



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**

Signed _____ Date _____

Past medical history:

Medical Conditions: (Circle all that apply to you)

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Other _____ | | |

Surgeries: (Circle all that apply to you)

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical spine | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate | <input type="checkbox"/> Lumbar spine | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Spinal Fusion | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Thoracic spine | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Urogenital | <input type="checkbox"/> Hernia | |
| Other _____ | | | |

Allergies: (Circle all that apply to you)

- LATEX Seasonal Milk or Lactose Animal Mold
 Other _____

Social History: (Circle all that apply to you)

- | | | | |
|--|---|--|-----------------------------------|
| Caffeine use: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Alcohol: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Exercise: | <input type="checkbox"/> occasional | <input type="checkbox"/> often | <input type="checkbox"/> never |
| Drink Water: | <input type="checkbox"/> <8 glasses | <input type="checkbox"/> >8 glasses | <input type="checkbox"/> never |
| Cigarettes: | <input type="checkbox"/> <1 pack/day | <input type="checkbox"/> >1 pack/day | <input type="checkbox"/> never |
| Sleep: | <input type="checkbox"/> <8 hours/night | <input type="checkbox"/> >=8 hours/night | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Other (vaping, tobacco, etc.) | | | |

Family History: Write any medical conditions below

Mother: _____
Father: _____
Grandmother: _____
Grandfather: _____
Sibling: _____

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

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business Owner | <input type="checkbox"/> Clerical/Secretary | <input type="checkbox"/> Computer User |
| <input type="checkbox"/> Heavy Equipment operator | <input type="checkbox"/> Daycare/Childcare | <input type="checkbox"/> Construction | <input type="checkbox"/> Health Care |
| <input type="checkbox"/> Food Service Industry | <input type="checkbox"/> Medium Manual Labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Home Services |
| <input type="checkbox"/> Heavy Manual Labor | <input type="checkbox"/> Light Manual Labor | <input type="checkbox"/> Executive/Legal | <input type="checkbox"/> Housekeeper |
| <input type="checkbox"/> Other _____ | | | |

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

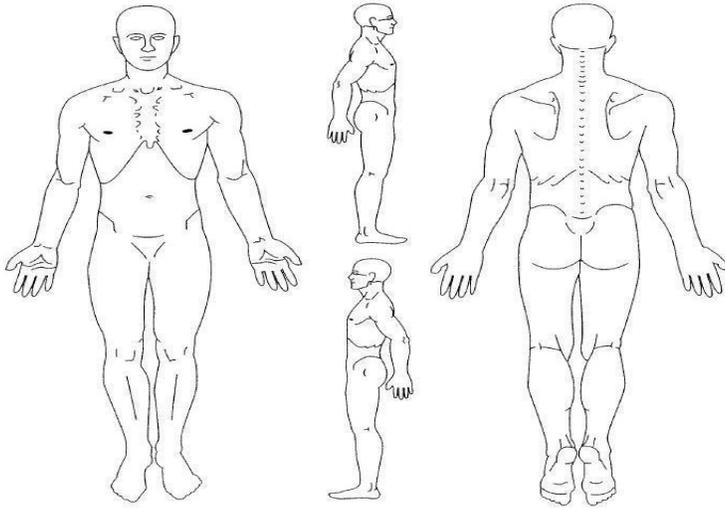
Cardiovascular	Past	Present	Respiratory	Past	Present	Allergic/Immunologic	Past	Present
Poor Circulation			Asthma			Hives		
Hypertension			Tuberculosis			Immune Disorder		
Aortic Aneurism			Short Breath			HIV/AIDS		
Heart Disease			Emphysema			Allergy Shots		
Heart Attack			Cold/Flu			Cortisone Use		
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?** _____

Patient Name _____ Date _____

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 Inclined



PAYMENT POLICY

Thank you for choosing Elevate Wellness as your provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. **INSURANCE.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral, it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. **CO-PAYMENT AND DEDUCTIBLES.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. **PROOF OF INSURANCE.** All patients must complete out-patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. **CLAIM SUBMISSION.** We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance pays your claim or not. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. **COVERAGE CHANGES.** If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. **MISSED APPOINTMENT.** Our policy is to charge **\$25.00** after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment.**
7. **Package Deals:** Package deals are part of a discount medical plan. Payments are taken in advance for the total amount of visits. No refunds are available for package deals. Visits must be used within a 6-month period of time. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party

Date

Patient Name _____ 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, physio therapy, 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. 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. I also 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 this health 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, and/or 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.

I acknowledge that:

- No guarantees or assurances have been made regarding treatment results
- Individual responses to treatment vary
- I voluntarily elect to proceed with treatment **despite known and unknown risks**

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

X _____
Signature of Patient

Date

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

Date