**Adult Intake Form** 

Welcome to our Office!

Please complete this form as thoroughly as possible.

This from will be a permeant part of your records

and help us get a better understanding of your overall health.

**Personal Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (First) (Middle) (Last)

Date of Birth: \_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Sex: ⃝ Male ⃝ Female Marital Status: S / M / D / W

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Home #: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Cell #: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Work#: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security** #: \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

How Many Children? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact and Pho #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Did You Hear About Us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date and reason for your last doctor visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last known blood pressure \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Select which is true for you: ⃝ Self Pay ⃝ Insured

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this condition today due to an accident? ⃝ Yes ⃝ No ⃝ Auto ⃝ Work ⃝ Home ⃝ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Chiropractic History:**

Have you seen a Chiropractor in the past?: ⃝ No ⃝ Yes Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you respond in the past?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any chiropractic techniques you prefer?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain Profile:**

Please tell us where your pain is today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What caused this condition(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any previous episodes of this conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the date this condition began? \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

What is the date of this flareup if this is a chronic condition? \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

What is the frequency of this condition?

⃝ Constant (100%) ⃝ Frequent (75% - 50%) ⃝ Intermittent (50% - 25%) ⃝ Occasional (25% or Less)

Mark on the pain diagram below where you are having pain.)



What is your pain level today?: (Please circle 1 or more numbers.)

Complaint #1

1 2 3 4 5 6 7 8 9 10

(little to no pain) (moderate pain) (Going to the ER)

Complaint #2

1 2 3 4 5 6 7 8 9 10

(little to no pain) (moderate pain) (Going to the ER)

Complaint #3

1 2 3 4 5 6 7 8 9 10

(little to no pain) (moderate pain) (Going to the ER)

Quality of discomfort: ⃝ Aching ⃝ Dull ⃝ Sharp ⃝ Stabbing ⃝ Shooting ⃝ Throbbing ⃝ Burning ⃝ Stabbing

 ⃝ “shock Like” ⃝ Tightness ⃝ Stiffness ⃝ Catching ⃝ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the pain radiate to other areas in the body? ⃝ Yes ⃝ No Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What improves this condition or gives you relief? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What aggravates this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your specific therapeutic goals?: ⃝ Improved Sleep ⃝ Improved ROM ⃝ Flexibility ⃝ Relive Pain ⃝ Decrease Stiffness ⃝ Walking ⃝ Return to Sports ⃝ Return to Work ⃝ Decrease Swelling ⃝\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition: ⃝ Improving ⃝ Unchanged ⃝ Getting Worse ⃝ Unsure ⃝ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**:

Current work habits: select all that apply ⃝ Permanently fully disabled

 ⃝ Permanently partial disabled

 ⃝ Cannot work due to current condition

 ⃝ Full-time (20-40+ hours/week)

 ⃝ Part-time (1-19 hours/week)

 ⃝ Retired ⃝ Student ⃝ Homemaker ⃝ Unemployed

Personal social habits: select all that apply ⃝ Smoke or use tobacco products (How Much \_\_\_\_\_\_\_\_\_\_\_\_\_) ⃝ Drink alcohol (How Much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

⃝ Drink caffeine (How Much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

⃝ Use recreational drugs (How Much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Present exercise habits: select all that apply ⃝ No current exercises

⃝ Exercise daily

⃝ Exercise 3+ time per week

⃝ Cannot return to exercise due to current condition

Any Surgeries/Hospitalizations? ⃝ Yes ⃝ No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any significant falls, or other injuries/accidents? Yes ⃝ No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Other ongoing illnesses?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any allergies(Medications/Seasonal/Food?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any medications and their purpose? ⃝ Yes ⃝ No List or provide\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take supplements or homeopathic? ⃝ Yes ⃝ No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your Family History, such as diabetes, cancer, hypertension and progressive neurological disease that we should be aware of? ⃝ Yes ⃝ No List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently pregnant?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, how far along are you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any recent medical procedures/ Tests?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Dietary Restrictions/Issues?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following: ⃝ Pacemaker

 ⃝ Defibrillator

 ⃝ Metal Implants/Joint Replacements

 ⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any other medical information you feel the doctor needs to know about you today?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**: Check any that apply.

**General HEENT Skin/Hair Cardiovascular**

⃝ WNL ⃝ WNL ⃝ WNL ⃝ WNL

⃝ Lethargy/Weakness ⃝ Headaches/ Migraines ⃝ Skin Trouble/Rashes ⃝ Chest Pain/Tightness

⃝ Recurring Fever ⃝ Eye or Visual Changes ⃝ Flushing ⃝ Heart Attack

⃝ Recent Weight Loss/Gain ⃝ Eyeglasses/Contacts ⃝ Excessive Acne ⃝ Shortness of Breath

⃝ Dizziness ⃝ Nose Bleeds ⃝ Eczema ⃝ Palpitations

⃝ Fever ⃝ Eye Surgery ⃝ Psoriasis ⃝ Swelling of hands or feet

⃝ Chills ⃝ Cataracts ⃝ Skin Cancer ⃝ High Blood Pressure

⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Glaucoma ⃝ Skin Pigmentation Issues ⃝ High Cholesterol

 ⃝ Sore Throat ⃝ Change in Hair /Nails ⃝ Heart Murmur

 ⃝ Hoarseness ⃝ Gum Issues ⃝ Blood Clots

 ⃝ Swollen Glands ⃝ Other:\_\_\_\_\_\_\_\_\_\_\_ ⃝ Pacemaker

 ⃝ Nose/sinus issues ⃝ Mitral Valve Prolapse

 ⃝ Ear/Hearing Trouble ⃝ Congenital Heart Defects

 ⃝ Dental Problems ⃝ Rheumatic Fever

 ⃝ Gum Problems ⃝ Leg Pain upon Walking

 ⃝ TMJ Problems ⃝ Varicose Veins

 ⃝ Postnasal Drip ⃝ Dizziness

 ⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Excessive Bruising

 ⃝ Coronary Artery Disease

 ⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Respiratory GastroIntestinal Neurological Musculoskeletal**

⃝ WNL ⃝ WNL ⃝ WNL ⃝ WNL

⃝ Persistent Cough ⃝ Loss of Appetite ⃝ Frequent Headaches ⃝ Arthritis

⃝ Spitting up Blood ⃝ Nausea/Vomiting ⃝ Migraines ⃝ Joint Pain/Swelling

⃝ Asthma or Wheezing ⃝ Diarrhea ⃝ Dizziness ⃝ Neck Pain

⃝ Shortness of Breath ⃝ Constipation ⃝ Fainting ⃝ Back Pain

⃝ Exercise Intolerance ⃝ Abdominal Pain ⃝ Memory Loss ⃝ Trauma

⃝ Sleep Apnea ⃝ Stomach Ulcer ⃝ Poor Balance ⃝ Osteoporosis

⃝ Emphysema ⃝ Bloating/Cramping ⃝ Numbness/Tingling ⃝ Scoliosis

⃝ Snoring Issues ⃝ Heartburn ⃝ Pins and Needles ⃝ Cramping

⃝ Tuberclulosis ⃝ Hemorrhoids ⃝ Epilepsy/Seizures ⃝ Fractures

⃝ Pneumonia ⃝ Hepatitis ⃝ Stroke ⃝ Implants, Pins/Screws

⃝ Breathing ⃝ Cirrhosis ⃝ Tremors ⃝ Hip Disorders

⃝ Hay Fever ⃝ Difficulty Swallowing ⃝ Head Injury ⃝ Knee Problems

⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Jaundice ⃝ Anxiety/Panic Attacks ⃝ Foot/Ankle Problems

 ⃝ Liver Disease ⃝ Depression ⃝ Shoulder Problems

 ⃝ Gallbladder Problems ⃝ Sleeping Issues ⃝ Elbow/Wrist/Hand issues

 ⃝ Pancreatitis ⃝ Weak Muscles ⃝ Poor Posture

 ⃝ Change in bowels ⃝ Loss of Taste/Smell ⃝ Gout

 ⃝ Black/bloody stool ⃝ Temporary loss of vision ⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ⃝ Colon Cancer/polyps ⃝ Difficulty Concentrating

 ⃝ Food Sensitivies ⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ⃝ Irritable Bowel Issues

 ⃝ Crohn’s Disease

 ⃝ Gastric/Acid Reflux

 ⃝ Collitis

 ⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Blood/Lymph Allergies Psychiatric Endocrine**

⃝ WNL ⃝ WNL ⃝ WNL ⃝ WNL

⃝ Anemia ⃝ Seasonal ⃝ Alzheimer’s Disease ⃝ Diabetes

⃝ Bleeding ⃝ Medication ⃝ Insomnia ⃝ Thyroid Problems

⃝ Bruising ⃝ Food ⃝ Difficulty Concentrating ⃝ Sweating

⃝ Blood Clots ⃝ Other:\_\_\_\_\_\_\_\_\_\_ ⃝ Memory Loss/Confusion ⃝ Heat Intolerance

⃝ Past Transfusions ⃝ Depression ⃝ Cold Intolerance

⃝ Leukemia ⃝ Anxiety ⃝ Weight Loss

⃝ Lymphoma ⃝ Agitation/Irritability ⃝ Weight Gain

⃝ HIV/AIDS ⃝ Suicidal Thoughts ⃝ Frequent Urination

⃝ Sickle Cell ⃝ Chemical Dependency ⃝ Excessive Thirst

⃝ Other:\_\_\_\_\_\_\_\_\_\_\_ ⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Change In Appetite

 ⃝ Hair Changes

 ⃝ Hyperthyroidism

 ⃝ Hormonal/Glandular

 ⃝ Hyperparathyroidism

 ⃝ Testosterone Issues

 ⃝ Cushing’s Syndrome

 ⃝ Steroid Treatments

 ⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Urinary Male Female**

**⃝** WNL ⃝ WNL ⃝ WNL

⃝ Painful/Frequent Urination ⃝ Dribbling ⃝ Painful Sex

⃝ Incontinence ⃝ Loss of libido ⃝ Vaginal Discharge

⃝ Hesitancy ⃝ Erectile Dysfunction ⃝ Breast pain or lumps

⃝ Urgency ⃝ Sexually Transmitted Disease ⃝ Hot Flashes

⃝ Blood In Urine ⃝ Testicular Pain/Lumps ⃝ Menstrual Irregularities

⃝ Kidney Stones ⃝ Prostrate Disease ⃝ Loss of libido

⃝ Urinary Infections ⃝ Penile Discharge ⃝ Menopause

⃝ Genital/bladder complaints ⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Sexually Transmitted Disease

⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⃝ All WNL. No review of symptoms complaints

Please list any other issues you may have here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Payment Policy:***

**Carpenter Chiropractic Health Center, LLC**

Thank you for choosing us as your Chiropractic 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 us in upholding the law by paying your co-payment at each visit.
3. **PROOF OF INSURANCE**. All patients must complete our 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. **CONVERAGE 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 30 days, the balance will automatically be billed to you.
6. Personal Injury Patients: Many auto insurance policies include “Med Pay” which will pay your medical expenses within the limits of your policy. If your auto policy does not include “Med Pay” we will ask you to sign a lien to authorize and guarantee payment for your medical expenses for services rendered.

 **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**

CARPENTER CHIROPRACTIC HEALTH CENTER, LLC

714 MAIN STREET, PLEASANTON, KS 66075 913 352 8344

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be use by Carpenter Chiropractic Health Center, LLC. or may be disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. A copy of our Privacy Practices is available upon your request.

Requesting a Restriction on the Use or Disclosure of Your Information

* You may request a restriction on the use or disclosure of your Protected Health Information
* This office may or may not agree to restrict the use or disclosure of your Protected Heath Information
* If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

*By my signature below I give my permission to use and disclose my health information.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legally Authorized Individual Signature Date

Print Patients Full Name

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Witness Signature Date

**ACCEPTANCE OF TERMS & CONSENT TO TREAT**

**Medicare Limits and Responsibilities**

**The only charge for Chiropractic that is covered is manipulation of the spine. I accept responsibility to know the current Medicare guidelines and limits for covered services. I understand that Medicare may reimburse me for chiropractic adjustments, and that the Medicare program frequently does not consider treatments for me medically necessary. I accept responsibility to pay for all covered, non-covered and denied services. If Medicare denies payment, I agree to be personally and fully responsible for payment. I understand that I must pay for services at the time of service. I also understand that Carpenter Chiropractic Health Center, LLC will bill all charges directly to Medicare as required by law. I authorize the release of my records as necessary for Medicare billing.**

**Statement of Acknowledgement of Financial Responsibility**

**I understand that I may be responsible for any charges incurred at this office, including co-pays, deductibles and any services denied or not covered by my insurance company. I realize my care may be subject to pre-authorization by the insurance company and I accept any responsibility for charges not approved. The insurance company will review any/all documentation submitted by either chiropractor for their assessment of medical necessity and base their approval/denial upon this documentation.**

**I understand that this office agrees to notify me as soon as possible if a service is not covered and will notify me if my insurance does not approve my care. If a treatment plan is approved, this office will make me aware of the number of visits allowed and the time frame of the authorization. Initial visits may be denied and this may be beyond the office’s ability to notify the patient prior to rendering acute care, while waiting for insurance coverage approval. The3se charges will be the patients’ responsibility if denied by the insurance company.**

**This office may seek payment from you for any services your health insurance determines to be not medically necessary or not covered by your plan. Signing below indicates that you have read and understand your obligation for payment for care in the absence of insurance coverage. Patient is responsible for collection fees, court cost and reasonable attorney fees to collect unpaid accounts.**

**Informed Consent/Consent to Treat**

**I have been informed of the nature, purpose and scope of care to be provided by the doctors of this office of the possible limitations and consequences of that care and the possibility that the care given may not completely resolve my complaint, dysfunction or condition. I consent to care and recommendations made by the doctors for myself (or my children, if minors including, but not limited to examinations, x-rays, chiropractic adjustments, adjunctive therapies and rehabilitation.) Understand that my care will be individualized and therefore may not be comparable with standards or guidelines required by insurance companies, Medicare, professional association and /or consensus groups. I understand that my treatment will comply with the standard of care defined by the laws in the State of Kansas. I recognize that all health care procedures, including those used in the clinic, have risk associated with them. Risks, although rare, associated with chiropractic adjusting procedures may include minor aggravation of symptoms, musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome, including cerebral vascular accident (stroke) or death through complicating factors. I hereby accept the risk associated with any care by the doctor or any liability for any injury or loss directly related to care I have received at this clinic. In the event or emergency, I grant doctor and staff permission to provide Emergency Care and any follow-up necessary, including referral to Emergency Medical Services.**

**I am signing this consent and acceptance of terms after having been fully informed to my satisfaction of the risks and benefits of proceeding with care and declining care. I have been informed and fully understand that there are no guarantees of treatment success. By my presence and continuation of appointments, I consent and elect to care provided by Carpenter Chiropractic Health Center, LLC.**

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**Patient Name (Please Print)**

**Patient/Guardian Signature Date**

**Witness Date**