# **CHIROPRACTIC INTAKE FORM**

#### Provider: CATHRYN WOON DC

### **Patient Information**

(Please Print Name:	/	Date:	HIC/I	patient	ID#:	
	t, Middle Initial, Last			Sacione		
Address:		City:	Stat	e:	Zip Code:	
Sex:	Gender:		ate of Birth:		_ ·	
Contact Inf						
Home Phone:Cell		ell Phone:	Phone: W		ork Phone:	
Email:						
Where Do Yo	ur Prefer to Receive (	Calls? (please o	circle): Home	/Work/	Cell/No Preference	
Are you com	fortable with us leavin	ng a voicemail?	Yes/no			
Who are you	comfortable with sha	aring appointm	ent informati	on with	( <b>no</b> medical information -	
date of appo	intment and time only	/):				
Patient empl	oyer/School Occupation	tion:				
i acionic oninpe	haal Address		Cit <u>y:</u>	State	:	
Employer/sc	nool Address:					
Employer/sc	Employe					
Employer/sc Zip Code <u>:</u>		r Work Phone:				

## **Responsible Party**

Name of person respons	ible for this acco	unt:		
Relationship to Patient:		Phone:		
Address:	City:	State:	Zip Code:	
Name of Employer:		Work Phone:		

# **Insurance Information:**

PLEASE PROVIDE YOUR INSURANCE	E CARD TO THE FRONT DESK TO WE CAN RETAIN A COPY FOR
OUR RECORDS. IF YOU DO NOT PRO	VIDE YOUR MOST UP TO DATE INSURANCE, YOUR DATES OF
SERVICE WILL BE BILLED TO YOU DI	RECTLY. THANK YOU FOR YOUR UNDERSTANDING.
Name of Insurance:	
Name of Insured:	Relationship to Patient:
Policy Effective Date:	If you are not the insured, please provide, the
insured's date of birth:	
Do you have a secondary insurance (	please circle one answer): yes/no
If you answer if yes, please provide th	ne following information:
Name of Secondary Insurance:	
Name of Insured:	Relationship to Patient:
Policy Effective Date:	If you are not the insured, please provide, the
insured's date of birth:	

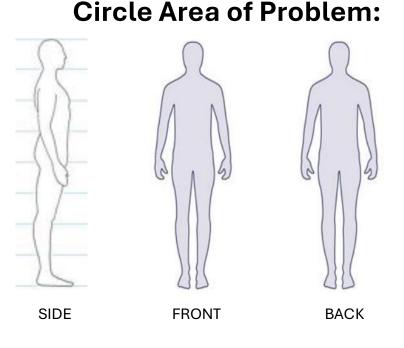
Other Notes About Insurance (PLEASE READ BEFORE CONTINUING): Cathryn Woon cannot treat you if you are under Medicare. Because we are not contracted with them, Medicare prevents us from treating their clients and therefore has the right to revoke our business license if they become aware of us treating a "Medicare" patient. If you are a Medicare patient, please contact the front desk so you can be referred to another clinic. Please sign the following line if you understand and can certify that you are not under Medicare as of filling out this form:

Signature of Patient, Guardian, or Personal Representative	Date
Signature of Fatient, Guardian, of Fersonal Representative	Date

# Symptoms:

Reason for visit:

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



### **Health History:**

Check only those that are applicable:

- AIDS/HIV
- ALLERGIES
- ANOREXIA/BULIMIA
- ANXIETY
- o ARTHRITIS
- o ASTHMA
- BLEEDING DISORDER
- BREAST LUMP
- **BRONCHITIS**
- CANCER
- CHEMICAL
  DEPENDENCY
- DEPRESSION
- DIABETES
- EPILEPSY
- FRACTURES

- GLAUCOMAGOITER
- 0 GUILER
- HEADACHES
- HEART DISEASE
- o HERNIA
- HERNIATED DISC
- HERPES
- HIGH BLOOD
  PRESSURE
- o HIGH
- CHOLESTEROL
- KIDNEY DISEASE
- LIVER DISEASE
- LONG COVID
- MIRGRAINES
- o MULTIPLE
- SCLEROSIS

- o OSTEOPOROSIS
- PINCHED NERVE
- o PNEUMONIA
- PROSTATE
  PROBLEMS
- PSYCHIATRIC CARE
- o SPRAIN/STRAINS
- STROKE
- SUICIDE ATTEMPTS
- THYROID
  PROBLEMS
- o TUMORS,
- GROWTHS
- o ULCERS
- OTHER: \_\_\_\_\_

#### Date of last exams:

(Woman) Are you pregnant? Yes/No Nursing? Yes/No Taking birth control pill? Yes/No List any type of surgeries which you had and the dates which they occurred:

Describe current health: good / fair / poor / chronically ill Please list all medications you are currently taking.

#### **Daily Habits:**

What type of exercise do you perform on a daily basis (please circle one)? None Moderate Heavy What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)

Can you perform daily activities unmodified: yes / no

What vitamins do you currently take?\_\_\_\_

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

Do you smoke? Yes No How much per day?

How much liquor do you consume on a weekly basis?

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

Self-medicating to cope, sleep, etc.?

Sleep Habits:

Do you have insomnia, sleep apnea, or other sleep disorders? If so, please list them:

How many hours do you sleep per night?\_\_\_\_\_

On a scale from 1-10, 1 being the worst and 10 being the best, how would you say your quality of sleep is? 1 2 3 4 5 6 7 8 9 10

#### **Certification and Assignments:**

To the best of my knowledge, the above information is complete and correct. I understand that is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I, and/or my dependent(s), have insurance coverage with

#### Name of Insurance Company(ies)

and assigned directly to Dr. \_\_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. Even when benefits have been confirmed, insurance company(ies) may not cover all charges. I authorize the use of my signature on all insurance submissions.

I certify that as of \_\_\_\_\_, I am not under Medicare and understand that I

Date

cannot go forward with treatment if I am under Medicare:

X

Signature of Patient, Guardian, or Personal Representative

I also hereby understand that it is my responsibility to update my insurance information and address as soon as possible so that my dates of service can be billed correctly and so I can receive paper statements via mail:

X\_\_\_

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for related services. This consent will end when my current treatment plan is completed or one year from the date signed below (next page):

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Signature of Patient, Guardian, or Personal Representative

Date