Patient Intake Form

Patient Information

Full Name:_____Date: _____
First MI Last

Address:_____City:_____State: _____Zip: _____

Age: _____Birth Date: _____/_____/_____ Gender/Identity (circle one): Male - Female – Other:_____

Email Address: _____ Cell/Other: _____

(Email address and phone number are used for online booking, appointment reminders, sending exercise prescriptions, and marketing, etc.)

Emergency Contact:_____Emergency Contact Phone Number: _____

How did you hear about our office? ☐ Friend ☐ Google ☐ Passing by ☐ Social media ☐ Other : _____

Insurance Information (only fill out if we do not have a photocopy of your insurance card)

Do you have health insurance?_____Yes_____No

Primary Insurance	Secondary Insurance (if any)
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize Elevate Wellness LLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Elevate Wellness LLC and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*
By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests, and procedures for the above minor patient

x_____ _____
Signature of Patient or Representative/Guardian **Date**
(if patient is minor or handicapped)

Past medical history:

Medical Conditions: (Mark all that apply to you)

□ Arthritis	□ Rheumatoid Arthritis	□ Stroke
□ Cancer	□ Diabetes	□ Heart Disease
□ Hypertension	□ Psychiatric Illness	□ Skin Disorder
□ Fibromyalgia	□ Asthma	□ Osteoporosis

□ Other_____

Surgeries: (Mark all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Spinal Fusion	□ Shoulder	□ Thoracic spine	□ Knee
□ Gastrointestinal	□ Urogenital	□ Hernia	

Other _____

Allergies: (Mark all that apply to you)

□ LATEX □ Seasonal □ Milk or Lactose □ Animal □ Mold

□ Other _____

Social History: (Circle all that apply to you)

Caffeine use:	□ occasional	□ often	□ never
Drink Alcohol:	□ occasional	□ often	□ never
Exercise:	□ occasional	□ often	□ never
Drink Water:	□ <8 glasses	□>8 glasses	□ never
Cigarettes:	□<1 pack/day	□ >1 pack/day	□ never
Sleep:	□<8 hours/night	□ >=8 hours/night	□ Insomnia

□ Other (vaping, tobacco, etc.)

Family History: Write about any family medical conditions below

Mother: _____

Father: _____

Grandmother: _____

Grandfather: _____

Sibling: _____

Occupational Activities: (Circle one that best describes your job description)

□ Administration	□ Business Owner	□ Clerical/Secretary	□ Computer User
□ Heavy Equipment operator	□ Daycare/Childcare	□ Construction	□ Health Care
□ Food Service Industry	□ Medium Manual Labor	□ Manufacturing	□ Home Services
□ Heavy Manual Labor	□ Light Manual Labor	□ Executive/Legal	□ Housekeeper

□ Other _____

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			**Respiratory**			**Allergic/Immunologic**		
	Past	Present		Past	Present		Past	Present
Poor Circulation			Asthma			Hives		
Hypertension			Tuberculosis			Immune Disorder		
Aortic Aneurism			Short Breath			HIV/AIDS		
Heart Disease			Emphysema			Allergy Shots		
Heart Attack			Cold/Flu			Cortisone Use		
Chest Pain			Cough					
High Cholesterol			Wheezing					
Pacemaker						**Ear, Nose and Throat**		
Jaw Pain			**Eyes**				Past	Present
Irregular Heartbeat				Past	Present	Difficulty Swallowing		
Swelling of legs			Glaucoma			Dizziness		
			Double Vision			Hearing Loss		
Genitourinary			Blurred Vision			Sore Throat		
	Past	Present				Nosebleeds		
Kidney Disease			**Psychiatric**			Bleeding Gums		
Burning Urination				Past	Present	Sinus Infections		
Frequent Urination			Depression					
Blood in Urine			Anxiety			**Gastrointestinal**		
Kidney Stones			Stress				Past	Present
Lower Side Pain						Gall Bladder Problems		
			Endocrine			Bowel Problems		
Neurologic				Past	Present	Constipation		
	Past	Present	Thyroid			Liver Problems		
Stroke			Diabetes			Ulcers		
Seizures			Hair Loss			Diarrhea		
Head Injury			Menopausal			Nausea/Vomiting		
Brain Aneurysm			PMS			Bloody Stools		
Numbness						Poor Appetite		
Severe Headaches			**Hematologic**					
Pinched Nerves				Past	Present	**Musculoskeletal**		
Parkinson's			Hepatitis				Past	Present
Carpal Tunnel			Blood Clots			Gout		
Vertigo			Cancer			Arthritis		
			Bruising			Joint Stiffness		
Constitutional			Bleeding			Muscle Weakness		
	Past	Present	Fever, Chills			Osteoporosis		
			Sweating			Broken Bones		
Weight Loss			Varicose Vein			Joints Replaced		
Weight Gain						Neck Pain		
Difficulty Sleeping						Low Back Pain		
Low energy						Upper Back Pain		

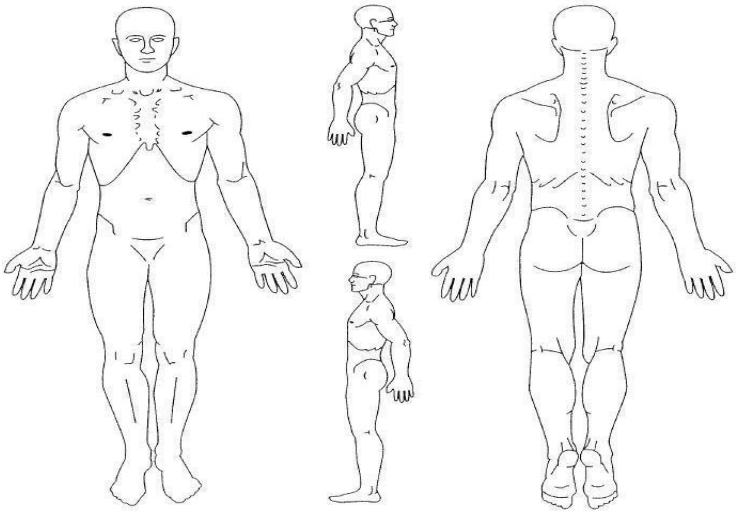
Please list all current medications being taken: _____

_____

_____

Are You Pregnant? Yes No **If Yes, how many weeks?** _____

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



Average Pain Intensity:
Last 24 hours:
0 1 2 3 4 5 6 7 8 9 10
Least **Worst**

My pain is
□ Sharp □ Ache □ Numb □ Shooting
□ Burning □ Tingling □ Throbbing □Tight
□ Other _____

My symptoms have been occurring for ___year(s)___month(s)___week(s)___day(s)____

Since my symptoms began, the pain has been □Getting better □ Getting worse □ the same

I first noticed my symptoms when_____

I experience my symptoms…
□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

My symptoms are BETTER when…
□bending □sitting □turning □lying □moving □when still □upon waking □in the evening
□lifting □other_____

My symptoms are WORSE when…
□bending □sitting □turning □lying □moving □when still □upon waking □in the evening
□lifting □other_____

My symptoms are a result of: □Motor Vehicle Accident □Work Related Accident □ Other_____

Have you experienced/had
Disturbed sleep? YES/NO Unexplained weight loss? YES/NO
Recent surgeries? YES/NO Imaging (X-ray or MRI)? YES/NO

In the past, I have tried (circle all that apply)

Physical therapy	Massage	Acupuncture	Ultrasound	Stretching
Chiropractic	Traction therapy	Laser therapy	Dry Needling	Ice or Heat

How inclined are you to do home exercises and other prescribed treatments outside of your visit?
Not at all 0 1 2 3 4 5 6 7 8 9 10 Very Incli

Financial Policy & Credit Card on File Authorization

Financial Responsibility

I understand that I am ultimately responsible for payment for services provided to me, regardless of whether my insurance company pays for all, part, or none of my care. Insurance benefits are estimates and are not a guarantee of payment.
I authorize Elevate Wellness Chiropractic Medicine to verify my insurance benefits and submit claims on my behalf when applicable. I understand that deductibles, copayments, coinsurance, non-covered services, denied claims, and other amounts determined to be my responsibility are due according to the practice's payment policies.
If my insurance company makes a payment or adjustment different from what was originally estimated, I understand that my account may be adjusted accordingly and that I remain responsible for any outstanding balance.

Payment Policy

Payment is expected at the time when services are provided unless other arrangements have been approved in advance.
If an insurance claim is denied, partially paid, or additional patient responsibility is determined after the claim has been processed, I agree to pay the resulting balance upon notification.
I understand that statements may be provided for outstanding balances. Balances that remain unpaid may be subject to additional collection efforts consistent with applicable law and practice policy.
Package payments are part of a discount medical plan. Payments are made in advance for the entire package and visits must be completed in 6 months.

Credit Card on File Authorization

I authorize Elevate Wellness Chiropractic Medicine to securely maintain my payment card (if provided) information through its payment processing system and to charge the card on file for amounts that I am responsible for under this Financial Policy.
This authorization may be used for:

- Copayments, deductibles, and coinsurance
- Balances remaining after insurance processing
- Services that are not covered by my insurance
- Previously unpaid balances
- Other charges that I have agreed to in writing or that are otherwise permitted under the practice's policies
- Missed appointment / Last minute cancellation charge: $25

Before charging a card for an **unexpected or newly identified balance**, the practice will make reasonable efforts to notify me and provide an explanation of the amount due when appropriate.
I understand that keeping a card on file does not change my financial responsibility or guarantee that insurance will pay for services.

I understand that my card information will be maintained through the practice's payment processing system and that Elevate Wellness Chiropractic Medicine will not intentionally retain my full card number or security code outside of that payment system.

I agree to notify the practice if my payment information changes. I may revoke this authorization by providing written notice; however, revoking the authorization does not eliminate any balance already owed.

Patient Acknowledgment

By signing below, I acknowledge that I have read and understand this Financial Policy and Credit Card on File Authorization. I have had an opportunity to ask questions and agree to the terms above.

Printed Name of Patient

X_____

X_____ _____
Signature of Patient or Legal Guardian **Date**

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the Doctor of Chiropractic in this facility and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations, burns. In rare cases, some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. Ialso understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

Media: Our practice is committed to keeping an online presence and might ask for your permission to share content including videos and pictures for educational/marketing purposes. Verbal permission will always be obtained beforehand. No patient health information will be shared.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at thishealth care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

Printed Name of Patient: _____

x_____ _____
Signature of Patient **Date**

x_____ _____
Signature of Representative/Guardian (if patient is minor or handicapped) Date

Informed Consent, Assumption of Risk & Release of Liability for modalities

I understand and acknowledge that as part of my care at **Elevate Wellness Chiropractic Medicine** I may receive one or more of the following treatments: **Shockwave Therapy, Dry Needling, Class IV Laser Therapy and Cupping or TENS therapy**. I understand that these treatments involve inherent risks, including the possibility of injury, even when performed according to accepted clinical standards.

Shockwave Therapy
Potential risks and adverse reactions may include, but are not limited to:

- Pain or discomfort during or after treatment
- Redness, swelling, bruising, or skin irritation
- Temporary or prolonged soreness, tenderness, or inflammation

Dry Needling
Potential risks and adverse reactions may include:

- Muscle soreness, stiffness, or fatigue
- Bruising, bleeding, or hematoma formation
- Dizziness, lightheadedness, fainting, or nausea
- Temporary worsening of symptoms
- Infection, nerve irritation, or other unforeseen complications

Class IV Laser Therapy
Potential risks and adverse reactions may include:

- Warmth, tingling, or discomfort during treatment
- Skin redness, irritation, blistering, or burns
- Temporary or prolonged increase in symptoms
- Burns or blistering of the skin if excessive heat is generated during treatment

I understand that **Class IV Laser Therapy produces heat** and that excessive heat exposure may result in **burns or skin injury**. I acknowledge that I will be provided with a **stop button or alert mechanism** and that it is **my responsibility to immediately activate the stop button or notify the provider** if I experience excessive heat, pain, or discomfort. I understand that failure to do so may increase my risk of injury.

Acknowledgment of Responsibility & Release

I certify that I have fully disclosed all relevant medical conditions, medications, implants, sensitivity, and prior injuries to my provider. I understand that withholding or failing to disclose such information may increase my risk of adverse outcomes.

To the fullest extent permitted by law, **I voluntarily assume all risks associated with these treatments** and hereby **release, waive, and discharge Elevate Wellness Chiropractic Medicine or Elevate Wellness LLC, its owners, providers, employees, and affiliates from any and all claims, demands, liabilities, or causes of action arising from injury, pain, burns, complications, or adverse outcomes**, except in cases of gross negligence or willful misconduct as defined by law.

I confirm that I have read and fully understand this consent, have had the opportunity to ask questions, and agree to proceed freely and voluntarily.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

Printed Name of Patient: _____

_____ _____
Signature of Patient or Legal Representative/Guardian **Date**