B Well
FAMILY CHIROPRACTIC

ADULT INTAKE FORM

Date: _____

PERSONAL INFORMATION

First Name: _____ M.I.:_____ Last Name: _____

Preferred Name: _____ Sex: M / F Birth Date: _____

Address: _____

City / State / Zip: _____

Home/Cell Phone: ( )_____ Email Address: _____

Occupation: _____ Employers Name: _____

Marital Status: Single / Married / Divorced / Widowed / Other Spouse's Name: _____

# of Children: _____ Children's Names/Ages: _____

_____

Emergency Contact: _____Relation: _____ Phone: ( )_____

We love our patients! Who can we thank for your referral or how did you hear about our office? _____

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at B Well Family Chiropractic? _____

_____

When did this begin? (if applicable) _____

Have you had any major injuries and/or surgeries? _____

_____

What is this affecting that is MOST important in your life? (List all that apply) _____

_____

Have you seen any other providers for this condition? Yes / No Explain: _____

Have you seen a chiropractor before? YES / NO Date of last visit: _____

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 goals, if you were to complete/accomplish, would have the greatest impact on your life?

_____

Print Patient's Name: _____ Date:_____

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Constipation
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Hypertension
- ☐ Arthritis
- ☐ Loss of Balance
- ☐ Neck/Back pain
- ☐ Pain in Arms/Legs
- ☐ Irritability/Nervousness
- ☐ Acid Reflux
- ☐ Fatigue/Sleep Issues
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Sensitivity to Light
- ☐ Loss of Concentration
- ☐ Memory Problems
- ☐ Headaches
- ☐ Stiffness/Flexibility
- ☐ Sinus Trouble/Allergies
- ☐ Cold Hands/Feet
- ☐ Hot Flashes
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above or additional concerns:

_____

_____

_____

_____

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

_____

_____

_____

_____

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Blood Pressure
- ☐ Pain Narcotics
- ☐ Muscle Relaxers
- ☐ Migraine/Headache
- ☐ Cholesterol
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

Explain any boxes checked above: _____

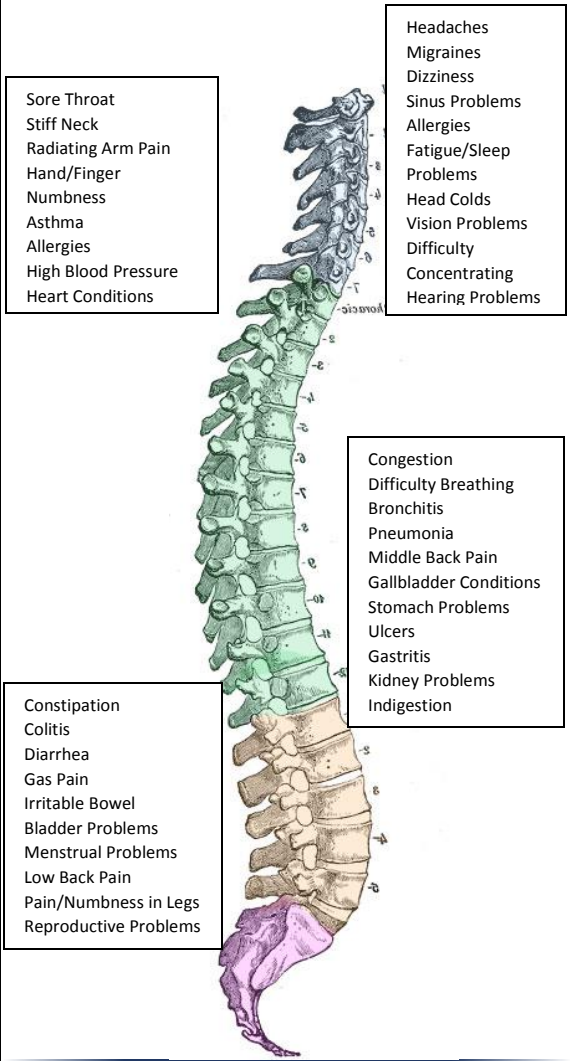
_____

_____

_____

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.



VITAMINS/SUPPLEMENTS

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

Explain any boxes checked above:

_____

_____

_____

Print Patient's Name: _____ Date:_____

HEALTH STATUS QUESTIONNAIRE

YOUR PHYSICAL LIFE

Rate based on 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/flu	1	2	3	4	5
Feelings of tension, stiffness	1	2	3	4	5	Ability to workout/engage in activity	1	2	3	4	5
Incidence of fatigue/low energy	1	2	3	4	5	Incidence of chronic disease	1	2	3	4	5

MENTAL/EMOTIONAL STATE

Rate based on 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/concentrating	1	2	3	4	5
Difficulty falling/staying asleep	1	2	3	4	5	Feelings of depression/anxiety	1	2	3	4	5

CHEMICAL/NUTRITIONAL LIFE

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

Eat a well-balance diet	1	2	3	4	5	Eat an organic, grass fed, hormone-free diet	1	2	3	4	5
Eat a diet rich in fruits 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 foods	1	2	3	4	5	Ingestion of chemicals	1	2	3	4	5

STRESS EVALUATION

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

Experience 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	1	2	3	4	5	The level of recreation in your life	1	2	3	4	5
Time devoted to things 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?

_____

_____

_____

Print Patient's Name: _____ Date:_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature	**Relationship to Patient**	**Date**

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature	**Relationship to Patient**	**Date**

X-RAY CONSENT This is to certify that Dr. VanKirk has my permission to perform an X-ray evaluation. To the best of my knowledge I am not pregnant and I have been advised that x-ray can be hazardous to an unborn child. If female, date of last menstrual period: _____.

Signature	**Relationship to Patient**	**Date**

INSURANCE Your insurance company will only pay for services that they determine are medically necessary. As a patient you must understand that some or all services provided for your care might not be covered by your contract benefits. You as a patient are liable for all charges that your plan does not cover. I have been notified by my physician that my insurance may not cover all the services provided for my care. If payment is denied for these services, I agree to be personally and fully responsible for payment. Any co-pay, coinsurance, or deductible is due at the time of service.

Signature	**Relationship to Patient**	**Date**

PERSONAL FINANCIAL RESPONSIBILITY I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. VanKirk will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. VanKirk will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature	**Relationship to Patient**	**Date**