Live Well CHIROPRACTIC
Dr. Jeffrey F. Dye, D.C.

Adult Intake Form

Date: _____

Personal Information		
First Name: M.I.: Last Name:		
Preferred Name: Social Security Number: _____-_____-_____		
Address:		
City/ State/ Zip:		
Birth Date:	Age:	Sex: M or F
Best Contact Phone: ( )		
Alternate Phone: ( )		
Email:		
Who can we thank for referring you or how did you hear about Live Well Chiropractic?_____ _____		

Reason for Seeking Care
What is your reason for seeking care at Live Well Chiropractic?_____ _____
When did this begin? (If applicable)_____
Are there any major injuries and/or surgeries we should know about?_____ _____
What is this affecting that is MOST important in your life? (List all that apply)_____ _____
Have you seen any other providers for this condition? (List all that apply)_____ _____
Have you seen a chiropractor before? Yes or No How long ago?_____ Clinic/Doctor Name:_____ What is your reason for the change? (If applicable)_____ What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10 Explain:_____ What health goal, if you were to complete or accomplish it, would have the greatest impact on your life? _____

Health Concerns

☐ Anxiety/Depression	☐ Fatigue/Sleep Issues
☐ Constipation/Diarrhea	☐ Asthma/Chronic Bronchitis
☐ Nausea/Vomiting	☐ Colic/Acid Reflux
☐ Diabetes	☐ Back/Neck Pain/Stiffness
☐ Bed Wetting	☐ Difficulty Gaining Weight
☐ Overweight	☐ Ear or Other Infections
☐ Frequent Sickness	☐ Headaches
☐ ADD/ADHD	☐ Learning Disorders
☐ Detachment/Distant	☐ Sinus Troubles/Allergies
☐ Irritability/Nervous	☐ Autism/Asperger's
☐ Other:	
☐ Other:	
☐ Other:	

Explain any boxes checked above:_____

_____

_____

_____

_____

Is there anything else regarding your current condition you feel the doctor should know?_____

_____

_____

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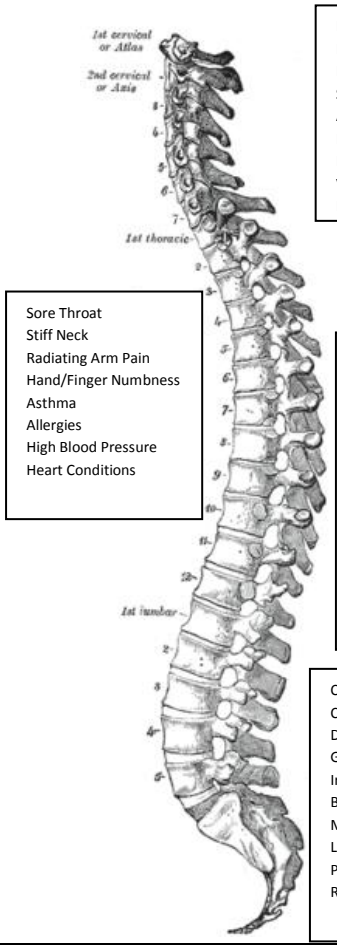
_____

Did You Know…

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue/Sleep Problems
Head Colds
Vision Problems
Difficulty Concentrating

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Galbladder Conditions
Stomach Problems
Stomach Problems
Ulcers
Gastritis
Kidney Problems
Indigestion

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in Legs
Reproductive Problems

Medications

☐ Anxiety/Depression	☐ Migraine/Headache
☐ Asthma	☐ Acid Reflux
☐ Pain Narcotics	☐ ADD/ADHA
☐ Antibiotics	☐ Digestive
☐ Other:_____	
☐ Other:_____	
☐ Other:_____	

Explain any boxes checked above:_____

_____

_____

_____

_____

_____

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_____

Vitamins/Supplements

☐ Multi-Vitamin	☐ Fish Oil/Omega-3
☐ Vitamin D3	☐ Probiotics
☐ Other:_____	
☐ Other:_____	
☐ Other:_____	

Explain any boxes checked above:_____

_____

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Health Status Questionnaire

Your Physical Life

Rate based on a frequency scale of 1-5 1=Never 2=Rarely 3= Occasional 4=Regularly 5=Constantly

Presence of physical pain 1 2 3 4 5	Incidence of colds or flu 1 2 3 4 5
Feelings of tension, stiffness, lack of flexibility1 2 3 4 5	Ability to work out or engage in activity 1 2 3 4 5
Incidence of fatigue or low energy1 2 3 4 5	Incidence of chronic disease 1 2 3 4 5

Chemical/ Nutritional Life

Rate based on a frequency scale of 1-5 1=Never 2=Rarely 3= Occasional 4=Regularly 5=Constantly

Eat a well-balanced diet 1 2 3 4 5	Eat an organic, grass fed, hormone-free diet 1 2 3 4 5
Eat a diet rich in fruit and vegetables 1 2 3 4 5	Use a lot of chemicals on your skin 1 2 3 4 5
Eat fast food or highly processed food 1 2 3 4 5	Ingestion of chemicals 1 2 3 4 5

Mental/Emotional State

Rate based on a frequency scale of 1-5 1=Never 2=Rarely 3= Occasional 4=Regularly 5=Constantly

Presence of negative feelings/energy 1 2 3 4 5	Being overly worried about small things 1 2 3 4 5
Moodiness, temper, or anger outbursts 1 2 3 4 5	Difficulty thinking or concentrating 1 2 3 4 5
Difficulty falling or staying asleep 1 2 3 4 5	Feeling of depression or anxiety 1 2 3 4 5

Stress Evaluation

Rate based on a frequency scale of 1-5 1=Never 2=Rarely 3= Occasional 4=Regularly 5=Constantly

Family 1 2 3 4 5	Work/School 1 2 3 4 5
Significant relationships 1 2 3 4 5	Day-to-day stress 1 2 3 4 5
Health 1 2 3 4 5	Finances 1 2 3 4 5

Life Enjoyment

Rate based on a frequency scale of 1-5 1=Never 2=Rarely 3= Occasional 4=Regularly 5=Constantly

Experiences of relaxation, ease, or well-being 1 2 3 4 5	Compassion and acceptance 1 2 3 4 5
Interest in maintaining a healthy lifestyle, diet, etc. 1 2 3 4 5	The level of recreation in your life 1 2 3 4 5
Time devoted to thing you enjoy 1 2 3 4 5	Your physical appearance 1 2 3 4 5

What else about your health or your life do you feel is important for the doctor to know?

_____

_____

_____

_____

X-Ray Consent for Women of Childbearing Age

X-ray examination of the abdomen and pelvis expose the uterus to radiation. The last ten days following the onset of the menstrual cycle are generally considered safe for x-ray examination.

Date of onset of last menstrual period:_____

I am pregnant: Yes or No

I had a hysterectomy: Yes or No

I use an IUD: Yes or No

I recognize that if I am pregnant and have radiation to the abdomen, there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this examination is important to my health. I therefore wish to have this x-ray examination preformed now.

Patient Signature:_____Date:_____

Witness Signature:_____Date:_____

Patient HIPAA Consent Form

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, and public health, research and law enforcement activities. Any other disclosure for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.
I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date:_____ Print Patient Name:_____

Signature:_____

Financial Policy

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize Live Well Chiropractic to release any information deemed appropriate concerning my physical condition to an insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- I authorize the direct payment to Live Well Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me or Live Well Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint Live Well Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic for payments due for services rendered on behalf of the undersigned by Live Well Chiropractic.
- In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it doesn't. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.
- Late payment for non-coverage, deductible, and co-payments may be subject to an 18% annual finance charge, which will be added monthly to that account.
- If you have any questions about our financial policies please ask to speak to our financial officer. If you need to make special arraignments, please ask. We will never deny care to anyone based solely on ability to pay. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN).* Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/ or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you hav other questions, please ask our front desk. Signing below means that you have received and understand this notice.

Date:_____ Signature:_____

Authorization for Care

I hereby authorize doctors and staff at Live Well Chiropractic to treat my condition as deemed appropriate. At Live Well Chiropractic, we do not diagnose or treat any disease or condition other than vertebral Subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Live Well Chiropractic responsible for any errors or omissions that may have made in the completion of this form. Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptoms, conditions, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Signature:_____ Date:_____