Eilrich Family Chiropractic & Wellness Adult Intake Form

We would like to take this opportunity to welcome you to Eilrich Family Chiropractic & Wellness. Please help us better serve you and your teen by taking time to fill in the information below to the best of your knowledge. At Eilrich Family Chiropractic & Wellness, we enjoy treating patients from newborn to long-lived and we look forward to working with you and your family.

Legal Information

Patient Full Name: _____ Preferred Name: _____
Home Address: _____City: _____ State: ____ Zip Code: _____
Best contact #: _____-_____-_____ Alternate Phone: _____-_____-_____
Email Address: _____ Birth Date: ____/____/____
Emergency Contact: _____ Phone #: ____-____-_____

Personal Information

Medical Dr and Clinic Name: _____ Date of Last Visit: _____
Past Chiropractor's Name: _____
Date of Last Visit: _____ Reason for Last Visit: _____

Employment

____ Full time ____ Part time ____ Retired ____ Unemployed _____ Student
Employer _____ Occupation _____
What types of activities does your job require? _____

Marital Status

___ Single ___ Married ___ Legally Separated ___ Divorced ___ Widowed ___ Partner

How did you hear about the clinic? _____

Present Condition History

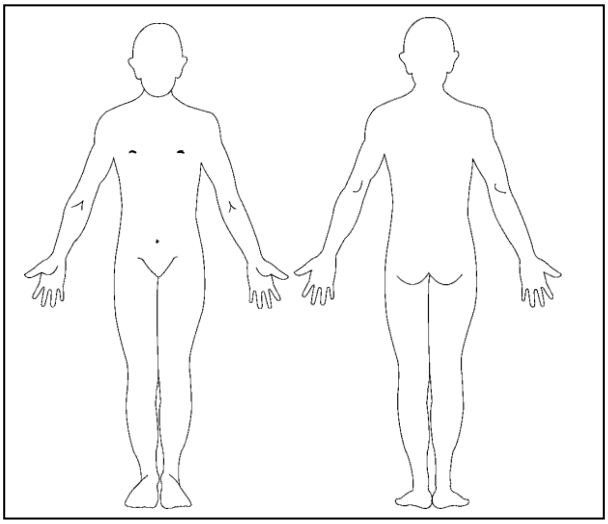
This section is you chance to describe what brings you in to our office, be honest and give as many details as you can to what is going on.

Describe what brings you in today (include **when** and **how** this started): _____
_____
_____
_____

Is this due to an accident or injury? □ Yes □ No Date: _____ Type of Accident: □ Auto □ Work □Other:_____
Claim #_____ Insurance Company to be billed: _____

These symptoms occur: □ Constantly □ Frequently □ comes/goes
Describe the nature of your symptoms: □ Sharp/Shooting □ Dull Ache □ Numbness/Tingling □ Throbbing □ Burning □ radiating pain, where: _____ □ other: _____
Are the symptoms worse: □ Morning (getting up) □ During day □ Evening □ Night □Other: _____
How are your symptoms changing since they began?
□ Getting Better □ Not Changing □Getting Worse
On a scale of 0-10 with 0 being no pain and 10 being the worst pain imaginable during the following times:
Right Now: ___/10
At Best: ___/10 At Worst: ___/10
What makes it worse? _____
What makes it better? _____

Please indicate where the discomfort is located using Mannequin.



In the past 4 weeks:

How has this interfered with your normal work (including both at home and away)?

_____

How has this affected your social activities? _____

Who have you seen anyone else for this, whom? _____

What treatment did you receive and when? _____

What tests have you had for your symptoms and when were they performed?

□ X rays' *date*: _____ □ CT Scan *date*: _____ □ MRI *date*: _____ □ Other *date*: _____

Have you had similar symptoms in the past? □ Yes □ No

If you have received treatment in the past for the same or similar symptoms, who did you see?

□ This Office □ Medical Doctor □ Other Chiropractor □ Physical Therapist □ Other

Health History

In general, would you say your overall health right now is ……

□ Excellent □ Very Good □ Good □ Fair □ Poor

List all prescription and all over-the-counter medications (if you have a current list of the medications, we will be happy to make a copy of it instead):

_____

_____

Major Surgery/Operation: □ Appendix □Tonsils □ Gallbladder □ Hernia □ Heart □ Back □ Neck □ Leg/Knee □ C-Section □ Other: _____

List any major past injuries (including work, home, auto, fractures, etc.): _____

_____

_____

In the past 6 months have you experienced the following conditions or symptoms:

□ Headache	□ Chest Pain	□ Walking Problems	□ Fatigue or Loss of Sleep
□ Neck Pain/Stiffness	□ Short Breath	□ Changes in Appetite or Thirst	□ Stress
□ Mid Back Pain/Stiffness	□ Ankle Swelling	□ Frequent Nausea/Vomiting	□ Drug/Alcohol Dependency
□ Low Back Pain/Stiffness	□ Cold/Tingling Limbs	□ Diarrhea/Constipation	□ Thyroid Problems
□ Shoulder/arm/hand Pain	□ Numbness	□ Digestive Trouble	□ Skin problems
□ Hip Pain/Stiffness	□ Fainting	□ Abdominal Cramps	□ Eyes Sensitive to Light
□ Leg/ Ankle/Foot Pain	□ Dizziness	□ Painful Urination	□ Visual Problems
□ Jaw Pain	□ Loss of Balance	□ Loss of Bladder Control	□ Smoking/Tobacco Use Product Use

Have you ever had or experienced any of the following conditions or symptoms? (in the past or present)

□ Cancer or Tumor	□ Blood Disorder	□ Heart Disease	□ Diabetes
□ Hyper/hypotension	□ Stroke	□ Lung Problems	□ Arthritis
□ Nervousness/Anxiety	□ Depression	□ Chronic Bladder Infections	□ Chronic Ear Aches/pain
□ Allergies to: _____		□ Other: _____	

Female Patients Only: Have you experienced or used any of the following:

□ Birth Control □ Hormone Replacement □ Menstrual Cycle Irregularities □ Menstrual Cramps

□ Menopause □ Breast Pain or Lumps □ Pregnancy (#: _____) □ Date Last Period? _____

Male Patients Only: Have you ever experienced prostate problems? _____

What other health concerns do you have at this time? _____

Family History

Please check any of the following conditions that an immediate family member (grandparents, mother, father, brother, sister, or children) has experienced.

	Blood pressure/ Cholesterol	Heart attack	Cancer	Diabetes	Lung Problems	Stroke	Arthritis	Thyroid Disease	Other
Mother									
Father									
Sister									
Brother									
Grandparents									
Children									

Patient Agreement (please read carefully)

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly mutual understanding between patient and provider.
- I understand and guarantee this form was completed with sound mind and understand it is my responsibility to inform Eilrich Family Chiropractic & Wellness of any changes in my medical status or health history.
- I authorize Eilrich Family Chiropractic & Wellness 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 the direct payment to you by any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services. I authorize the use of this signature on all insurance submissions.
- I understand that whatever amounts not collected from insurance proceeds (whether it be all or part of what is due) I personally owe Eilrich Family Chiropractic & Wellness the remaining account balance.
- I understand that if I do not notify Eilrich Family Chiropractic & Wellness 24 business hours prior to my scheduled appointment and/or miss a scheduled appointment**,**
    - **I will be charged a $15.00 cancellation fee for any Doctor Appointment and/or**
    - **Half the cost of scheduled massage.**

      These fees will not be covered by my insurance and will be billed to me personally
- I understand and agree health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that I am personally responsible for payment for services not-covered by insurance and/or per Insurance Deductible or Co-pays.
- I understand that if I arrive to my appointment more than 7 minutes late, I may have to wait to get seen by the Dr or reschedule for another day.
- Super Thursday (20% off all nutrition) is every 3rd Thursday of the month. There are no longer exceptions to this rule. We allow people to get items at this discount if they are in for a scheduled appointment that week, however we will not allow anyone to use this discount outside of this designated time frame. You may call and pay via Credit Card if you are unable to pick up on Super Thursday.

_____ _____ _____

Patient (or Legal Guardian) Signature Relationship to Patient Date

Notice of Privacy Practices Acknowledgement and Consent

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and specifically its privacy rule, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that my PHI will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers that may be involved in my treatment directly or indirectly.
- Obtain payment and reimbursement from health coverage programs and others.
- Conduct normal healthcare business operations including routine aspects of operating a health-related practice or business.

I also understand that I may request in writing that you restrict how my PHI is used and disclosed to carry out treatment, payment, or healthcare operations. However, I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I further understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.

Signature: _____

Legal Guardian Signature (if applicable): _____

Print Name: _____ Date: _____

Informed Consent

Any procedure intended to help, may also do harm. While chiropractic, massage and therapeutic procedures (e.g. spinal adjustments, ultrasound, heat and cold application, electrotherapy and manual muscle therapy) are considered remarkably safe and effective, please understand that occasionally there may be adverse reactions.

Although the chances of experiencing any of these complications are extremely small, it is the practice of Eilrich Family Chiropractic & Wellness, to fully inform and educate all our patients. These complications include, but are not limited to:

Pain Swelling Bruising Disc Injury Sensory Changes Bleeding Burns
Nausea Stroke Dizziness Weakness Bone Fracture Soft Tissue Injury
Worsening of Condition Spinal Cord Damage Discoloration

I understand there is no guarantee or warranty for a specific cure or result. I understand that I can request further explanation regarding any and all possible attendant to my care.

Signature: _____

Legal Guardian Signature (if applicable): _____

Print Name: _____Date: _____