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)

□ Arthritis □ Rheumatoid Arthritis □ Stroke
□ Cancer □ Diabetes □ Heart Disease
□ Hypertension □ Psychiatric Illness □ Skin Disorder
□ 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: _____
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: _____

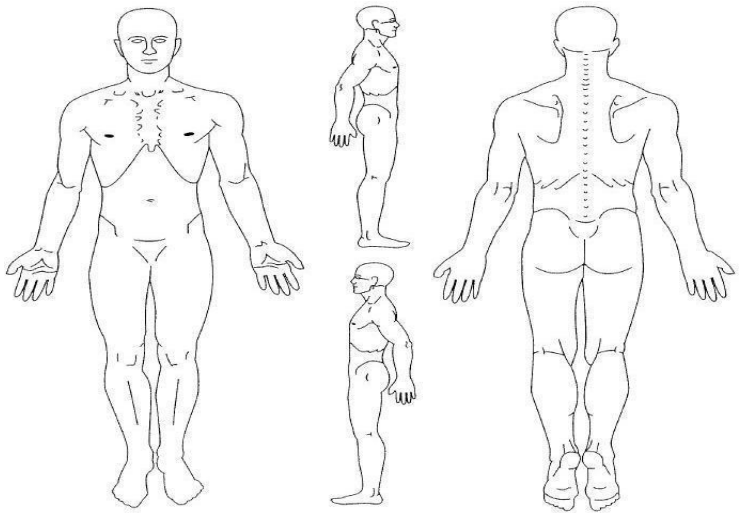
_____

_____

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

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 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 youbetter 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 leadingto 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