Elemental Chiropractic
1640 Old Apex Road
Cary, NC 27513

Elemental Chiropractic Patient Intake Form

Patient Name _____Date_____

Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____-_____ Sex: _____DOB_____

Email _____ Are you a veteran? Yes No

Insurance Type _____

Job Description: _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Phone (_____) _____-_____

How did you hear about our office? _____

HEALTH HISTORY

Surgeries:

_____
_____
_____

Allergies:

_____
_____

Injuries/Hospitalizations:

_____
_____

Social History: (Mark all that apply to you)

Caffeine use: ___ ≤ 2 Cups/day ___more than 2 cups/day ___never
Drink Water: ___less than 8 cups/day ___more than 8 cups/day ___never
Tobacco Use: ___less than 1 pack/day ___more than 1 pack/day ___never ___ Quit
How many alcoholic beverages do you consume per week? _____
How many hours do you sleep per night?_____
How many hours do you exercise per week?_____

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Family History: (Mark all that apply)

Arthritis:	___Parent	___Sibling	Hypertension	___Parent	___Sibling
Cancer:	___Parent	___Sibling	Stroke	___Parent	___Sibling
Diabetes:	___Parent	___Sibling	Thyroid	___Parent	___Sibling
Heart Disease	___Parent	___Sibling			

Other _____

Review of Systems – Check box if you have ever experienced any of the following:

Cardiovascular	Past	Present	**Respiratory**	Past	Present	**Allergic/Immunologic**	Past	Present
Poor Circulation			Asthma			Hives		
Hypertension			Tuberculosis			Immune Disorder		
Aortic Aneurism			Shortness of Breath			HIV/AIDS		
Heart Disease			Emphysema			Allergy Shots		
Heart Attack			Cold/Flu			Cortisone Use		
Chest Pain			Cough					
High Cholesterol			Wheezing			**Ear, Nose and Throat**	Past	Present
Pace Maker						Difficulty Swallowing		
Swelling of legs			**Eyes**	**Past**	Present	Dizziness/Vertigo		
Irregular Heartbeat			Glaucoma			Hearing Loss		
			Double Vision			Sore Throat		
Genitourinary	Past	Present	Blurred Vision			Nosebleeds		
Kidney Disease			Contacts			Sinus Infections		
Burning Urination			**Psychiatric**	Past	Present			
Frequent Urination			Depression			**Gastrointestinal**	Past	Present
Blood in Urine			Anxiety			Gall Bladder Problems		
Kidney Stones			Stress			Bowel Problems		
Lower Side Pain						Constipation		
			Endocrine	Past	Present	Liver Problems		
	Past	Present	Thyroid			Ulcers		
Unexplained Weight Loss/Gain			Diabetes type I or II			Diarrhea		
Low Energy Level/fatigue			Hair Loss			Nausea/Vomiting		
Difficulty Sleeping			Menopausal			Bloody stools		
			PMS/cramps					
Neurologic	Past	Present	**Hematologic**	Past	Present	**Musculoskeletal**	Past	Present
Stroke			Hepatitis			Jaw pain		
Seizures			Blood Clots			Arthritis		
Head Injury/concussion			Cold hands/feet			Joint Stiffness		
Brain Aneurysm			Bruising			Muscle Weakness		
Numbness/tingling			Bleeding			Osteoporosis		
Severe Headaches			Fever, Chills			Broken Bones		
Dizziness/light headedness			Varicose veins			Joints Replaced		
Vertigo			Cancer			Fibromyalgia		

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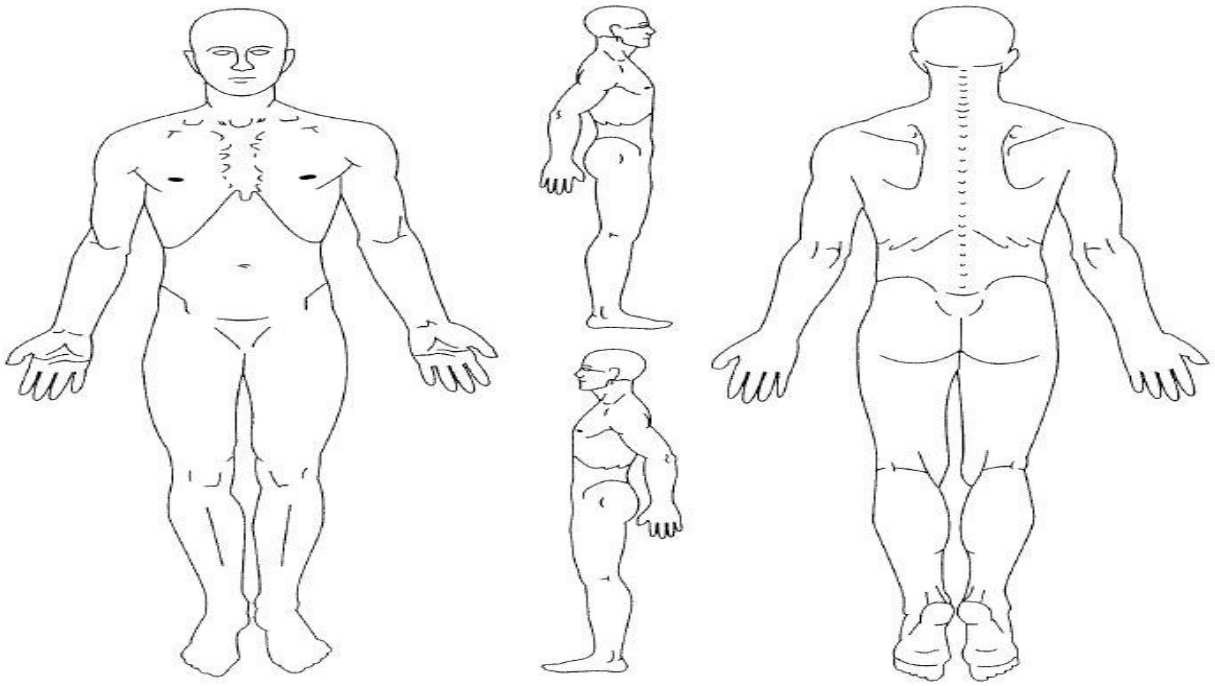
Please list all current medications/Supplements being taken _____
_____

FEMALES ONLY:
Do you have any menstrual concerns? Please explain:_____
_____
Are You Pregnant? (Circle) Yes No
Have you ever been pregnant? How many children do you have?_____
_____

CURRENT COMPLAINT

Where is your pain? _____

Indicate on the body diagram where you are experiencing the following symptoms:



Average Pain Intensity: (please circle)

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How did your symptoms begin? _____
_____

How long have you had your symptoms? _____

How are your symptoms changing? Getting better Not changing Getting worse

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How often do you experience your symptoms? (Circle)

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

___Sharp	___Dull Ache	___Numb	___Shooting
___Burning	___Tingling	___Throbbing	Other _____

Does your pain radiate? If yes, where? _____

My pain/symptoms have previously been made better by: (Check all that apply)

□ Chiropractic	□ Physical Therapy	□ Massage	□ Advil/Tylenol	□ Heat	□ Ice
□ Rest	□ OTC Pain Meds	□ Exercise	□ Stretching	□ Dry Needling	

□ Other: _____

Activities of Daily Living - Please check if you have pain or difficulty performing the following:

□ Change of Position	□ Driving	□ Extended Computer Use	□ Stairs
□ Bending	□ Walking	□ Exercising	□ Sleep
□ Sitting	□ Standing	□ Housework	

Other_____

Do you experience headaches? (circle) Yes No

If so, please describe how often and how severe_____

_____

Please list all x-rays taken in the last year: _____

_____

Have you ever been to a chiropractor before? (circle) Yes No

If so, when and for what?_____

What type of treatment are you looking for?

___ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem
___ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem
___ I am looking to take care of my problem, then go on to "achieve optimal health and wellness"

I would be interested in:

___ Dry Needling
___ Supplement/Vitamin Suggestions
___ Infrared Sauna
___ Cupping
___ Custom Orthotics

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PAYMENT POLICY

Thank you for choosing Elemental Chiropractic as your Chiropractic provider. We are committed to providing you with quality and affordable health care. We want to be clear about our policies in this clinic. Please read the following and let us know if you have any questions. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral, it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. PROOF OF INSURANCE. All patients must complete our patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. COVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. CASH PAYMENT. We are enrolled in ChiroHealth USA (CHUSA) that allows us to provide reduced fees for our patients who are uninsured or do not wish to use their insurance and pay out of pocket. It costs $49 to enroll for the year into this program, and all of our practice members pay at the time of service or follow a treatment plan with a payment schedule. If payment is not rendered at the time of service, the patient is expected to remit payment within 30 days of the patient visit. All balances remaining unpaid after 30 days may be turned over to a collection agency.
7. MISSED APPOINTMENT. Our policy is to charge $25.00 after one missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regular scheduled appointments.

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I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition/minor child, as the doctor sees fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. If I do not show up for a scheduled appointment, I understand that it is my responsibility to pay a missed appointment fee. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

I have read and understood the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party Date

Authorization for care of a minor

I hereby authorize this clinic and it's Doctor(s) to administer care as they deem necessary to my son/daughter/ward (upon approval of parent or guardian)
Signed:_____ Witnessed:_____ Date:_____
I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.
Signed:_____ Date:_____