Patient Intake Form

Patient Information

Full Name: _____ Date: _____
First MI Last

Address: _____ City:_____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Male/Female/Other

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

Emergency Contact: _____Emergency Contact Phone Number: _____

How did you hear about our office? _____

Insurance Information

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 to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Elevate Wellness 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 _____

Patient Name_____Date_____

Past medical history:

Medical Conditions: (Circle all that apply to you)

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

□ Other _____

Surgeries: (Circle 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: (Circle 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: (Circle all that apply) (Mother, Father, grandparent, etc.)

Arthritis:	□ Mother	□ Father	□Grandmother	□Grandfather	□Brother	□Sister
Cancer:	□ Mother	□ Father	□Grandmother	□Grandfather	□Brother	□Sister
Diabetes:	□ Mother	□ Father	□Grandmother	□Grandfather	□Brother	□Sister
Heart Disease	□ Mother	□ Father	□Grandmother	□Grandfather	□Brother	□Sister
Hypertension	□ Mother	□ Father	□Grandmother	□Grandfather	□Brother	□Sister
Stroke	□ Mother	□ Father	□Grandmother	□Grandfather	□Brother	□Sister
Thyroid	□ Mother	□ Father	□Grandmother	□Grandfather	□Brother	□Sister

Other _____

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 _____

Patient Name_____Date_____

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

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	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							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		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**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Please list all current medications being taken: _____

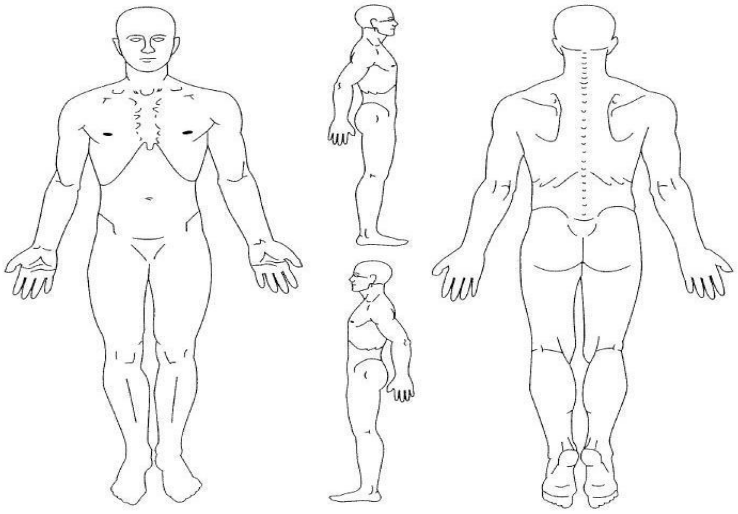
_____

_____

Are You Pregnant? Yes No

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
□ Other _____

My symptoms/pain has been occurring for ____years ____months ____weeks ____days

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 or not your insurance pays your claim. 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**.

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.

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

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Large Truck ☐ Bus
Other

2. Your position in vehicle

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
Other

3. What was your vehicle doing at the time of the accident?

☐ Stopped at intersection ☐ Stopped in traffic ☐ Stopped at light
☐ Making a right turn ☐ Making a left turn ☐ Parking
☐ Proceeding along ☐ Slowing down ☐ Accelerating
Other

4. Time/Speed/Damage

Time of accident
Your Vehicle's
Speed: mph
Their Vehicle's
Speed: mph

5. Details of Accident

Visibility at time of accident
☐ Poor ☐ Fair ☐ Good

Who hit who/what?
☐ You hit other vehicle
☐ Other vehicle hit you
You hit (Object)-

6. Read conditions

Road conditions at the time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry

Point of impact
☐ Head-on ☐ Left Front ☐ Right Front
☐ Read-End ☐ Left Rear ☐ Right Rear

7. Body Position, etc.

Did you see the accident coming:	☐ Yes ☐ No
Were you braced for the impact?	☐ Yes ☐ No
Did you have a seat belt on?	☐ Yes ☐ No
Did you have a shoulder harness on?	☐ Yes ☐ No

Does your vehicle have headrests? ☐ Yes ☐ No

What was the position of your headrest at the time of the impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck

What was the direction of you head at the time of the impact?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Did driver side air bags deploy? ☐ Yes ☐ No Did passenger side airbags deploy? ☐ Yes ☐ No Did side airbags deploy? ☐ Yes ☐ No

8. Additional accident information

In the case of a motor vehicle accident, enter any addional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle?	☐ Yes ☐ No
If yes, describe:	
Did you lose consciousness during the injury?	☐ Yes ☐ No
If yes, for how long?	
Did police show up at the scene?	☐ Yes ☐ No
Was an accident report filled out?	☐ Yes ☐ No

10. After the accident:

Check off your symptoms right after and a few days following:

☐ Headache	☐ Dizziness	☐ Mid back pain	☐ Cold hands
☐ Neck pain	☐ Nausea	☐ Low back pain	☐ Cold feet
☐ Neck stiffness	☐ Confusion	☐ Nervousness	☐ Diarrhea
☐ Fainting	☐ Fatigue	☐ Loss of taste	☐ Depression
☐ Ringing in ears	☐ Tension	☐ Toe numbness	☐ Anxious
☐ Loss of smell	☐ Irritability	☐ Constipation	☐ Chest Pain
☐ Pain behind eyes	☐ Shortness of breath	☐ Sleeping problems	

Other

11. Emergency Room?

Where did you go after the accident?
☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor

How did you get there?
☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police

Were X-rays done? ☐ Yes ☐ No **Was lab work done?** ☐ Yes ☐ No

Body parts X-rayed?

What lab work?

The X-rays revealed:

Treatments: ☐ Cervical Collar ☐ Ice ☐ Other:

Medications:

Follow-up instructions:

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.

1. Dr. First visit date
Specialty: X-rays done? ☐ **Yes** ☐ **No**
Types of treatments recieved:
How many treatments recieved? Currently treating? ☐ **Yes** ☐ **No**
Did treatments benefit you? ☐ **Yes** ☐ **No**
Last visit date:

2. Dr. First visit date
Types of treatments recieved:
How many treatments recieved? Currently treating? ☐ **Yes** ☐ **No**
Did treatments benefit you? ☐ **Yes** ☐ **No**
Last visit date:

Office Use Only:
MRN

Patient-Specific Functional Scale

Name: _____ Date: _____

Please read the following and complete.

Please identify **up to three important activities** that you are unable to do or are **having difficulty with** as a result of your current problem/diagnosis (i.e. the reason your doctor has referred you to therapy). Today, are there any activities that you are unable to do or having difficulty with because of your problem/diagnosis?

Please rate each of these problems on the 0-10 scale below.

0 = Able to perform activity at the same level as before injury or problem (No issues)

10 = Unable to perform activity (Cannot perform)

Patient-specific activity scoring scheme (Circle one number or provide a range):

1. Activity:										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No Issues										**Cannot perform**

2. Activity:										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No Issues										**Cannot perform**

3. Activity:										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No Issues										**Cannot perform**