CHIROPRACTIC INTAKE FORM

Provider: CATHRYN WOON DC

Patient Information

Thank you for choosing our practice for chiropractic needs. Please complete this form in ink.
(Please Print)
Name:_____ Date:_____HIC/patient ID#: _____
First, Middle Initial, Last
Address:_____ City:_____ State:_____ Zip Code: _____
Sex: _____ Gender: _____ Date of Birth:_____
Contact Information:
Home Phone:_____Cell Phone: _____ Work Phone: _____
Email: _____
Where Do Your Prefer to Receive Calls? (please circle): Home/Work/Cell/No Preference
Are you comfortable with us leaving a voicemail? Yes/no
Who are you comfortable with sharing appointment information with (**no** medical information - date of appointment and time only): _____
Patient employer/School Occupation:_____
Employer/school Address: _____ City:_____ State: _____
Zip Code:_____ Employer Work Phone:_____
Whom may we thank for referring you to us?_____
Person to contact in case of emergency:_____Phone: _____

Responsible Party

Name of person responsible for this account: _____
Relationship to Patient:_____ Phone:_____
Address:_____ City:_____ State:_____ Zip Code:_____
Name of Employer:_____ Work Phone:_____

Insurance Information:

PLEASE PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK TO WE CAN RETAIN A COPY FOR OUR RECORDS. IF YOU DO NOT PROVIDE YOUR MOST UP TO DATE INSURANCE, YOUR DATES OF SERVICE WILL BE BILLED TO YOU DIRECTLY. 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 the 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

Symptoms:

Reason for visit:

When did you first notice the symptoms (date or time frame): _____

Is this condition getting any worse (please circle one answer): yes/no/stays the same

Where specifically is the problem(s) located? _____

Which activities are difficult to perform (please circle all that apply):

Sitting, Standing, Walking, Bending Down, Lying Down, Other (elaborate): _____

Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting Burning

Tingling Cramps Stiffness Swelling Other (elaborate): _____

Rate the severity of your pain. (1 mild pain or discomfort, to 10, severe 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 all that apply)?

Medication/ Surgery/ Physical Therapy/ Other (elaborate/please list surgeries with dates):

_____

_____

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

_____

Circle Area of Problem:

SIDE

FRONT

BACK

Health History:

Check only those that are applicable:

- AIDS/HIV
- ALLERGIES
- ANOREXIA/BULIMIA
- ANXIETY
- ARTHRITIS
- ASTHMA
- BLEEDING DISORDER
- BREAST LUMP
- BRONCHITIS
- CANCER
- CHEMICAL DEPENDENCY
- DEPRESSION
- DIABETES
- EPILEPSY
- FRACTURES
- GLAUCOMA
- GOITER
- HEADACHES
- HEART DISEASE
- HERNIA
- HERNIATED DISC
- HERPES
- HIGH BLOOD PRESSURE
- HIGH CHOLESTEROL
- KIDNEY DISEASE
- LIVER DISEASE
- LONG COVID
- MIRGRAINES
- MULTIPLE SCLEROSIS
- OSTEOPOROSIS
- PINCHED NERVE
- PNEUMONIA
- PROSTATE PROBLEMS
- PSYCHIATRIC CARE
- SPRAIN/STRAINS
- STROKE
- SUICIDE ATTEMPTS
- THYROID PROBLEMS
- TUMORS, GROWTHS
- 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):

x _____ _____
Signature of Patient, Guardian, or Personal Representative Date