BioNeuroLogics, LLC DBA My ChiroIQ
419 Hibben Street Mount Pleasant, SC 29464
843-766-4444
www.mychiroiq.com
info@mychiroiq.com

Patient Intake Form

Date: _____

First Name: _____ **Phone 1:** _____ **Marital Status:**

Last Name: _____ ☐ **Home** ☐ **Mobile** ☐ **Work** ☐ **Other** ☐ **Single** ☐ **Married** ☐ **Other**

DOB: _____ **Phone 2:** _____ **Job Status** **Height**___' ___''

Sex: ☐ **Male** ☐ **Female** ☐ **Home** ☐ **Mobile** ☐ **Work** ☐ **Other** ☐ **Not Employed**

Address: _____ **Email:** _____ ☐ **Employed** **Weight** ____ **lbs**

City: _____ **Employer:** _____ ☐ **Part – Time Student**

State: _____ **Employer Phone:** _____ ☐ **Full – Time Student**

Zip Code: _____ **Occupation:** _____ ☐ **Retired**

Reason for you Visit:

☐ **Wellness and Health Maintenance**		
☐ **Injury, Pain, Ailment**	**Date of Injury:** **(When did your pain start)**	
☐ **Accident** ☐ **Auto** ☐ **Other**	**Date of Accident:**	**State where Accident Occurred:**

Referred By: ☐ **Provider** ☐ **Friend** ☐ **Family** ☐ **Other** _____

Referred By Name: _____

How Heard of Us: ☐ **Walk in** ☐ **Referral** ☐ **Phone Book** ☐ **Website** ☐ **Advertisement** ☐ **Other** _____

Demographics:

Race: ☐ **White** ☐ **Black or African American** ☐ **American Indian or Alaska Native** ☐ **Asian**

☐ **Native Hawallan or Other Specific Islander** ☐ **Other** _____

Ethnicity: ☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino** ☐ **Unknown** ☐ **Other** _____

Dominance: ☐ **Right** ☐ **Left** ☐ **Ambidextrous**

Emergency Contact Information:

First Name: _____ **Relationship:** _____

Last Name: _____ **Phone 1:** _____ **Phone 2:** _____

Employer / Company Name:		**Phone Number:**
Street Address:		**Suite / Unit #:**
City:	**State:**	**Zip:**
Job Title / Position	**Currently Working:** ☐ **Yes** ☐ **No** **Date Stopped Working:** _____	

Pt. Name: _____ D.O.B: _____

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

Please initial each item below indicating that you understand the Following:

- ***We do not treat symptoms or diseases:*** _____
- ***A symptom is an attempt by your body to tell you something:*** _____
- ***We will attempt to find the underlying cause:*** _____
- ***We do not use drugs in this program:*** _____
- ***There is no single "healthy" diet that will work for everyone:*** _____
- ***Just because food is considered "healthy", does not mean it is "healthy" for you:*** _____
- ***Your diet consists of everything you eat, drink, rub on your skin, or inhale:*** _____
- ***Our procedures are safe and painless:*** _____
- ***There are no "refunds"*** _____

Briefly describe the reason for your visit and what you hope to accomplish:

_____

_____.

AGE WHEN SYMPTOMS WERE FIRST OBSERVED:

☐ **Infant (Age 0 – 2)** ☐ **Child (Age 3 – 5)**

☐ **Child (Age 6 – 12)** ☐ **Adolescent (Age 13 – 18)**

☐ **Adult (Age 19 – 25)** ☐ **Adult (Age 26 – 40)**

☐ **Adult (Age 41 and Over)**

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED? ☐ **Yes** ☐ **No**

_____.

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? ☐ **Yes** ☐ **No**

_____.

Pt. Name: _____ D.O.B: _____

Medical History:

Do you Smoke…? ☐ **Yes** ☐ **No**	**If yes, How Often…?**
Do you drink Alcohol…? ☐ **Yes** ☐ **No**	**If yes, How Often…?**
How would you describe your overall stress level…? ☐ **Low** ☐ **Medium** ☐ **High**	**Stressors:**
Do you Exercise…? ☐ **Yes** ☐ **No**	**If yes, How Often…?**
How many glasses of Water do you typically drink per Day…?	**How many Hours of Sleep per night do you get regularly…?**
Have you ever been Hospitalized…? ☐ **Yes** ☐ **No**	**Have you had any Surgeries…?** ☐ **Yes** ☐ **No**
If yes, Please provide Details:	
Do you take any Medications or Supplements…? ☐ **Yes** ☐ **No**	
If yes, Please list of Supplements, Vitamins, Medications and Dosages (How much & How Often):	
Do you have any Allergies…? ☐ **Yes** ☐ **No**	**Do you Require Medical Treatment for you Allergies…?** ☐ **Yes** ☐ **No**
Are you currently being treated for any other Medical Conditions I should know about…? ☐ **Yes** ☐ **No**	
Do you currently use any personal therapeutic energy devices? (ie magnetics, tens units, pemf mats) ☐ **Yes** ☐ **No**	

Pt. Name: _____ **D.O.B:** _____

List Current Complaints Separately in Order of Severity:

1st Body Part: _____

Date Symptom First Appeared: _____

How often do you Experience these Symptoms…?

☐ **Constant 100%** ☐ **Frequent 75%** ☐ **Intermittent 50%**

☐ **Occasionally 25%** ☐ **Rarely 10% or Less**

What makes the Symptoms Worse…? _____

What makes the Symptoms Better…? _____

Type of Pain…? ☐ **Sharp** ☐ **Dull** ☐ **Aching** ☐ **Burning**

☐ **Throbbing** ☐ **Numb** ☐ **Other**

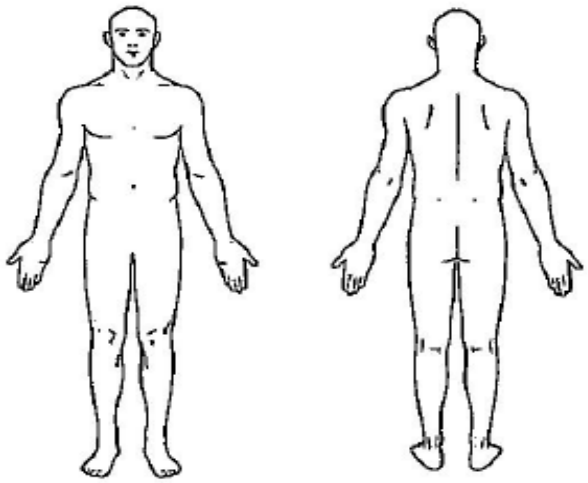
Does the Pain Radiate…? ☐ **Yes** ☐ **No**

If yes, to Where…? _____

Please rate the Intensity of your Pain on a Scale of 1 – 10:

0 being No Pain 10 being Excruciating: _____

Please mark areas of pain on the figure below



2nd Body Part: _____

Date Symptom First Appeared: _____

How often do you Experience these Symptoms…?

☐ **Constant 100%** ☐ **Frequent 75%** ☐ **Intermittent 50%**

☐ **Occasionally 25%** ☐ **Rarely 10% or Less**

What makes the Symptoms Worse…? _____

What makes the Symptoms Better…? _____

Type of Pain…? ☐ **Sharp** ☐ **Dull** ☐ **Aching** ☐ **Burning**

☐ **Throbbing** ☐ **Numb** ☐ **Other**

Does the Pain Radiate…? ☐ **Yes** ☐ **No**

If yes, to Where…? _____

Please rate the Intensity of your Pain on a Scale of 1 – 10:

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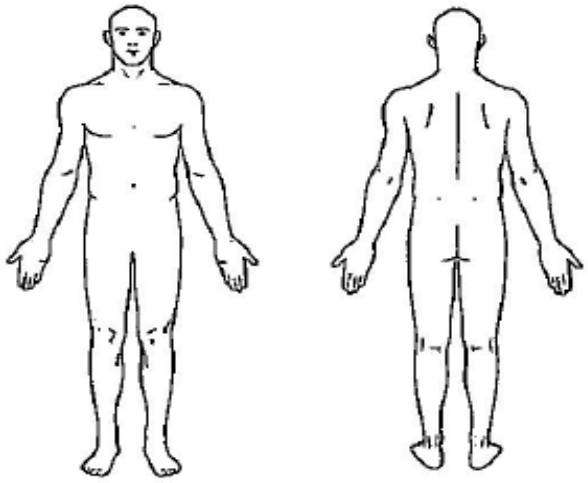

3rd Body Part: _____

Date Symptom First Appeared: _____

How often do you Experience these Symptoms…?

☐ **Constant 100%** ☐ **Frequent 75%** ☐ **Intermittent 50%**

☐ **Occasionally 25%** ☐ **Rarely 10% or Less**

What makes the Symptoms Worse…? _____

What makes the Symptoms Better…? _____

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☐ **Throbbing** ☐ **Numb** ☐ **Other**

Does the Pain Radiate…? ☐ **Yes** ☐ **No**

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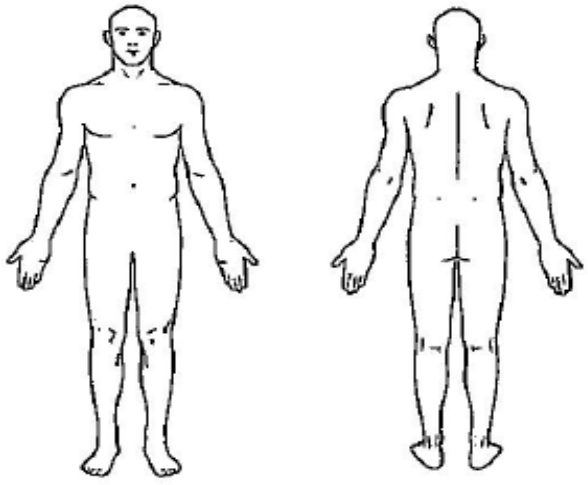

Pt. Name: _____ D.O.B: _____

Please check if you have or have had any of the Following:

☐ Headaches / Migraines	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Osteoarthritis	☐ Rheumatoid Arthritis	☐ Arm / Leg Pain	☐ Jaw Pain / Clicking
☐ Dizziness	☐ Fatigue	☐ Fibromyalgia	☐ Asthma	☐ Numbness / Tingling
☐ Allergies	☐ High Cholesterol	☐ Digestive Problems	☐ Joint Pain / Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Glaucoma	☐ Diabetes	☐ High Blood Pressure
☐ Cancer	☐ Nervousness	☐ AIDS / HIV	☐ Osteoporosis	☐ Heart Disease
☐ Paralysis	☐ Parkinson's	☐ Kidney Disease	☐ Prostate Problems	☐ Disc Degeneration
☐ Sciatica	☐ Sinus Pain	☐ Pacemaker	☐ Stroke	☐ Thyroid Problems
☐ Tumors / Growths	☐ Urinary Problems	☐ Vascular Disease	☐ Vision Problems	☐ Herniated Disc
☐ Anemia	☐ Bronchitis	☐ Gout	☐ Venereal Disease	☐ Bleeding Disorder
☐ Chemical Dependency	☐ Tuberculosis	☐ Ulcers	☐ Breast Lump	☐ Depression
☐ Liver Disease				

Is there any history in your family for the above conditions? ☐ Yes ☐ No Who? What did they have?

_____

_____

Pt. Name: _____ D.O.B: _____

What daily activities are affected due to the Problem?

☐ Bathing ☐ Cleaning ☐ Climbing Stales ☐ Cooking ☐ Doing Laundry
☐ Caring for Children ☐ Dressing ☐ Driving ☐ Eating ☐ Exercising
☐ Going from lying down to sitting ☐ Going from Sitting to Standing ☐ Grooming
☐ House Work ☐ Lying Down ☐ Lifting ☐ Oral Care ☐ Sex
☐ Shopping ☐ Sitting ☐ Sleeping ☐ Social / Recreational Activities
☐ Standing ☐ Stretching ☐ Toileting ☐ Transferring ☐ Using Technology
☐ Using Phone ☐ Walking ☐ Watching TV ☐ Yard Work

Have you been given a diagnosis for this problem? If so, what was the diagnosis?

_____

What treatments(s) have you tried for your condition?

☐ None ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other: _____

Nose: Please check all the Apply:

☐ None ☐ Allergies ☐ Blocked Sinuses ☐ Discharge ☐ Excessive Mucus ☐ Hay Fever ☐ Nose Bleeds
☐ Sinus Pressure / Plan ☐ Stuffiness / Blockage ☐ Other: _____

Gastrointestinal: Please check all that Apply:

☐ None ☐ Change in appetite ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea ☐ Heartburn
☐ Nausea ☐ Rectal Bleeding ☐ Swallowing Difficulties ☐ Yellow Eyes or Skin (Jaundice)
☐ Other: _____

Endocrine: Please check all that Apply:

☐ None ☐ Change in appetite ☐ Cold Intolerance ☐ Constipation ☐ Diarrhea ☐ Dry Skin
☐ Excessive Thirst ☐ Frequent Urination ☐ Heat Intolerance ☐ Sweating

Vascular / Hematologic: Please check all that Apply:

☐ None ☐ Calf Pain with Walking (Claudication) ☐ Cold hands and Feet ☐ Ease of Bleeding
☐ Ease of Bruising ☐ Leg Cramping

Neurologic: Please check all that Apply:

☐ None ☐ Dizziness ☐ Easily Angered / Irritated ☐ Fainting ☐ Frequent Crying ☐ Memory Confusion
☐ Nervousness ☐ Neuralgia ☐ Numbness ☐ Poor Concentration ☐ Seizures ☐ Suicidal thoughts
☐ Tingling ☐ Tremors ☐ Weakness ☐ Worry / Anxiety ☐ Other: _____

Psychiatric: Please check all that Apply:

☐ None ☐ Anxiety ☐ Depression ☐ Memory Loss ☐ Nervousness ☐ Stress ☐ Other: _____

Pt. Name: _____ D.O.B: _____

Female:

Are you Pregnant? ☐ **Yes** ☐ **No** **Date of Last Period: _____** **Number of Days between periods: _____**

Age Started: _____ **Age Stopped: _____**

Number of pregnancies: _____ **Number of Deliveries: _____** **Number of Miscarriages: _____**

Number of abortions: _____ **Number of Cesareans: _____** **Operation:** ☐ **Cervix** ☐ **Uterus** ☐ **Ovaries**

Please check all that Apply:

☐ **None** ☐ **Clotting** ☐ **Dark Color** ☐ **Discharge** ☐ **Food Cravings** ☐ **Heavy Bleeding** ☐ **Hot Flashes**

☐ **Infections** ☐ **Irregular Periods** ☐ **Itching or Rash** ☐ **Leg Cramps** ☐ **Light Bleeding**

☐ **Little / No Sex Drive** ☐ **Menstrual Pain / Cramps** ☐ **Missed Periods** ☐ **Mood Swings** ☐ **Painful Breasts**

☐ **Pain with Sex** ☐ **STD's** ☐ **Vaginal Discharge** ☐ **Vaginal Dryness** ☐ **Vaginal Sores** ☐ **Water Retention**

☐ **Other: _____**

Male: Please check all that Apply:

☐ **None** ☐ **Discharges** ☐ **Erectile Dysfunction** ☐ **Hernia** ☐ **Impotence** ☐ **Low Sex Drive** ☐**Masses or Pain**

☐ **Painful Urination** ☐ **Pain with Sex** ☐ **Painful Discharge** ☐ **Prostate Problems**

☐ **Sores** ☐ **STD's** ☐ **Other: _____**

Pt. Name: _____ D.O.B: _____

BIONEUROLOGICS, LLC DBA CHIRO IQ

WAIVER OF LIABILITY, ASSUMPTION OF ALL RISKS, AND ARITRATION AGREEMENT

In consideration of the services of BioNeurologics, LLC DBA Chiro IQ, its agents, shareholders, subsidiaries, affiliates, directors, successors, representatives, owners, officers, employees, assigns and all other persons or entities acting in any capacity on its behalf, I have read and consent to this Waiver of Liability, Assumption of All Risks, and Arbitration Agreement ("Waiver") and I agree to the following terms:

1. Consideration and Intent – I acknowledge that in exchange for accessing the machines, treatments, services and product available at BioNeurologics, LLC DBA Chiro IQ, I assume all the risks associated and to release BioNeurologics, LLC DBA Chiro IQ, from any and all liability to the maximum extent permitted by law. This waiver shall be legally binding upon me personally, all members of my family and all minors under my care of supervision, my and their heirs, successors, assigns, and legal representatives.
2. Assumption of Risk
    a. I have voluntarily availed myself of the services, treatments, machines and products available at BioNeurologics, LLC DBA Chiro IQ, and I acknowledge that I have been advised of the risks associated with each classification. I understand the hazards involved, and I elect to participate in spite of the potential risks and hazards.
    b. I certify that I have no medical or physical conditions which could interfere with my safety in this activity or services, and by failing to fully disclose a conditions, I am willing to assume all costs that may be created, directly or indirectly, by any such condition.
3. Waiver of Liability – I hereby voluntarily release, waive, forever discharge, agree not to sue, and agree to indemnify and hold harmless BioNeurologics, LLC DBA Chiro IQ from any and all claims, demands, costs, losses, causes of action, liability, expense, obligation, damages, recoveries, or judgments, including interest, penalties and reasonable attorney's fees, which are in any way connected with my participation and use of services at BioNeurologics, LLC DBA Chiro IQ.
4. Arbitration Agreement, Governing Law, and Forum Selection
    a. I agree that any dispute concerning, relating to, or referring to this Waiver, the BioNeurologics, LLC DBA Chiro IQ Terms and Conditions of registration ("Terms and Conditions"), or any other contract, form, brochure, or other Literature concerning my treatment, available services commercial rules of the American Arbitration Association ("AAA") in person in Charleston Country, South Carolina, United States of America. Such proceedings will be governed by the substantive law of South Carolina, without reference to any conflict of law rules. The arbitrator and not any federal, state, or local court or agency shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability, conscionability or formation of this contract, including but not limited to any claim that all or any of this contract is void or voidable. I understand that I am giving up any right that I may have to a jury trial or to bring claims in court against BioNeurologics, LLC DBA Chiro IQ. I agree that payment of all filing, administration and arbitrator fees will be governed by the AAA's rules, and that the arbitrator shall be entitled to award attorney's fees as permitted under South Carolina Law judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

b. Should any party to this Waiver hereafter institute any legal action or administrative processing against the other by any method other than by binding arbitration as specified in this paragraph, then the responding party shall be entitled to recover from the initiating party prevails in having the legal action or administrative processing referred to arbitration in accordance with this arbitration provision.

This Agreement, Waiver and Indemnification constitute the sole and entire agreement among the Parties. The validity, construction, and enforceability of this Agreement shall be construed under and governed by the laws of South Carolina.

I have read and understand this Agreement.

_____ (Initial) I am the registered participant, I am 18 years of age or older, and I have read and agree to be bound by the terms of this Waiver of Liability. Assumption of Risk, and Arbitration Agreement or I am the parent or guardian of the registered participant; who is a minor child under the age of 18 years, and I give my permission for my child or ward to participate in the trip and I further accept and agree to be bound, individually and on behalf of my child or ward, by this Waiver of Liability, Assumption of Risk, and Arbitration Agreement.

_____ _____

Printed Name: **Date:**

_____

Signature:

AUTHORIZATION FOR CARE OF MINOR **Consent to treat a minor:** I hereby authorize the doctor(s) at BioNeurologics, LLC and whomever they designate as assistants to administer care to child.
Name of Minor Child:
Name of Parent / Guardian (Print):
Parent / Guardian signature:
Date: