Chiropractic Intake & History

Patient Name: ____________________ Date: ____________ DOB: ____________

PATIENT INFORMATION

Address____________________

City,State, Zip____________________

Phone(H)____________ Phone(C)____________

Email____________________

❑ Male ❑ Female Date of Birth ____________ Age ______

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered

Have you seen a chiropractor before?
If yes, when was the last time? ____________________

Employer/School ____________________

Occupation ____________________

Spouse's Name ____________________

Spouse's Occupation ____________________

IN CASE OF EMERGENCY, CONTACT

Name ____________________

Relationship ____________ Phone ____________

Who may we thank for referring you? ____________________

HOW CAN WE HELP YOU?

What brings you in today? ____________________

____

If you are already experiencing a symptom, what is it? ____________________

____

How bad is it? How intense are your symptoms? (circle)

1 2 3 4 5 6 7 8 9 10

No Symptoms — **Intense Symptoms**

How are your symptoms changing with time? ____________________

❑ Getting Worse ❑ Staying the Same ❑ Getting Better

How often do you experience your symptoms?

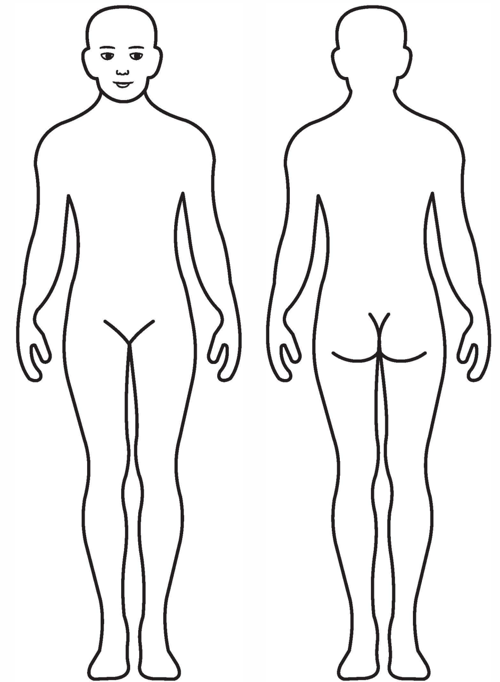
❑ Constantly (76-100% of the time) ❑ Occasionally (26-50% of the time)

❑ Frequently (51-75% of the time) ❑ Intermittently (1-25% of the time)

How long have you had this condition? ____________________

How do you think this condition began? ____________________

Please circle areas to the right where you have pain or other symptoms.



What does it feel like? (check where appropriate)

❑ Numbness ❑ Sharp ❑ Tingling ❑ Shooting ❑ Stiffness ❑ Burning ❑ Dull

❑ Throbbing ❑ Aching ❑ Stabbing ❑ Cramping ❑ Swelling ❑ Nagging ❑ Other ____________

IMPACT OF YOUR SYMPTOMS

How is the symptom/condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Recreation	❑	❑	❑	❑
Relationships	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Energy	❑	❑	❑	❑
Attitude	❑	❑	❑	❑
Patience	❑	❑	❑	❑
Productivity	❑	❑	❑	❑
Creativity	❑	❑	❑	❑
Other ________	❑	❑	❑	❑

How committed are you to correcting this issue? (circle)

1 2 3 4 5 6 7 8 9 10

Not Committed — **Very Committed**

Chiropractic Intake & Wellness Assessment

Patient Name: ______________________________ Date: ________________ DOB: ________________

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple Medications	Symptoms	No Symptoms	Regular Exercise	100% Function
Poor Quality of Life	Drug Therapy	Nutrition Inconsistent	Good Nutrition	Continuous Development
Potential Becomes Limited	Surgery	Exercise Sporadic	Wellness Education	Active Participation
Body Has Limited Function	Losing Normal Function	Health Not High Priority	Minimal Nerve Interference	Wellness Lifestyle

On the arrow diagram above:

What number do you think represents your health today? (circle) **0 1 2 3 4 5 6 7 8 9 10**

In which direction is your health currently headed? (circle) **LEFT** (sicker) **RIGHT** (healthier)

Rate the quality of your nutritional intake — 10 being greatest? (circle) **0 1 2 3 4 5 6 7 8 9 10**

Rate your average stress level — 10 being the most? (circle) **0 1 2 3 4 5 6 7 8 9 10**

Hours of sleep you average per night? (circle) **0 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6 6.5 7 7.5 8 8.5 9 9.5 10**

How many times do you exercise each week? (circle) **0 1 2 3 4 5 6 7 8 9 10** How long each time? ________________

Check the areas you want to learn more about:

- ❑ Nutrition
- ❑ Stress
- ❑ Sleep
- ❑ Exercise
- ❑ Athletic Performance
- ❑ Raising Healthy Children
- ❑ Energy
- ❑ Alignment
- ❑ Balance
- ❑ Strength
- ❑ Immune System
- ❑ Other ________________

WHAT ARE YOUR HEALTH GOALS?

Immediate: ______________________________

Short term: ______________________________

Long term: ______________________________

CHILDREN & PREGNANCY

How many children do you have? ______________________________

Children's Names/Ages ______________________________

____

____

Children's health concerns? ______________________________

____

Are you currently pregnant? ❑No ❑Yes, due date ________________

Number of past pregnancies? ______________________________

Health concerns regarding this pregnancy?

____

____

____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)

Chiropractic Intake & Wellness Assessment

Patient Name: ______________________________ Date: ____________________ DOB: ______________

HEALTH & ILLNESS HISTORY

Indicate if you have any immediate family members with any of the following:

- ❑ Rheumatoid arthritis
- ❑ Heart problems
- ❑ Diabetes
- ❑ Cancer
- ❑ Lupus
- ❑ ALS

Indicate if you have any of the conditions listed below.

- ❑ Headaches
- ❑ Neck Pain
- ❑ Upper Back Pain
- ❑ Mid Back Pain
- ❑ Low Back Pain
- ❑ Shoulder Pain **L/R**
- ❑ Elbow/Up-Arm Pain **L/R**
- ❑ Wrist Pain **L/R**
- ❑ Hand Pain **L/R**
- ❑ Hip Pain **L/R**
- ❑ Upper Leg Pain **L/R**
- ❑ Knee Pain **L/R**
- ❑ Ankle/Foot Pain **L/R**
- ❑ Jaw Pain
- ❑ Joint Pain / Stiffness
- ❑ Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Cancer
- ❑ Asthma
- ❑ Sleep Concerns
- ❑ Chronic Sinusitis

- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Chest Pains
- ❑ Stroke
- ❑ Angina
- ❑ Kidney Stones
- ❑ Kidney Disorders
- ❑ Bladder Infection
- ❑ Painful Urination
- ❑ Loss of Bladder Control
- ❑ Prostate Problems
- ❑ Abnormal Weight Gain/Loss
- ❑ Loss of Appetite
- ❑ Abdominal Pain
- ❑ Ulcer
- ❑ Hepatitis
- ❑ Liver/Gallbladder Disorder
- ❑ General Fatigue
- ❑ Tumor

- ❑ Diabetes
- ❑ Excessive Thirst
- ❑ Frequent Urination
- ❑ Smoking / Tobacco Use
- ❑ Drug/Alcohol Dependence
- ❑ Allergies
- ❑ Depression
- ❑ Systemic Lupus
- ❑ Epilepsy
- ❑ Dermatitis/Eczema/Rash
- ❑ HIV/AIDS
- ❑ Difficulty with Speech
- ❑ Double Vision
- ❑ Visual Disturbances
- ❑ Balance Problems
- ❑ Dizziness/Vertigo
- ❑ Other ______________________

For Females Only:

- ❑ Birth Control Pills
- ❑ Hormonal Replacement
- ❑ Pregnancy

Have you ever been hospitalized? ❑No ❑Yes. Please provide year(s) hospitalized. ______________________

Reason for hospitalization. ______________________

____

List all surgical procedures (with dates) you have had. ______________________

____

____

What activities do you do outside of work? ______________________

____

____

Have you had significant past trauma (car crash, sports, falls)? ❑No ❑Yes. Please provide details. ______________________

____

____

Is there anything else pertinent to your visit today? ______________________

____

____

Patient Signature ______________________ Date: ______________

Patient Name: ________________________ D.O.B.:____________________ Date:______________________

Financial Policies

Proof of Insurance: New patients must complete our new patient information forms before seeing a doctor. We must obtain a copy of your picture ID and current insurance card to have proof of insurance. If you do not provide us with the correct insurance information in a timely manner, you will be responsible for any balance accrued. If your insurance lapses or expires we require full payment within 10 days unless you provide proof of valid insurance coverage.

❑ Self-Pay: Patients without health coverage are expected to make payment in full at the time services are rendered. Any Plan Discounts can only be applied to services paid at the time the services/plans are rendered/initiated. A service charge of 15.00% per annum may be applied to all unpaid balances over sixty days. Financial Hardship is only available upon proof of said hardship and exclusively at the discretion of the doctor.

❑ Medicare: Deductible and/or Co-Insurance is due at time of service when no secondary insurance coverage is available, or benefits cannot be verified. Services not statutorily covered by the Medicare Program are due at the time services are rendered. An Advance Beneficiary Notice will be required for all services not covered or not believed to be covered. Deductibles will be billed and shall be due within ten days. A service charge of 15.00% per annum may be applied to all unpaid balances over sixty days.

In-network plans: I understand Family First Chiropractic will submit claims on by behalf and prepare any necessary reports and forms to assist me in making collection from the insurance company. Family First Chiropractic will accept direct assignment of benefits under this policy and will credit any payments received from insurance company to your account.

I have read and understand the above Financial Policy fully understand that I am ultimately responsible for payment of all services and any costs associated with the collections including but not limited to service charges and other fees for any balance due at to the above office and doctor.

____ ____________________
Signature of patient or authorized representative Date

____ ____________________
Authorized Representative Name Printed Relationship to Patient

Financial Policies S:\090101 Revised 5-22-19

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: ________________________________Last Name: ______________________________

Preferred Language: _______________ D.O.B.___/____/_______ Sex: _________

Sex at Birth:______________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity If yes, start date:____________

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

☐ I choose to decline receipt of my clinical summary after every visit.

Patient Signature:____ Date: ________________

For office use only
Height: ________ Weight: _________ Blood Pressure: _______/_______ Pulse:________

Patient Name: ______________________________ DOB: __________________ Date: ______________

Consent for Care

The process of determining suitability of Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health conditions during the Consultation.

If warranted, a physical examination will be performed that can include but is not limited to: vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress joints of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping tendons) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms.

Radiographs (X Rays) may be taken or ordered to further the Chiropractor's understanding of the underlying condition, positions and alignment of the spine and associated structures. There is limited but present risk to radiation exposure. If you are or think you may be pregnant alert the Chiropractor and/or X ray lab technician; X Rays are not allowed to pregnant women in any trimester.

Privacy Notice Acknowledgment

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I consent to the performance of the above-mentioned procedures performed by the doctor involved in my case: ____ YES _____ NO

I acknowledge that I have been offered a copy of Family First Chiropractic's *Notice of Privacy Practices for Protected Health Information.*

Patient Signature: ____ Date:________________

Witness Signature: ____Date:________________