

**Dr. Dawn Huntsinger**  
[A Wellness From Within, LLC Family Chiropractic Center](#)  
 265 W. Uwchlan Ave. Downingtown, PA 19335  
[www.livewell-dc.com](http://www.livewell-dc.com)  
 (484) 593-4178

**NEW PATIENT INTAKE**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/20\_\_\_\_

**Personal Information:**

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Sex:  Female  Male  
 Home Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: ( ) \_\_\_\_\_  
 Cell Phone: ( ) \_\_\_\_\_  
 Home E-Mail: \_\_\_\_\_ @ \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_  
 Other: \_\_\_\_\_

**Employer Information:**

Employer: \_\_\_\_\_  
 Work Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Type of work: \_\_\_\_\_  
 Work requirements: \_\_\_\_\_  
 \_\_\_\_\_

**Prior Doctor of Chiropractic (DC):**

Name: \_\_\_\_\_  
 Phone Number: ( ) \_\_\_\_\_  
 Preferred Adjusting Technique: \_\_\_\_\_  
 Last Adjustment Date: \_\_\_\_\_

**Primary Care Doctor (MD, DO):**

Name: \_\_\_\_\_  
 Phone Number: ( ) \_\_\_\_\_

**Other Specialists:**

Name: \_\_\_\_\_  
 Specialty: \_\_\_\_\_  
 Phone Number: ( ) \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Specialty: \_\_\_\_\_  
 Phone Number: ( ) \_\_\_\_\_

***Please State Any Treatments & Medications Received***

• Treatment: \_\_\_\_\_  
 Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Results: \_\_\_\_\_

<u>Date(s)</u>	<u>Surgery(s)</u>	<u>Reason(s)</u>
_____	_____	_____
_____	_____	_____

\_\_\_\_\_

**WHOM MAY WE THANK FOR RECOMMENDING  
 CHIROPRACTIC CARE?**

**Insurance | Online | YellowPages| Friend/Family:**

**HEALTH COMPLAINTS**

*PLEASE LIST IN ORDER SEVERITY & IMPORTANCE*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Please List Any Hobby/ Outside Interests:**

**Please Describe How You Hurt Yourself?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PLEASE NOTIFY FRONT DESK IF YES BELOW:

**Was this injury from Auto-Accident ?**  Yes  No

Date of accident: \_\_\_\_\_

Claim # \_\_\_\_\_

PLEASE NOTIFY FRONT DESK IF YES BELOW:

**Was this injury from Working ?**  Yes  No

Date of accident: \_\_\_\_\_

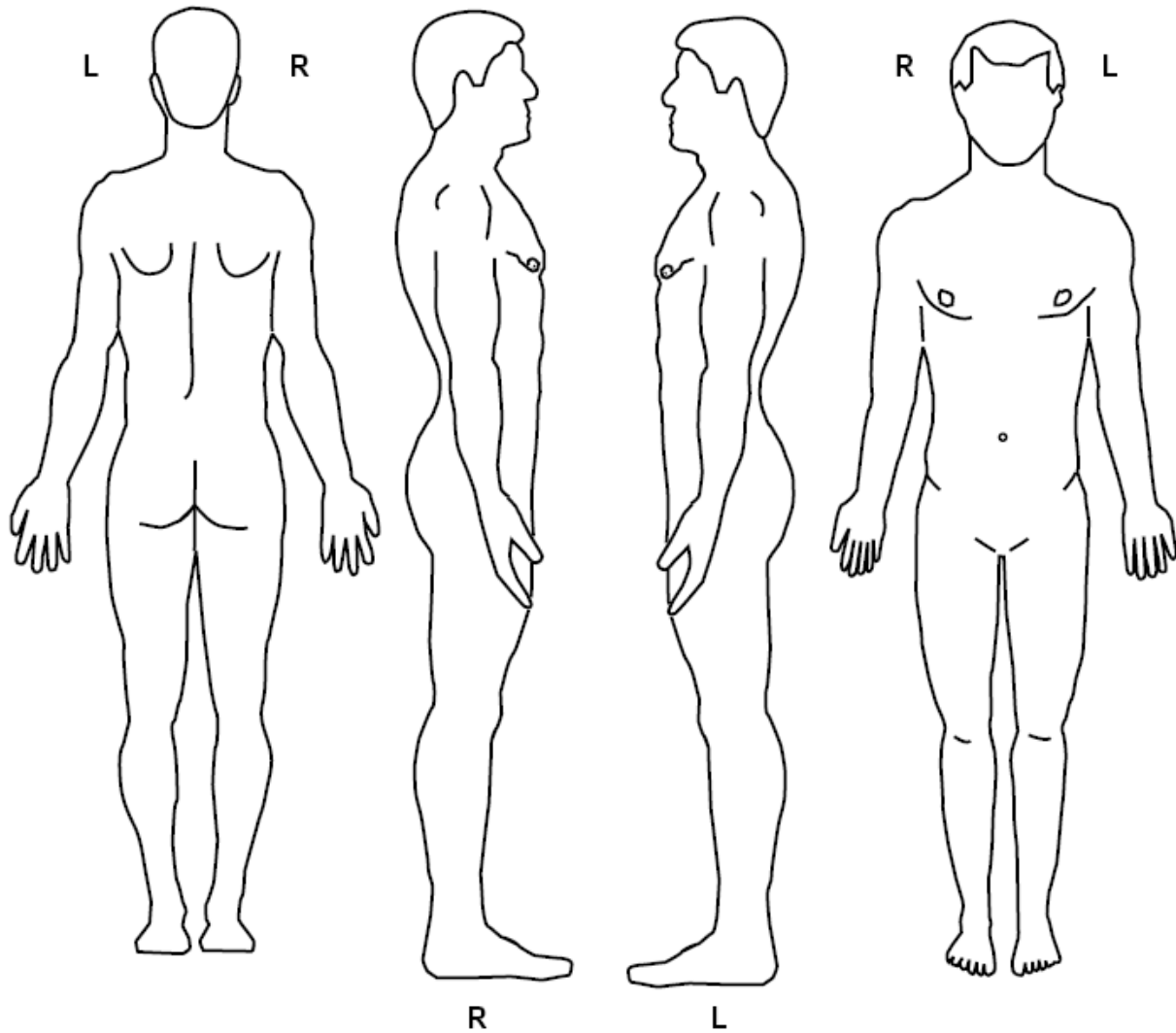
Claim # \_\_\_\_\_

**PAIN DRAWING**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

**Numbness: N    Pins & Needles: P    Burning: B    Stabbing Pain: S    Aching: A**



**Dr. Dawn Huntsinger**  
**A Wellness From Within, LLC Family Chiropractic Center**  
**265 W. Uwchlan Ave Downingtown, PA 19335**

**www.livewell-dc.com**  
**(484) 593-4178**

**SYMPTOM SURVEY**

**MISC:**

- Headache
- Seizures
- Sinus problems
- Allergies: \_\_\_\_\_
- Migraines
- Loss of memory
- Fainting
- Light bothers eyes
- Blurred vision
- Loss of vision
- Loss of taste
- Loss of hearing
- Pain in ears
- Ringing in ears
- Arthritis
- Swollen joints
- Cold extremities
- Smoker
- TMJ syndrome
- Stiffness in morning

**NECK:**

- Pain in neck
- Neck pain with movement
- Pinched nerve in neck
- Neck feels out of place
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

**►Have you had this type of head/neck/face pain before**

YES     NO

**SHOULDERS:**

- Pain in shoulder joints
- Pain across shoulders
- Bursitis (R-L)
- Can't raise arm
  - Above shoulder level
  - Over head
- Tension in shoulder

**ARM & HANDS:**

- Pain in upper arm
- Pain in elbow
- Tennis elbow
- Sensation of pins & needles
- Numbness in arms/fingers
- Fingers go to sleep
- Loss of grip strength

**MID-BACK:**

- Pain between shoulder blades
- Rib pain

**CHEST:**

- Chest pain
- Shortness of breath
- Irregular heartbeat

**ABDOMEN:**

- Nervous Stomach

- Feel Bloated
- Nausea
- Vomiting
- Gas
- Constipation
- Diarrhea
- Hemorrhoids
- IBS
- Cohn's disease
- Reflux

**LOW BACK:**

- Low back pain
- Sacroiliac
- Low back pain is **worse:**
  - Standing     Sitting
  - Coughing     Walking
  - Lying down (sleeping)
  - Pain relieves when: \_\_\_\_\_

**HIPS, LEGS & FEET:**

- Pain in buttocks (R-L)
- Pain down leg (R-L)
- Pain down both legs
- Knee pain
  - Inside     Outside
- Hip pain
- Leg cramps
- Cramps in feet (R-L)
- Pins & needles in legs (R-L)
- Numbness of leg (R-L)
- Numbness of toes /feet (R-L)
- Feet feel cold
- Swollen ankles /feet(R-L)
- Morton's neuroma
- Bunions
- Arch pain

**WOMEN ONLY:**

**►Are you PREGNANT?**

Yes     No

- Menstrual pain
- Irregular periods
- Cystic breasts
- Cystitis
- Yeast infections
- Hysterectomy
- Menopausal
- Post-menopausal
- Taking estrogen
- PMS Symptoms

**MEN ONLY:**

- Urinary frequency
- Prostate pain
- High PSA

**GENERAL:**

- Depression/Depressed
- Fatigue/Tire easily
- Generally feel run-down/ Malaise

- STD's \_\_\_\_\_
- Diabetes
- Hypoglycemia
- Had kidney stones
- Coffee \_\_\_\_\_ cups/day
- Tea \_\_\_\_\_ cups/day

**Check "NO" If you CAN NOT:**

- Smile
- Raise Both Arms
- Stand steady on both feet with eyes closed
- Speak simple sentences
- Stick out tongue

**Check "YES" If you have:**

- Double vision
- Dizziness/lightheaded
- Sudden numb/weakness of face/arm/leg
- Speech disorders
- Difficulty swallowing
- Difficulty walking
- Vomiting/nausea
- Loss of sensation on 1side
- Involuntary rapid eye movement

**Please Describe a Subluxation?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Taking any Vitamins: (please list)**

Type: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Taking any Medication: (please list)**

Type: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are interested in or do you currently use any of the following:**

- Orthotics     Cervical pillow
- Back brace     Other \_\_\_\_\_
- Wellness Care

**Patient Signature:**

X \_\_\_\_\_

**Date:** \_\_\_\_\_ / \_\_\_\_\_ /20\_\_\_\_\_

**Dr. Dawn Huntsinger**  
**A Wellness From Within, LLC Family Chiropractic Center**  
265 W. Uwchlan Ave Downingtown, PA 19335  
**www.livewell-dc.com**  
**(484) 593-4178**

## **Services & Supplies**

### **Thank you for choosing the A Wellness From Within, LLC for your health care needs.**

- CHIROPRACTIC HAS ONE MISSION: ELIMINATE MISALIGNMENTS/SUBLUXATIONS THAT INTERFERE WITH THE EXPRESSION OF THE BODY'S INNATE WISDOM.
- SUBLUXATION CAUSES ALTERATION OF NERVE FUNCTION AND INTERFERENCE TO THE TRANSMISSION OF MENTAL IMPULSES, RESULTING IN A LESSENING OF THE BODY'S ABILITY TO EXPRESS ITS MAXIMUM HEALTH POTENTIAL.
- HEALTH BEING A STATE OF OPTIMAL PHYSICAL, MENTAL AND SOCIAL WELL-BEING, NOT MERELY THE ABSENCE OF DISEASE, PAIN OR INFIRMITY.
- OUR ONLY PRACTICE OBJECTIVE IS TO ELIMINATE MAJOR INTERFERENCE TO THE EXPRESSION OF THE BODY'S INNATE WISDOM. SPECIFIC ADJUSTING IS USED TO CORRECT THE SUBLUXATION.

### **SERVICES AND SUPPLIES WE OFFER**

*The following list of services and supplies is offered by this office for your convenience.*

- Chiropractic PP, TT, Div, Act & Flexion Distraction (COX)
- Electro Therapy & Cold Laser Therapy | Exercise & Rehabilitation Instruction
- Orthotics & Orthopedic Supplies
- Vitamin & Nutritional Supplements | Weight Loss & Detoxification Programs
- Whole Body Health-Holistic Approaches & Health Conscious Newsletters

### **Insurance Coverage Varies and Depends on your PLAN's Coverage**

Our priority is to get you better as quick as possible and keep you healthy:

*Your treatment plan is determined by YOUR needs...NOT by what your Ins. Company Covers.*

*If you are having financial difficulties, please speak with the front desk for payment options*

Please Keep In Mind:

Many insurance companies, for the most part, *will NOT cover*: anything that seeks to prevent disease, promote health and prolong and enhance the quality of life (eg: maintenance/ wellness care, gym memberships, vitamins, electro-therapy pads, most orthopedic supplies, massage, and other health maintaining/preventative measures).

- **You are responsible for all services rendered by this office.** Please speak with our office if you need a payment plan. Unpaid balances may be subject to fees if they go to collections. If your insurance company DOES pay for a service you have been charged for, we will credit your account for that amount.
- In order to keep our fees down, **payment is due at time of service.** We may send out bills patients for services overdue or carry credits forward for your next appointment. ***If this is inconvenient for you, you may pay for services in advance.***
- It is **your responsibility to contact our office if you need to reschedule your appointment.** If you repeatedly miss your appointments or we must continually call you to reschedule your appointments, we regretfully have to discharge you from our care.

X \_\_\_\_\_  
Signature



\_\_\_\_\_  
Date

## GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, *how much is your pain preventing you from doing what you would normally do*, or from doing it as well as you normally would. Please indicate the *overall* impact of \_\_\_\_\_ in your life, not just when the pain is at its worst.



**PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ABILITY.**

- ▶ **OVERALL: Disruption of Chores-Home Responsibilities:** Activities performed around the house.  
 (Examples -yard work, driving the children to school, running errands)


 \_\_\_\_\_ 0    1    2    3    4    5    6    7    8    9    10 \_\_\_\_\_
 



Completely Able to Function Totally Unable to Function

- ▶ **OVERALL: Disruption of Hobbies-Recreation:** Activities of leisure time.  
 (Examples-after school sports, hiking, going to the gym)


 \_\_\_\_\_ 0    1    2    3    4    5    6    7    8    9    10 \_\_\_\_\_
 



Completely Able to Function Totally Unable to Function

- ▶ **OVERALL: Disruption of Social Life:** Activities with friends & events.  
 (Examples- attending parties, theater/concerts & dining out )


 \_\_\_\_\_ 0    1    2    3    4    5    6    7    8    9    10 \_\_\_\_\_
 



Completely Able to Function Totally Unable to Function

- ▶ **OVERALL: Disruption of Occupation:** Activities directly related to work, homemaker or volunteer work.  
 (Examples-sitting at computer, lifting heavy objects, standing for long periods of time, repetitive motions)


 \_\_\_\_\_ 0    1    2    3    4    5    6    7    8    9    10 \_\_\_\_\_
 



Completely Able to Function Totally Unable to Function

- ▶ **OVERALL: Disruption of Self Care:** Activities such as personal maintenance & independent daily living  
 (Examples-bathing, driving, getting dressed).


 \_\_\_\_\_ 0    1    2    3    4    5    6    7    8    9    10 \_\_\_\_\_
 

Completely Able to Function Totally Unable to Function

- ▶ **OVERALL: Disruption of Life- Support:** Activities of basic life-supporting behaviors  
 (Examples-eating, sleeping, reproduction & breathing)


 \_\_\_\_\_ 0    1    2    3    4    5    6    7    8    9    10 \_\_\_\_\_
 

Completely Able to Function Totally Unable to Function

SIGNATURE: \_\_\_\_\_ DATE : \_\_\_\_\_ TOTAL SCORE: \_\_\_\_\_

### FOR OFFICE USE ONLY

Disability Rating: 0-20% Min    21-40% Moderate    41-60% Severe    61-80% Crippling    81-100% Bed bound

Key: Total / 60 \* 100 = Disability index

**Dr. Dawn Huntsinger**  
**A Wellness From Within, LLC Family Chiropractic Center**  
**265 W. Uwchlan Ave Downingtown, PA 19335**  
**www.livewell-dc.com**  
**(484) 593-4178**

**Patient Consent & Authorization**

**I. My Consent**

*I hereby give consent to A Wellness From Within, LLC: Family Chiropractic Center:*

- To perform pertinent diagnostic testing, chiropractic care and other adjunctive treatments at the doctor's discretion regarding my care.

**II. My Authorization**

*You may use or disclose the following health care information:*

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers ( eg: your insurance company).

**I GIVE PERMISSION TO INFORM THE FOLLOWING PEOPLE ABOUT MY PROGRESS:**

(FOR EXAMPLE: SPOUSE/OTHER FAMILY MEMBERS/EMERGENCY CONTACTS/CLOSE FRIENDS, ETC)

Please list here: \_\_\_\_\_

*You may contact me:*

- Through mail, e-mail or phone. You may leave a message either at work or at home to a person or on an answering machine directly related to my health & care plan.
- Send birthday cards, reminders, newsletters/mailings generated by **A Wellness From Within, LLC: Family Chiropractic Center.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

**Patient Rights**

**III. My Rights**

- I may revoke this consent and authorization in writing at any time, however, it will not affect any actions already taken by **A Wellness From Within, LLC: Family Chiropractic Center** based upon the consent and authorization already granted. Once health care information is disclosed to the person (eg: other healthcare provider) or organization (eg: insurance company) they may re-disclose it. Privacy laws may no longer protect it.

*If you understand and agree with all of the above policies, please sign your name below.*

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

OFFICE USE ONLY INITIALS: \_\_\_\_\_