Name:

EMBRACING LIFE CHIROPRACTIC

giving hope for a brighter tomorrow

Adult Intake Form

Date:_____

Personal Information

First Name: _____ M.I.: _____Last Name:_____

Preferred Name:_____ Social Security Number:_____

Address: _____

City / State / Zip: _____

Cell Phone: ( ) _____ Work Phone: ( )_____

Home Phone: ( ) _____ Email: _____

Birth Date: _____ Age:_____ Sex: M F

Occupation:_____ Employer's Name: _____

Marital Status: S M D W Other Spouse's Name: _____

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

_____

Who can we thank for referring you or how did you hear about Embracing Life? _____

_____

Reason for Seeking Care

What is your reason for seeking care at Embracing Life 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)

Name:

Have you seen a chiropractor before? Yes 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? _____

_____

Medications

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

- ☐ Allergies
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above:

_____

_____

Vitamins & Supplements

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

- ☐ Explain any boxes checked above:

_____

_____

Emergency Contact

First Name: _____ M.I. _____

Last Name: _____

Preferred Name: _____

Address: _____

City/State/Zip: _____

Phone: ( ) _____

Relation: _____

Name:

Current Lifestyle

It has been shown that daily lifestyle stress significantly impacts overall health and wellbeing. As a family wellness office we specialize in removing the cause of your health challenges. We also focus on teaching you how to manage the lifestyle stresses that prevent you from realizing your optimum health and wellness.

Please rate the following on a scale 1-10 and circle ALL answers that apply to your habits (1 = couldn't be worse & 10 = couldn't be better)

Eating Habits: ____

a. I eat 3-5x's a day
b. I eat fruits and veggies daily
c. I eat out 2-3 times weekly (min)
d. I drink 3-5 sodas weekly
e. I crave sweets
f. I don't watch what I eat

Exercise Habits: ____

a. I exercise 3-5 times a week
b. I walk daily
c. I don't exercise
d. I want to exercise
e. I sit at a computer 6-8 hours/day

Mind Set: ____

a. I have a positive outlook
b. I have a negative outlook
c. I am always in a bad mood
d. I am always in a good mood
e. I trap things inside
f. I share easily

Sleep: ____

a. I sleep 7-9 hours/night
b. I wake up well-rested
c. I wake up tired
d. I toss and turn
e. I stay up late

General Habits: ____

a. I am not on medications
b. I take care of myself
c. I watch what I eat
d. I base my health on how everyone around

Stress Questionnaire

Most life stresses can be grouped into 3 main categories: physical, chemical, and emotional stress. Please check any of the following stresses you experience on a regular basis.

Physical Stress:

- ☐ Physical Pain
- ☐ Low Energy/Fatigue
- ☐ Job/Hobbies Cause Discomfort
- ☐ Tightness/Stiffness
- ☐ History of Accidents/Injuries
- ☐ Inability to Exercise/Perform Physical Activities
- ☐ Other

  _____
- ☐ Explain:

  _____

  _____

Chemical Stress:

- ☐ Fast Food/Highly Processed Food
- ☐ Medications (Prescription or OTC)
- ☐ Consume Alcohol
- ☐ Tobacco
- ☐ Amalgam Fillings
- ☐ Makeup/Lotion/Skin Products
- ☐ Other

  _____
- ☐ Explain:

  _____

  _____

Emotional Stress:

- ☐ Work/Job
- ☐ School
- ☐ Health
- ☐ Finances
- ☐ Family
- ☐ Daily Schedule/Time
- ☐ Other

Name:

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, public health, research, and law enforcement activities. Any other disclosures for the purposes 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. 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: _____ Relationship to Patient: _____

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, your care plan must be followed.
- I authorize Embracing Life Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- I authorize direct payment to Embracing Life 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 Embracing Life Chiropractic based in whole or in part upon the charges made for service received. I hereby appoint Embracing Life Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as a co-payee with this clinic or payments due for services rendered on behalf of the undersigned by Embracing Life Chiropractic.
- An itemized receipt will be provided upon request, although we cannot guarantee reimbursement by a third party carrier. This does not apply to PI, WC, or Medicare. HSA and FLEX spending accounts may be utilized.
- If you have any questions about our financial policies, please ask our staff. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.

Name:

Consent to Chiropractic Services

I hereby authorize Dr. Nicole Mattson and staff, now and in the future, at Embracing Life Chiropractic, to treat my condition as deemed appropriate. At Embracing Life Chiropractic, we do not diagnosis 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 information obtained in the above health history is correct to the best of my knowledge. I will not hold the doctor or any staff members of Embracing Life Chiropractic responsible for any errors or omissions that I have made in the completion of this form. Chiropractic treatment, while remarkably safe, you still need to be informed of the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgement during the course of any procedure which the Doctor feels at the time is in my best interest. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below, I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____