CONFIDENTIAL INTAKE & CASE HISTORY

Completing this form will help us determine how our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

PERSONAL INFORMATION

Patient name: ____ Date: ____________________

Date of Birth: mm________dd________yr________ Age: _______ Sex (circle): ●Male ●Female

Address: ____

Current Weight: _____________ Height: ______________

Phone (cell): ____________________________ Phone (home): ___________________________

Type of Work: ____

E-Mail: ____________________________________

Emergency Contact Name, Relation, and Phone:

____

How did you hear about us: ____

HEALTH INFORMATION

Primary care physician: ____

Have you seen a chiropractor in the past: ●Yes ●No If yes, name and date: __________________

Were X-rays taken: ●Yes ●No

Results: ____

Are you receiving care from any other health professionals: ●Yes ●No

If yes, please name them and their specialty: ____

Current medications or supplements and reason for use: ____________________________________

____

List surgical operations and/or major injuries: ____

____

Have you been in an auto accident? If yes, when: ____

Describe the accident: ____

Have you had any other personal injury or accidents? If yes, when: ______________________________

Describe: ____

Date of most recent physical examination: ____

Circle all that you have had or currently have:

- Acid Reflux
- Autoimmune
- Arthritis
- Cancer
- Chronic Back Pain
- Chronic Neck Pain
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestive Problems
- Dizziness
- Eye Pain Difficulties
- Epilepsy
- Fatigue
- Frequent Urination
- Gout
- Headache
- High BP
- Hypoglycemia
- Kidney Infection
- Loss of Memory
- Loss of Balance
- Lumbago
- Migraine Headaches
- Multiple Sclerosis
- Pacemaker
- Poor Posture
- Prostate Problems
- Psoriasis
- Rheumatoid Arthritis
- Seizures
- Sciatica
- Scoliosis
- Shortness of Breath
- Skin Sensitivity
- Spine Surgery
- Swollen Joints
- Thyroid Condition
- Other: ______________________________

Do you Smoke: ____________________

How much water do you drink a day: ____________________

Do you Exercise: ____________________

Type of Exercise: ____________________

How often do you Exercise: ____________________

PREGNANCY

Are you currently pregnant: ____________________

When are you due: ____________________

Is this your first pregnancy: ____________________

What would you like to gain from chiropractic care during your pregnancy: ____________________

____

PRESENT COMPLAINT

Reason for visit: ____________________

____

Does this concern affect (circle all that apply):

●sleep ●daily routine ●work ●other activities ●does not affect

Please explain: ____________________

Have you had any past treatment for this complaint: ●Yes ●No

If yes, please explain: ____________________

When did the present complaint begin: ____________________

____

It began… (circle the appropriate answer): ●Suddenly ●Gradually ●Post-injury

If injury-related, please explain: ____________________

The condition is getting (circle all that apply):

●worse ●improving ●intermittent ●constant ●not sure

What makes the problem better: ____________________

What makes the problem worse: ____________________

Have you ever had a similar condition: ●Yes ●No

If yes, please explain: ____

____

Anything else you would like us to know about this concern: ________________________

____

Any other health concerns: ____

____

YOUR HEALTH GOALS

What are your top 3 goals in receiving chiropractic care?

1. ________________________

2. ________________________

3. ________________________

What would you like to gain from Chiropractic care:

●Resolving existing condition ●Overall wellness ●Both

INSURANCE & PAYMENT FOR CARE

How do you plan to pay for care?

____Personal Insurance ____Third – Party Insurance ____No Insurance, Self -Pay

Primary Insurance

Insurance Name: ________________________

Phone: ________________________ (located on the back of the card)

Member ID/Policy #: ________________________

Secondary Insurance

Insurance Name: ________________________

Phone: ________________________ (located on the back of the card)

Member ID/Policy #: ________________________

DO YOU KNOW ABOUT CHIROPRACTIC?

Do you know what a subluxation is?	●Yes	●No
Were you aware that chiropractic is the largest natural healing profession in the world?	●Yes	●No
Did you know that Doctor of Chiropractic Work with the nervous system?	●Yes	●No
Did you know that the nervous system controls all bodily functions and systems?	●Yes	●No

AUTHORIZATION

I, the undersigned, having been explained the risks of treatment, do hereby request and consent to the performance of chiropractic treatment and related physical therapy procedures upon the above- named patient (my dependent or myself). I wish to rely on the chiropractor to exercise judgement for my best interest during the course of treatment. I will inform the chiropractor or certified assistant who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submission. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health / accident insurance policies are an arrangement between an insurance carrier and yourself. I understand that fees for professional services will become due upon suspension or termination of my care of treatment.

____________________________________ ________________________

(Patient's Signature/Parent or Guardian's Signature) (Today's Date)