NEW PATIENT INTAKE

HEXIS CHIROPRACTIC
PRENATAL · FAMILY · PEDIATRIC

Name: _____ Date: _____

Address: _____City:_____ State:_____ Zip:_____

Home Phone (____)_____Cell (____)_____ Work (____)_____

We use text messages for appointment reminders. Who is your cell phone company? _____

Email Address: _____

Male_____ Female_____ Birth Date: _____ Age:_____

Occupation: _____Employer Name _____

Single____ Married____ Spouse's Name _____

Whom may we thank for referring you to our office? _____

YOUR HEALTH SUMMARY

What is your chief complaint?_____

Have you seen a Chiropractor before? _____ If yes, when?_____

Check all symptoms you have ever had even if they do not seem related to your current problem.

___Headaches
___Pins and needles in arms
___Ringing in ears
___Depression
___Sleeping problems
___Migraines
___Pins and Needles in legs
___Back Pain
___Numbness in fingers
___Tension
___Neck Stiffness
___Problem Urinating
___Neck Pain
___Loss of balance
___Numbness in toes
___Menstrual irregularity
___Heartburn
___TMJD
___Dizziness
___Fatigue
___Cold Feet
___Cold Hands
___Vertigo
___Shoulder Pain

Please list any medications you are taking: _____

_____

If this is due to an injury or auto accident, what is the date of injury or accident?_____

Has this problem been getting better, worse, or staying the same?_____

What activities make your condition worse? _____

Any surgeries or hospitalizations?_____

Injuries or illnesses that you have had that are not listed above:_____

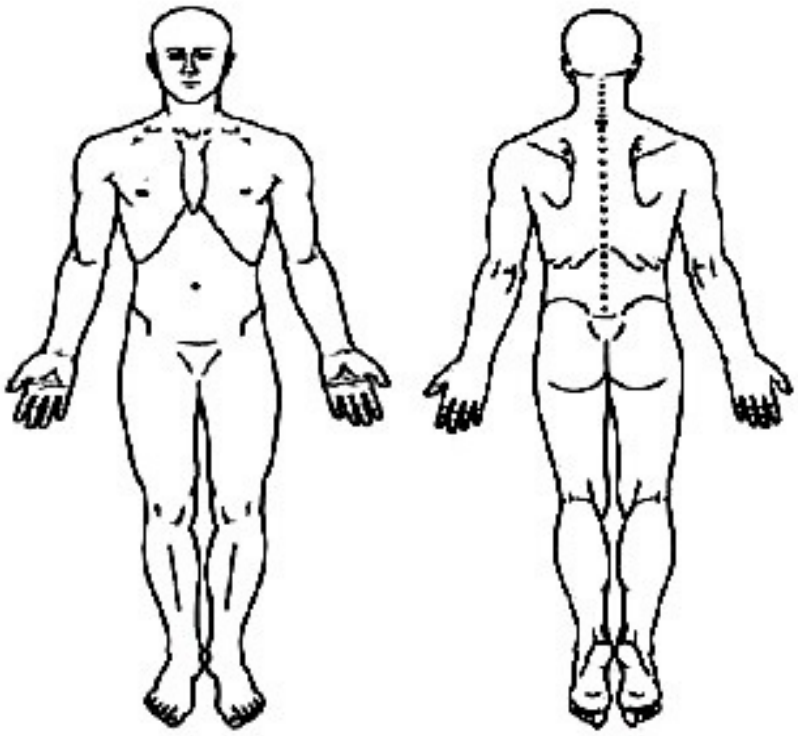
Do you have health insurance? ☐ Yes ☐ No Or a HSA account? ☐ Yes ☐ No

If so, please provide the front desk with your card so we can verify your benefits with our office.

Name of Policy Holder: _____ DOB:_____ Relationship to them_____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, *dull, sharp, constant, off and on, when standing, when sitting, etc., etc.*

COMPLETE THESE DIAGRAMS



Type of Pain: _____

_____

_____

Frequency: _____

_____

_____

What makes it worse:_____

_____

_____

Have you had this before? Yes No

If yes, when? _____

Method of payment you plan to use for today's charges: ☐ **Check** ☐ **Cash** ☐ **Credit Card**

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE OR VERIFY A DIAGNOSIS, TYPE OF TREATMENT AND LENGTH OF TREATMENT. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. **All first visit charges are payable when services are rendered.**
2. **The fee paid for x-rays is for analysis only. Colorado state law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.**

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES.

Our office uses sign in sheets, travel cards, and provides care in an open door adjusting environment. As a result patients are in sight of each other, and some ongoing / routine details of care may be in ear shot of other patients and staff. This environment is used for on going care and is not the environment for taking patient's histories, performing examinations, or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open door adjusting environment, other arrangements will be made for you. Your signature below authorizes us to contact you at all phone numbers / addresses you list on this intake form. If you do not wish to be contacted at any listed numbers / addresses, please let us know.

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient's Signature_____Date_____