ALCOVY *Sports & Family*
CHIROPRACTIC
JOHN C. SCHRAUB D.C., D.A.C.B.S.P.

Patient Intake Form

Patient Information
(Please Print)

Name _____ Date _____
- *First* *Middle Initial* *Last*

Sex *(Circle one)* **Female** **Male** Date of Birth _____
Address _____ City _____
State _____ Zip Code _____
Email _____
Home Phone _____ Cell Phone _____
Work Phone _____ Relationship
Status *(Circle one)* *Single* *Married* *Widowed* *Divorced* *Minor*
Employer/School _____ Occupation _____
Employer/School Address _____ City _____
State _____ Zip Code _____

Emergency Contact Information
Person to contact in case of emergency _____
Relationship to patient _____ Phone Number _____
Address _____ City _____
State _____ Zip Code _____

Responsible Party (If Other than Patient)
Name of person responsible for this account _____
Relationship to patient _____ Phone Number _____
Address _____ City _____
State _____ Zip Code _____ Name of Employer _____

Symptoms

Reason for visit _____ Date symptoms first noticed? _____

Is this condition getting progressively worse?_____

Where specifically is the problem(s) located?_____

Which activities are difficult to perform *(circle one or more)*? *Sitting* *Standing* *Walking*
Bending *Lying Down* *Other, If other:*_____

Type of pain *(circle one or more)*:
Sharp *Dull* *Throbbing* *Numbness* *Aching* *Shooting*
Burning *Tingling* *Cramps* *Stiffness* *Swelling* *Other*

Rate the severity of your pain. (1, mild pain/discomfort, to 10, unbearable pain):

1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition (circle one or more)?
Medication *Surgery* *Physical Therapy* *Other, If other:*_____

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Health History

Check only those conditions which are applicable:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Typhoid Fever
- ☐ Ukers
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other,_____

Date of last exams _____

Are you pregnant? *Yes* *No* Nursing? *Yes* *No*

List any types of surgeries which you have had and the dates which they occurred: _____

_____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? *None* *Moderate* *Heavy*

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

_____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? *Yes* *No* If yes, how much per day? _____

Do you use nicotine products? *Yes* *No* Tobacco products? *Yes* *No*

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I understand that I am financially responsible for all charges.

_____ _____

Signature of Patient, Parent, Guardian or Persona Representative Date

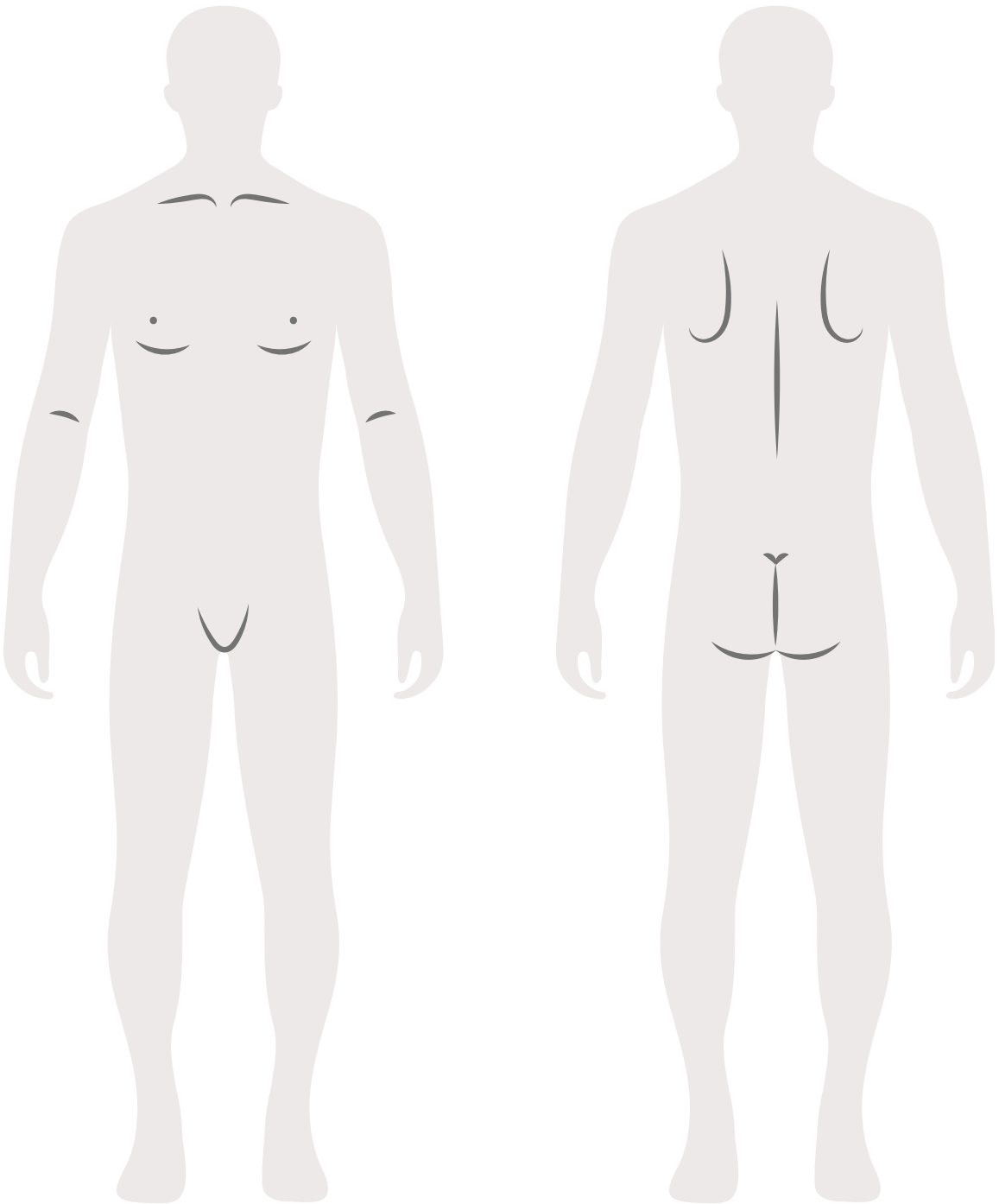
_____ _____

Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Name _____

Date _____

PLEASE SHADE IN THE AREA YOU HAVE PAIN OR OTHER SYMPTOMS



Right Left Left Right

Check Symptoms You Have Noticed

____Headache
____Head Seems too Heavy
____Head & Shoulders Tired & Heavy
____Mental Dullness
____Loss of Memory
____Equilibrium Problems
____Dizziness
____Fainting
____Tremors
____Palpation
____Neck Pain
____Neck Stiffness
____Neck Motion Restricted
____Upper Back Pain/Stiffness
____Mid-Back Pain/Stiffness
____Low-Back Pain/Stiffness
____Anxiety
____Insomnia
____Face Flushed
____Excess Perspiration
____Nausea
____Constipation
____Pins & Needles in Arms/Legs
____Numbness in Fingers, Arms, Legs
____Chest Pain
____Shortness of Breath
____Eye Strain
____Pain Behind Eyes
____Eyes Sensitive to Light
____Eyes-Loss of Focus
____Double Vision
____Ears Buzzing/Ringing
____Loss of Taste
____Loss of Smell
____Sinus Trouble
____Extreme Nervousness
____Irritability
____Extreme Fatigue
____Neuritis
____Face Pale
____Digestive Disorders
____Diarrhea
____Depression
____Feet/Hands Cold

Difficulty in excessive (circle): *Standing* *Walking* *Riding* *Bending*
Neck, Low-back pain & stiffness upon rising (circle): *Yes* *No*
Pain radiating into (circle): *Right arm* *Right leg* *Both* *Left leg* *Left arm* *Both*
Difficulty in excessive lifting (circle): *Light* *Moderate* *Heavy* *Repetitive*
Pain radiating into (circle): *Neck* *Base of skull* *Shoulder* *Arms* *Hips* *Legs*

Symptoms other than above:

Informed Consent to Chiropractic Adjustments and Care

- [ ] It is not uncommon that patients have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms, I will call Alcovy Sports & Family Chiropractic immediately. If I am out of town or unable to contact the doctor, I can present myself to the emergency room.

- [ ] I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by Dr. Schraub.

- [ ] I further understand that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and cerebrovascular accidents. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time based upon the facts the known and is in my best interests.

Patient Name	Patient Signature	Date
Doctor Name	Doctor Signature	Date

Privacy Practices Acknowledgement

ACKNOWLEDGEMENT FORM

I have received the HIPAA Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____ Date _____

Insurance Policy Update

To our valued patients,

Starting January 1, 2021, we will no longer be accepting insurance plans with the exception of Medicare. However, we will provide you with a detailed receipt so that you may file your visit on your own. We will also be implementing a new cancellation policy.

We will be implementing the following policies in order to better serve you:

The cancellation policy is as follows: all patients must cancel their appointment 3 hours before their scheduled appointment time. If a patient does not give at least 3 hours' notice of cancellation is a no show, the patient will be charged the full amount of the visit.

In addition to the cancellation policy, we ask that you please arrive to your appointment on time. If you do arrive late, we will do our best to still see you. However, if we cannot work you in, you will still be charged for your visit.

We appreciate your business and your understanding! Thank you!

Signature _____ Date _____

Late Cancellation and No-Show Policy

Late Cancellation and No-Show Policy

To ensure fairness and availability for all patients, Alcovy Sports & Family Chiropractic has implemented the following policy regarding late cancellations and missed appointments:

- **Chiropractic or MyACT Appointments**: Cancellations made fewer than 3 hours before the scheduled time or missed appointments (no-shows) will incur a charge equal to the full cost of the visit.
- **Massage Therapy Appointments**: Cancellations must be made at least 24 hours in advance. Cancellations made with less than 24 hours' notice or missed appointments will be charged the full amount of the session.

This policy helps us manage our schedule effectively and continue providing exceptional care to all our patients. We appreciate your understanding and cooperation.

As a new patient, I understand that the fee that I would incur would be $100 for a late cancellation or missed appointment.

Signature _____ Date _____