Dixon Chiropractic & Wellness Center
Your Center for Personal Growth & Transformation

3500 Hulen St, Ste 100, Fort Worth, TX 76107
www.dixonchiropracticwellnesscenter.com
PH | 817-313-8026 Fax | 844-783-2533

Welcome to Dixon Chiropractic and Wellness Center (DCWC). We are glad you are here, and we look forward to helping you with your health and wellness goals. Please complete all intake forms so we can offer you the best care possible. Thank you for taking your time to be as thorough as you can.

Appt. Date: _____

Name:_____ **Date of Birth**: _____

What is your motivation for seeking care in this office?_____

_____

Demographic Information

Street Address:_____

City:_____State:_____Zip:_____

Email:_____ ❒ I would like to receive E-Mail Newsletters from Dixon Chiropractic and Wellness Center to stay informed of events and receive health tips.

Mobile Phone:_____ Work Phone:_____ Home Phone:_____

Emergency Contact Name:_____Relationship:_____Phone:_____

How do you prefer that we contact you? ❒ E-mail ❒ Phone ❒ Text ❒ Please do not contact me at all.

(no protected health information will ever be sent via text as it is not an encrypted means of communicating)

Employer:_____ Occupation: _____

Number of Years in Occupation:_____ Are you satisfied with your occupation? ❒ Yes ❒ No

Marital/Relationship Status: ❒ Single ❒ In a Relationship ❒ Married ❒ Widowed ❒ Divorced

If applicable, ages of children:_____Do you have any pets?_____

Most people are referred to our office by a caring family member or friend. How did you discover our office?

❒Website ❒Google ❒Yelp ❒Facebook ❒Eventbrite Referred by:_____

Financial Arrangement

Our office primarily provides the chiropractic service known as "Network Spinal Care." We have yet to see a health insurance company reimburse anyone for this service as it does not fit into the regular chiropractic coding and condition focused care model. Therefore, our office does not accept health insurance payments and we do not bill health insurance for the services we provide. We accept cash, checks, all major credit and debit cards, and PayPal payments.

Are you eligible for Medicare benefits? ❒ Yes ❒ No (Note: Network Spinal care is not a Medicare covered service)

Is someone else financially responsible for your healthcare?_____

_____ (Initial) I understand that I am financially responsible for any services provided at Dixon Chiropractic and Wellness Center. I will receive full disclosure of all fees for services before they are ever provided.

- The initial 15-20 minutes of consultation is provided at no cost to help us determine if our services are the right choice to help you achieve your goals.
- The initial exam is typically $70 and ongoing cost of care can range from $40-$100 per visit depending on what is needed. All recommended care will be provided in writing with full disclosure of anticipated charges.

The above information is true and accurate to the best of my knowledge_____(Client Initials) File #_____

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Spinal Health and Care History

1. Research shows that your spine should be checked regularly for proper movement and nerve function. Please estimate how many times have you visited a chiropractor in your lifetime: _____ ❒ Too many to count ❒ Never

   Why were you seen? _____ Were you helped? ❒ Yes ❒ No

Have you ever had your spine professionally manipulated by a physical therapist or an osteopathic doctor? ❒ Yes ❒ No

2. When was your last complete spinal examination?_____ ❒ Never

   Have you had x-rays of your spine? ❒ Yes ❒ No If yes, when were they taken? _____

   Where did you have the x-rays taken?_____

   What were you told about them? _____

3. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? ❒ Yes ❒ No
4. *Neuro-Spinal Dysfunctions* may cause decay and degeneration which results in grinding or cracking. Do you ever hear noise when you move your head or neck? ❒ Yes ❒ No If yes, how often?_____
5. *Neuro-Spinal Dysfunctions* can make you feel like you need to twist, stretch or "crack" your neck or back. Do you ever feel the need to crack or pop your neck or back? ❒ Yes ❒ No
   a. If yes, do you attempt to? ❒ Often ❒ Sometimes ❒ No
6. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?
   Poor ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 Excellent
7. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
   Low ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 High
   What is the most significant source of stress in your life?_____
8. Have you ever been diagnosed with cancer? ❒ Yes ❒ No If yes, what kind?_____
   Year Diagnosed:_____ Are you currently undergoing treatment? ❒ Yes ❒ No
   If yes, where and what kind? _____
   ____(Initial) I understand that DCWC provides spinal care for those diagnosed with cancer, but they do not provide treatment for cancer.

9. Have you ever had a spinal surgery? ❒ Yes ❒ No If yes, where in your spine: _____

   Were there complications? ❒ Yes ❒ No If yes, describe:_____

10. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? ❒ Yes ❒ No

General Health and Care History

1. How would you rate your health right now?

   Poor ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 Excellent
   a. If you rated less than 8, when was the last time you felt REALLY healthy?_____

2. Are there any activities you like to do that your health is impairing you from doing? ❒ Yes ❒ No

   If yes, please describe:_____

3. How would your life change if you had optimal health? _____
4. What do you think needs to happen for you to have optimal health and healing? _____

   _____

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History of Current Concern(s)

Primary concern(s):_____

When did this begin?_____ Have you seen anyone else for this? _____

Severity right now: Barely noticeable - ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 - Very severe

Average severity: Barely noticeable - ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 - Very severe

Secondary Concern(s):_____

When did this begin?_____ Have you seen anyone else for this? _____

Severity right now: Barely noticeable - ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 - Very severe

Average severity: Barely noticeable - ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 - Very severe

Tertiary Concern(s):_____

When did this begin?_____ Have you seen anyone else for this? _____

Severity right now: Barely noticeable - ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 - Very severe

Average severity: Barely noticeable - ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 - Very severe

Auto and work-related injuries can cause serious spinal problems. Are your concerns due to an accident? ❒ Yes ❒ No If yes, what type? ❒Work ❒Auto ❒Personal Date of Accident_____ If work or auto accident, have you reported this accident to anyone? ❒ Yes ❒ No If yes, who was it reported to?_____

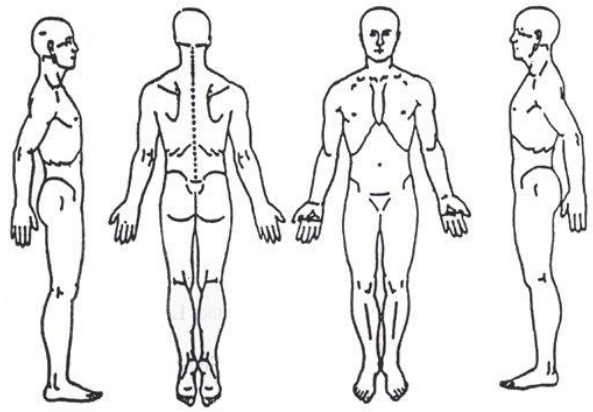
Please indicate how your concerns affect your functioning/quality of life by selecting the numbers below:

0 – Does not affect me 1 – Slightly affects me 2 –Moderately affects me 3 – Drastically affects me

Work	❒ 0	❒ 1	❒ 2	❒ 3	Eating	❒ 0	❒ 1	❒ 2	❒ 3
Social Life	❒ 0	❒ 1	❒ 2	❒ 3	Rest/Sleep	❒ 0	❒ 1	❒ 2	❒ 3
Exercise	❒ 0	❒ 1	❒ 2	❒ 3	Sitting	❒ 0	❒ 1	❒ 2	❒ 3
Recreation	❒ 0	❒ 1	❒ 2	❒ 3	Dress/Groom	❒ 0	❒ 1	❒ 2	❒ 3
Walking	❒ 0	❒ 1	❒ 2	❒ 3	Love Life	❒ 0	❒ 1	❒ 2	❒ 3

PLEASE MARK the areas on the diagram with the following **letters** to describe any symptoms you may be experiencing:

R = Radiating
B = Burning
D = Dull
A = Aching
N = Numbness
S = Sharp/ **S**tabbing
T = **T**ingling
O = **O**ther (please explain)



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Past Trauma History

Starting from birth, we all experience thousands of physical, mental, & chemical stresses. Due to the way our bodies adapt to these stresses, they can contribute to excess tension and misalignments of the spine, and lead to additional health problems.

Please write down any falls, injuries, and traumas that you have experienced. (Please put *NA* if it does not apply)

1. **Car Accidents** (List even minor ones. A 5mph crash from a 3,000 lb vehicle can cause damage to your spine even if you didn't feel like you were injured.)
   Date:_____ **Type of Collision: ❒Front end ❒Side ❒Rear Speed**_____ **Injuries:**_____

   _____

   Date:_____ **Type of Collision: ❒Front end ❒Side ❒Rear Speed**_____ **Injuries:**_____

   _____

2. **Sports Injuries** (If there are too many to list, please write the name of the sport and "MANY" next to it.)
   Date:_____ **Type of Sport:**_____ **Injuries:**_____

   _____

   Date:_____ **Type of Sport:**_____ **Injuries:**_____

   _____

3. **Slips, falls, & Bike Accidents** (We understand there may have been a lot of slips & falls since birth, so please list the major ones.)
   Date:_____ **Type of Injury:**_____

   Date:_____ **Type of Injury:**_____

   Date:_____ **Type of Injury:**_____

4. **Repetitive Injuries** (Please list **all** repetitive injuries you've had in the past.)
   Date:_____ **Type of Injury:**_____

   Date:_____ **Type of Injury:**_____

   Date:_____ **Type of Injury:**_____

Other physical or emotional trauma:_____

_____

Review of Health & Lifestyle History

Mark any Allergies:

❒ Animals	❒ Aspirin	❒Pain Meds	❒ Bee Stings	❒ Chocolate	❒ Dairy	❒ Dust
❒ Eggs	❒ Latex	❒ Molds	❒ Penicillin	❒ Ragweed	❒Pollen	❒ Peanuts
❒Rubber	❒ Seasonal	❒ Shellfish	❒ Soaps	❒ Soy	❒Wheat	❒ X-ray Dye

❒ Other: _____

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Prescription medications may cause various side effects, hide the severity of health problems, and hinder the body's ability to heal. What medications are you currently taking, and why are you taking them? (Prescription and non-prescription) ❒ I do not take anything. ❒ I have attached a list._____

_____

Please list any natural herbs/supplements you are taking and why. ❒ I do not take anything. ❒ I have attached a list.

_____

_____

Mark any surgeries you have had:

❒ Appendix	❒ Back	❒ Brain	❒ Carpal tunnel	❒ Cervical Disk
❒ Chest	❒ EENT	❒ Elbow	❒ Foot	❒ Gallbladder
❒ Gastrointestinal	❒ Gynecological	❒ Heart	❒ Heart Bypass	❒ Hernia
❒ Hip	❒ Hip Replacement	❒ Knee	❒ Knee Replacement	❒ Lumbar Disk
❒ Neck	❒ Neurological	❒ Obstetrical	❒ Pediatric	❒ Shoulder
❒ Thoracic Disk	❒ Tonsils	❒ Wrist		

❒ Other:_____

Lifestyle & Diet

Do you currently use tobacco? ❒ No ❒ Yes If yes, what form(s) and how much?_____

Do you have a history of tobacco use? ❒ No ❒ Yes If yes, what form(s) and how much?_____

Do you vape? ❒ No ❒ Yes If yes, with nicotine? How much? How often?_____

Do you drink alcohol? ❒ No ❒ Yes If yes, what form(s)? How much? How often? _____

Do you drink coffee? ❒ No ❒ Yes If yes, how much?_____ With how much sugar?_____

Do you drink tea? ❒ No ❒ Yes If yes, how much?_____ With how much sugar?_____

Do you drink energy drinks? ❒ No ❒ Yes If yes, which one(s) and how often?_____

Do you drink sodas or other sugary beverages? ❒ No ❒ Yes If yes, which one(s) and how often?_____

How much water do you drink?_____ Do you add anything to your water?_____

Do you exercise? ❒ No ❒ Yes If yes, what type and how often?_____

Do you have a prayer or meditation routine? ❒ No ❒ Yes If yes, how often?_____

How do you manage stress?_____

Do you use recreational drugs? (as with all of your information, this is strictly confidential and important for us to know)

❒ No ❒ Yes If yes, what type(s) and how often?_____

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Mark all current (C) and past (P) health conditions:

C P

MUSCULOSKELETAL SYSTEM

❒ ❒ Ankle pain
❒ ❒ Arm pain/problems
❒ ❒ Arthritis
❒ ❒ Broken bones
❒ ❒ Elbow pain
❒ ❒ Foot pain
❒ ❒ Genetic spinal disorder
❒ ❒ Hand pain
❒ ❒ Hip pain
❒ ❒ Jaw pain
❒ ❒ Joint stiffness
❒ ❒ Knee pain
❒ ❒ Leg pain/problems
❒ ❒ Low back pain
❒ ❒ Mid back pain
❒ ❒ Neck pain
❒ ❒ Pain between shoulders
❒ ❒ Painful joints
❒ ❒ Shoulder pain
❒ ❒ Sore muscles
❒ ❒ Spasms
❒ ❒ Sprain/Strain
❒ ❒ Swollen joints
❒ ❒ Walking problems
❒ ❒ Weak muscles
❒ ❒ Weakened grip
❒ ❒ Wrist pain

C P

FEMALE

❒ ❒ Breast pain
❒ ❒ Lumps on the breast
❒ ❒ Menstrual problems
❒ ❒ Vaginal bleeding
❒ ❒ Vaginal discharge
❒ ❒ Vaginal pain

ARE YOU PREGNANT?
❒ Yes ❒ No

MALE

❒ ❒ Abnormal discharge
❒ ❒ Prostate enlargement
❒ ❒ Prostate cancer
❒ ❒ Testicular tenderness

GENITOURINARY SYSTEM

❒ ❒ Bladder trouble
❒ ❒ Discolored urine
❒ ❒ Excessive urination
❒ ❒ Scanty urination
❒ ❒ Painful urination

CARDIOVASCULAR & RESPIRATORY

❒ ❒ Asthma
❒ ❒ Chest Pain
❒ ❒ Heart attack
❒ ❒ High Blood Pressure
❒ ❒ Low blood pressure
❒ ❒ Pacemaker
❒ ❒ Stroke

C P

ILLNESSES

❒ ❒ Cancer
❒ ❒ Depression
❒ ❒ Diabetes
❒ ❒ Hepatitis
❒ ❒ Tumor

GASTROINTESTINAL

❒ ❒ Abdominal pain
❒ ❒ Black stool
❒ ❒ Bloody stool
❒ ❒ Constipation
❒ ❒ Diarrhea
❒ ❒ Difficulty chewing
❒ ❒ Difficulty swallowing
❒ ❒ Excessive hunger
❒ ❒ Excessive thirst
❒ ❒ Gallbladder problems
❒ ❒ Hemorrhoids
❒ ❒ Liver trouble
❒ ❒ Nausea
❒ ❒ Poor appetite
❒ ❒ Significant weight change
❒ ❒ Stomach problems
❒ ❒ Ulcer(s)
❒ ❒ Vomiting blood

MOUTH & THROAT

❒ ❒ Dental problems
❒ ❒ Difficulty speaking
❒ ❒ Hoarseness
❒ ❒ Sore gums
❒ ❒ Sore mouth

C P

EYE

❒ ❒ Eye inflammation
❒ ❒ Eye strain
❒ ❒ Vision problems

EAR

❒ ❒ Ear discharge
❒ ❒ Ear pain
❒ ❒ Hearing loss
❒ ❒ Hearing problems
❒ ❒ Tinnitus

NOSE

❒ ❒ Difficulty breathing through nose
❒ ❒ Nose bleeding
❒ ❒ Nose discharge
❒ ❒ Nose pain
❒ ❒ Sinus

NERVOUS SYSTEM

❒ ❒ Dizziness
❒ ❒ Epilepsy
❒ ❒ Fainting
❒ ❒ Fatigue
❒ ❒ Fibromyalgia
❒ ❒ Headaches
❒ ❒ Multiple Sclerosis
❒ ❒ Neurological disorder
❒ ❒ Other disorder
❒ ❒ Parkinson's Disease
❒ ❒ Polio
❒ ❒ Spinal cord injury
❒ ❒ Tingling

Family Health History:

❒ Cancer Relation (Mother, Father, Sibling, etc.)_____

❒ Diabetes Relation (Mother, Father, Sibling, etc.)_____

❒ Heart Disease Relation (Mother, Father, Sibling, etc.)_____

❒ High Blood Pressure Relation (Mother, Father, Sibling, etc.)_____

❒ Stroke Relation (Mother, Father, Sibling, etc.)_____

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Focusing on More:

In a published study of over 2,800 patients in Network Care, conducted within the Medical College at the University of California-Irvine, patients reported an overall improvement in all the categories of health and wellness listed below.

How do you hope to benefit from care in the office?

0 – Does not apply 1 – Not so important to me 2 – Important to me 3 – Very important to me

Improvement of my physical symptoms	❒ 0	❒ 1	❒ 2	❒ 3
Improvement of emotional/mental symptoms	❒ 0	❒ 1	❒ 2	❒ 3
More efficient ability to react or respond to stress	❒ 0	❒ 1	❒ 2	❒ 3
Noticeable difference in enjoyment of life	❒ 0	❒ 1	❒ 2	❒ 3
Increased ability to make constructive choices	❒ 0	❒ 1	❒ 2	❒ 3
Overall improved quality of life	❒ 0	❒ 1	❒ 2	❒ 3

Is there some aspect of your life that really pleases you, brings you joy, or helps you to feel better about yourself?

Is there anything else you would like to tell Dr. Jason?