



REBELUTION HEALTHCARE

ADULT INTAKE PAPERWORK

HELLO AND WELCOME TO THE REBELUTION!

Who may we thank for referring you / how did you hear about us? _____

Please fill out the following information completely and to the best of your ability.
Remember to initial the bottom of each page.

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____
Preferred Name: _____ Gender: ☐ Male ☐ Female
Email: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W
Street Address: _____ Spouses Name: _____
Cell Phone: _____ City/State/Zip: _____
Occupation/Employer: _____ Home Phone: _____
Emergency Contact: _____ Work Phone: _____
Emergency Contact Phone: _____ Relationship to you: _____
Social Security #: _____

If you have Medicare, we need you to list your SSN above or provide us with your Medicare card

PERSONAL HEALTH HISTORY

Height: _____ ft _____ in Weight: _____ lbs
What is your typical daily work activity? ☐ Sitting ☐ Standing ☐ Working at a Computer ☐ Manual Labor ☐ Light Lifting
☐ Heavy Lifting ☐ Driving ☐ Other: _____
Do you have any genetic disorders or disabilities? ☐ No ☐ Yes If yes, explain: _____

SOCIAL HISTORY

Do you smoke?	☐ Never	☐ In the Past	☐ Occasionally	☐ Daily	How many daily? _____
Are you exposed to secondhand smoke?	☐ Never	☐ In the Past	☐ Occasionally	☐ Daily	
Do you drink alcohol?	☐ Never	☐ In the Past	☐ Occasionally	☐ Daily	How many weekly? _____
Do you use recreational drugs?	☐ Never	☐ In the Past	☐ Occasionally	☐ Daily	
How often do you exercise?	☐ Never	☐ In the Past	☐ Occasionally	☐ Daily	

PAST HISTORY

Has your symptom/pain/reason for seeking care happened BEFORE? ☐ No ☐ Yes

Help us identify past conditions or procedures that could be related to your main issue:

- ☐ N/A ☐ Past surgeries ☐ Childhood diseases ☐ Past injuries
☐ Been unconscious due to illness or injury ☐ Serious illnesses, operation, or health emergency
☐ Motor vehicle accident ☐ Fractured a bone

Explain (include year(s)): _____

OFFICE ONLY BC: _____

CHIEF COMPLAINT / HISTORY OF PRESENTING ILLNESS

Name: _____ Date: _____

What is the MAIN symptom/pain/reason you are seeking care?

PROBLEM/CONCERN #1: _____

- Rate your CURRENT pain/discomfort: ____ /10 WHEN did the problem begin? _____
- Did you do something/did something happen that caused/aggravated the problem?
☐ No ☐ Yes If yes, explain: _____
- Does the problem RADIATE outward? ☐ No ☐ Yes If yes, where? _____
- HOW OFTEN do you experience the problem?
☐ always ☐ often ☐ occasionally ☐ rarely ☐ monthly ☐ weekly ☐ daily (☐ AM / ☐ PM)
- WHEN is the problem at its worst? ☐ Morning ☐ Mid-day ☐ Evening ☐ Other _____
- What RELIEVES the problem? _____ What makes the problem WORSE? _____

Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

Are there any SECONDARY health concerns you wish to bring to our attention?

PROBLEM/CONCERN #2: ☐ N/A _____

- Rate your CURRENT pain/discomfort: ____ /10 WHEN did the problem begin? _____
- Did you do something/did something happen that caused/aggravated the problem?
☐ No ☐ Yes If yes, explain: _____
- Does the problem RADIATE outward? ☐ No ☐ Yes If yes, where? _____
- HOW OFTEN do you experience the problem?
☐ always ☐ often ☐ occasionally ☐ rarely ☐ monthly ☐ weekly ☐ daily (☐ AM / ☐ PM)
- WHEN is the problem at its worst? ☐ Morning ☐ Mid-day ☐ Evening ☐ Other _____
- What RELIEVES the problem? _____ What makes the problem WORSE? _____

Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

How would you describe the symptoms?

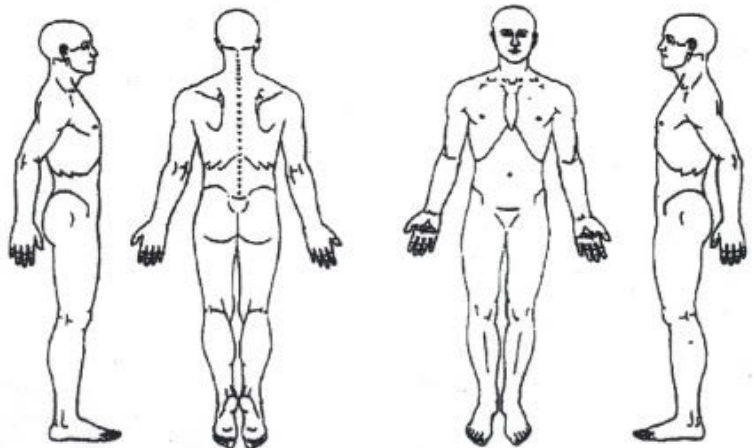
Please check ALL that apply

- | | |
|---|--|
| ☐ Aching Pain | ☐ Numbness |
| ☐ Stabbing Pain | ☐ Tingling |
| ☐ Sharp Pain | ☐ Pins & Needles Pain |
| ☐ Tiredness | ☐ Dead Feeling |
| ☐ Hot Sensation | ☐ Heavy Feeling |
| ☐ Cramping | ☐ Burning |
| ☐ Throbbing Pain | ☐ Electric Shocks |
| ☐ Swelling | ☐ Cold Hands/Feet |
| | ☐ Other: _____ |

Is your balance/walking ability affected?

☐ Yes ☐ No

Directions: On the diagrams CIRCLE the area(s) of your pain/symptom(s):



Name: _____ Date: _____

Which of the following have you tried for these problems: ☐ Physical Therapy ☐ Chiropractic ☐ Massage
☐ Pain Mediacion ☐ Tylenol ☐ Ibprofren ☐ Motrin ☐ Cymbalta ☐ Gabapentin ☐ Lyrica

Other: _____

How were your results? ☐ Good ☐ Poor ☐ Nothing changed ☐ Did not work very long

REVIEW OF SYMPTOMS

Please Check All That Apply

- | | | | | |
|--|--|--|--|--|
| ☐ Foot Pain | ☐ Diabetes | ☐ Spinal Stenosis | ☐ Cancer | ☐ Pinched Nerve |
| ☐ Hand Pain | ☐ High Cholesterol | ☐ Degenerative disc | ☐ Chemotherapy | ☐ Poor Circulation |
| ☐ Low Back Pain | ☐ High Blood Pressure | ☐ Vascular Problems | ☐ Arthritis in Hands | ☐ Joint Replacement |
| ☐ Neck Pain | ☐ Pacemaker/Defibrillator | ☐ Leg Pain | ☐ Arthritis in Feet | ☐ Foot Surgery |
| ☐ Foot Numbness | ☐ Herniated Disc | ☐ Plantar Fasciitis | ☐ Implanted Cord/Bladder Stimulator | ☐ Poor wound healing |
| ☐ Hand Numbness | ☐ Buldging Disc | ☐ Morton's Neuroma | ☐ Sciatica | ☐ Excessive thirst or urination |
| ☐ Night Sweats | ☐ Heart Attack | ☐ Stroke | ☐ Blood Clots | |

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

HEALTH LIFESTYLE GOALS

What are the health and lifestyle goals you hope you achieve while under care? PLEASE CHECK ALL THAT APPLY:

- ☐ Decrease the severity & intensity of my pain/problem(s)
☐ Decreasethefrequencyofmy pain/problem(s) (how often I experience the pain/problem(s))
☐ Bytheend of my corrective care, I hope to be able to... _____

How have others been affected by your health condition?

- ☐ No one is affected ☐ Haven't noticed any problem ☐ They tell me to do something ☐ People avoid me

What are you afraid this might be (or beginning) to affect (or will affect)?

- ☐ Job ☐ Kids ☐ Future Ability ☐ Marriage ☐ Self-esteem ☐ Sleep ☐ Time ☐ Finances ☐ Freedom

What are you most concerned with regarding your problem?

Office Only BC: _____

ACTIVITIES OF DAILY LIVING

Name: _____ Date: _____

DIRECTIONS: Assess your ability / lack of ability to complete the following activities.

Activity	CAN COMPLETE			CANNOT COMPLETE Due to Pain	N/A
	Without Pain or Difficulty	With Minimal Pain or Difficulty	With Significant Pain or Difficulty		
Bathe/Shower	☐	☐	☐	☐	☐
Groom Hair	☐	☐	☐	☐	☐
Brush Teeth	☐	☐	☐	☐	☐
Use Toilet	☐	☐	☐	☐	☐
Dress Upper Body	☐	☐	☐	☐	☐
Dress Lower Body	☐	☐	☐	☐	☐
Daily Physical Activities	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐
Sit	☐	☐	☐	☐	☐
Squat	☐	☐	☐	☐	☐
Kneel	☐	☐	☐	☐	☐
Reach Overhead	☐	☐	☐	☐	☐
Bend Forward	☐	☐	☐	☐	☐
Turn Left	☐	☐	☐	☐	☐
Turn Right	☐	☐	☐	☐	☐
Move from Seated to Standing	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐
Eat	☐	☐	☐	☐	☐
Go Up/Down Stairs	☐	☐	☐	☐	☐
Get In/Out of Car	☐	☐	☐	☐	☐
Drive	☐	☐	☐	☐	☐
Use Computer	☐	☐	☐	☐	☐
Focus/Concentrate	☐	☐	☐	☐	☐
Prepare Food	☐	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐	☐
Lift Children	☐	☐	☐	☐	☐
Carry Bag/Purse	☐	☐	☐	☐	☐
Run/Hike	☐	☐	☐	☐	☐
Sexual Activity	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐

Name: _____

Date: _____

REVIEW OF SYSTEMS & ORGAN DYSFUNCTION

DIRECTIONS: Check the box(es) that apply to conditions that you or your family members currently suffer from or have suffered from in the past. (Adopted? ☐ No ☐ Yes)

CONDITION	SELF	CHILD	SIBLING	PARENT	GRANDPARENT
Acid Reflux/Heartburn/GERD	☐	☐	☐	☐	☐
ADHD/ADD	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Arthritis/Joint Pain	☐	☐	☐	☐	☐
Asthma/Difficulty Breathing	☐	☐	☐	☐	☐
Autism Spectrum	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Carpal Tunnel Syndrome	☐	☐	☐	☐	☐
Chest Pain	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Difficulty Sleeping	☐	☐	☐	☐	☐
Disc Problems	☐	☐	☐	☐	☐
Dizziness/Vertigo	☐	☐	☐	☐	☐
Ear Problems	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Headaches/Migraines	☐	☐	☐	☐	☐
Hemorrhoids	☐	☐	☐	☐	☐
High/Low Blood Pressure	☐	☐	☐	☐	☐
Infertility	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐
Menstrual Dysfunction	☐	☐	☐	☐	☐
Mood Changes/Irritability	☐	☐	☐	☐	☐
Numbness/Tingling	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐
Sinus Problems	☐	☐	☐	☐	☐
Swelling of Legs/Feet	☐	☐	☐	☐	☐
TMJ/Jaw Pain	☐	☐	☐	☐	☐
Tremors	☐	☐	☐	☐	☐
*Organic / System Problems	☐	☐	☐	☐	☐

*Select ALL that apply: ☐ Digestive ☐ Gallbladder ☐ Heart ☐ Liver ☐ Stomach ☐ Pancreas

☐ Reproductive ☐ Lung/Respiratory ☐ Urinary ☐ Kidney ☐ Prostate ☐ Vision ☐ Thyroid ☐ Skin

☐ Other(s) _____ Explain:

PREVIOUS HEALTH HISTORY

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name _____ Signature _____

Please give name, address, and office phone number of your primary care physician.

Name _____ Phone _____

Address _____

When were you last seen there? _____

May we send them updates on your treatment/condition? ☐ Yes ☐ No

Please list any other doctors treating you for this condition: _____

List ALL allergies/sensitivities to medication, food, and other items here:

Items you react to:

Reaction:

List the prescription drugs you are currently taking (you may attach a list):

Name

Dose (mg or IU)

Times daily

List all nutritional supplements (vitamins, herbs, homeopathies, etc.) as above:

Have you received chiropractic care in the past? ☐ No ☐ Yes (from whom?)

WELLNESS EVALUATION

Leaky gut aka intestinal permeability is not typically diagnosed in today's modern medicine. However, that does not mean it is not affecting your health. Many times gut health issues go undiagnosed, misdiagnosed, or ignored by traditional medicine. Please complete this form to help our doctors determine how we can help.

Please check all that applies to you:

Sub-Clinical Symptoms:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance:

- ☐ PMS
- ☐ Emotional Imbalance

Gastrointestinal Issues:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease or other intestinal disorders

Respiratory Conditions:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions:

- ☐ Knee, Spine, or Shoulder

Autoimmune Conditions:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions:

- ☐ Eczema
- ☐ Hives
- ☐ Skin Rashes

Circle the number that best describes your symptoms, then add to get your results

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Weight issues	0	1	2	3

	None	Mild	Mod	Severe
Eczema, skin rashes or hives (urticaria)	0	1	2	3
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you sick	0	1	2	3
Gluten sensitivity or Celiac Disease	0	1	2	3
Nausea	0	1	2	3



Informed Consent for Care at Rebelution Healthcare

I consent to receive an examination, with the understanding that the doctor will explain their findings and discuss recommended diagnostic tests, procedures, and a treatment plan. I acknowledge that the treatment provided at this clinic is by licensed Doctors of Chiropractic and other licensed healthcare providers. If my condition requires care outside this clinic's scope, I will be referred to an appropriate provider.

Care and Procedures Offered at Rebelution Healthcare. I understand that not all procedures will be part of my care, but this is a comprehensive list of care offered in this clinic. Through our comprehensive examination process, we carefully assess and identify any potential risks or contraindications to ensure that each therapy we offer is safe and appropriate for your specific health needs.

Neuropathy Program

Procedures: May include Red Light Therapy, Spinal Decompression, Vibration Plate Therapy, and Nerve Retrainer Therapy.

- **Red Light Therapy**
 - **Benefits:**
 - **Skin Health:** Supports healing and reduces inflammation.
 - **Joint Pain Relief:** Eases joint discomfort and stiffness.
 - **Improved Mood and Energy:** Enhances overall mood and energy levels.
 - **Muscle Recovery:** Promotes faster recovery and better athletic performance.
 - **Risks:**
 - **Eye Conditions:** Contraindicated in retinal diseases and for those on photosensitizing medications.
 - **Pregnancy:** Should be avoided during pregnancy.
- **Spinal Decompression**
 - **Benefits:**
 - **Pain Relief:** Alleviates spine pain, nerve compression, and disc issues.
 - **Disc Conditions:** Helps with herniated discs, degenerative discs, and facet syndrome.
 - **Risks:**
 - **Soreness:** Common dull, achy soreness as the body adjusts.
 - **Contraindications:** Not suitable for those with disc fragmentation, severe arthritis, some types of surgical spinal hardware, specific spinal instabilities (e.g., recent fractures, unstable spondylolisthesis), or detached retina.
- **Vibration Plate Therapy**
 - **Benefits:**
 - **Muscle Recovery:** Enhances muscle strength and recovery.
 - **Balance and Flexibility:** Improves balance, coordination, and flexibility, reducing fall risk.
 - **Bone Density:** May help prevent osteoporosis.
 - **Joint Health:** Reduces stiffness and improves circulation, aiding those with arthritis or joint problems.
 - **Risks:**
 - **Contraindications:** Not suitable for individuals with blood clots or clotting disorders, epilepsy, heart disease, recent stroke, pacemakers with piezoelectric sensors, or those who are pregnant.
- **Nerve Retrainer**
 - **Benefits:**
 - **Pain Relief:** Utilizes electrical stimulation to block pain signals, increase blood flow, and stimulate nerve repair, providing relief from neuropathy symptoms.
 - **Nerve Repair:** Promotes healing of damaged nerves through microcurrent and galvanic stimulation, and improves muscle function through targeted stimulation.
 - **Drug-Free:** Offers a safe, at-home alternative to medications for nerve pain without the associated risks of medication use.
 - **Risks:**
 - **Mild Discomfort:** May cause tingling or unusual sensations during use.
 - **Contraindications:** Not suitable for individuals with implanted electronic devices, certain types of pacemakers, or severe circulatory issues including blood clots. Pregnant women should avoid use.

Chiropractic Care

Procedures: Spinal manipulation and physical therapy, including exercises and manual therapy, aimed at alleviating pain and improving function.

- **Benefits:**

- **Enhanced Nervous System Function:** Improves communication between the brain and body by reducing nerve interference. Stimulates the parasympathetic nervous system, which helps the body to heal.
- **Pain Relief:** Reduces acute and chronic pain, particularly in the back, neck, and joints.
- **Improved Mobility:** Restores and enhances the range of motion in the spine and other joints.
- **Reduced Headaches:** Eases tension in the neck and spine, decreasing the frequency and severity of headaches.
- **Improved Posture:** Corrects spinal misalignments, encouraging better posture.
- **Overall Well-Being:** Supports natural healing, boosts immune function, and promotes well-being.
- **Drug-Free Approach:** Offers a natural, non-invasive alternative to pain management.

- **Risks:**

- **Temporary Soreness:** Common after initial treatments.
- **Dizziness, Nausea, Flushing:** Rare, but possible. Notify your doctor if experienced.
- **Disc Herniation or Prolapse:** May worsen existing spinal disc conditions.
- **Stroke:** Extremely rare, with no evidence of increased risk specific to chiropractic care.
- **Bruising:** Possible with instrument-assisted soft tissue manipulation.
- **Fractures:** Rare, primarily in patients with conditions like osteoporosis. Your doctor will modify your treatment if such risks are identified.
- **Burns:** Rarely, from physiotherapy devices that produce heat.

X-Rays

Purpose: Used to assess spinal health and guide treatment, not for diagnosing medical conditions.

- **Benefits:**

- **Accurate Diagnosis:** Provides valuable information for a targeted treatment plan.

- **Risks:**

- **Radiation Exposure:** Minimal. If I am pregnant or suspect that I may be pregnant, I must inform my healthcare provider before the X-ray is performed.

_____ (Initials) I am not pregnant to my knowledge (Date of last menstrual cycle: _____).

Alternatives:

- **Options:** Alternatives to spinal manipulation as well as treatments provided at Rebelution Healthcare include Physical Therapy, Massage, Acupuncture, Medication, Cognitive-behavioral therapy, and Anti-inflammatory diets.
- **Risks of Refusal:** Declining recommended procedures may increase the risk of chronic pain or reduced daily function.

I understand that healthcare outcomes are not guaranteed. The material risks have been explained to me, and I consent to the proposed treatments, understanding these risks.

Patient Please Review Print & Sign Name

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my provider and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

Patient's Name (Print) _____

Date of Birth _____

Patient Signature _____

Date _____

Translator/Interpreter Name (Print)

Translator/Interpreter Signature

CLINICIAN ONLY

Based on my personal observation, the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

- | | | |
|---------------------------------------|---|--|
| ☐ OF LEGAL AGE | ☐ APPEARS UNIMPAIRED | ☐ CONSENT GIVEN THROUGH GUARDIAN/PATIENT REPRESENTATIVE |
| ☐ ORIENTED X3 | ☐ FLUENT IN ENGLISH | ☐ ASSISTED BY A TRANSLATOR OR INTERPRETER |

_____, D.C.
Signature

Date _____