF THE COMPLETE NOTICE IS AVAILABLE UPON REQUEST.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

This document is to be signed by persons legally responsible for the patient's medical decisions relative to the treatment situation.

We, _____, hereby acknowledge that we have been provided with a copy of the Notice of Privacy Practices that describes how medical information about our child/guardian may be used and disclosed, and how we can access that information. We understand that if we have questions or complaints, I may contact: **Faraneh Carnegie-Hargreaves, DC, Karen Peck CTRS, CST, QST**; **Sharon A. Vallone, DC, FICCP; or Lindsey Wells, ND at 860.432.9923.**

We also understand that we are entitled to receive updates upon request if this office amends or changes its Notice of Privacy Procedures in a material way.

_____

Patient Signature Date

This section is to be completed by our office, if unable to obtain written acknowledgement from patient.

I made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable because:

[ ] Patient declined to sign this written acknowledgement.

[ ] Other (specify):_____

_____

Name and title of employee Date