ADULT INTAKE FORM

PERSONAL INFORMATION

First Name: _____ M.I.: _____ Last Name:_____
Preferred Name: _____ Social Security Number:_____
Address:_____
City / State / Zip: _____
Home Phone: ( ) _____ Work Phone: ( ) _____
Cell Phone: ( ) _____Email: _____
Birth Date: _____ Age: _____ Sex: M F
Occupation: _____Employer's Name: _____
Marital Status: S M D W Other Spouse's Name: _____
# of Children: _____ Children 's Names & Ages: _____
_____
Who can we thank for referring you or how did you hear about Redmond Roots Chiropractic?
_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Redmond Roots Chiropractic? _____
When did this begin? (If applicable) _____
Are there any major injuries and/or surgeries we should know about? _____
_____
What is this affecting that is MOST important in your life? (List all that apply) _____
_____
Have you seen any other providers for this condition? (List all that apply) _____
_____
Have you seen a chiropractor before? Yes No
How long ago? _____ Clinic/Doctor Name: _____
What is your reason for the change? (If applicable) _____
What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10
Explain: _____
What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?
_____
_____
_____

HEALTH CONCERNS

☐Anxiety/Depression ☐Fatigue/Sleep Issues ☐Digestive Troubles ☐Dizziness ☐Nausea/Vomiting ☐Ringing in Ears
☐Diabetes ☐Sensitivity to Light ☐Hypertension ☐Loss of Concentration ☐Arthritis ☐Memory Problems
☐Loss of Balance ☐Headaches ☐Neck/Back Pain ☐Stiffness/Flexibility ☐Pain in Arms/Legs ☐Sinus Troubles
☐Allergies ☐Irritabilty ☐Cold Hands/Feet ☐Other _____

Explain any boxes checked above or add additional concerns: _____

_____

_____

Is there anything else regarding your current condition you feel the doctor should know?

_____

_____

MEDICATIONS

☐Anxiety/Depression ☐Migraine/Headache ☐Blood Pressure ☐Cholesterol ☐Pain Narcotics ☐ADD/ADHD
☐Muscle Relaxers ☐Diabetes ☐Others _____

_____

Explain any checked boxes above:_____

_____

SUPPLEMENTS/VITAMINS

☐Multi-Vitamin ☐Fish Oil/Omega-3 ☐Vitamin D3 ☐Probiotics ☐_____ ☐_____
☐_____ ☐ _____

Explain any boxes checked above: _____

_____

HEALTH STATUS QUESTIONNAIRE

Your Physical Life Rate

Based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Presence of physical pain 1 2 3 4 5
Incidence of colds or flu 1 2 3 4 5
Feelings of tension, stiffness, lack of flexibility 1 2 3 4 5
Ability to work out or engage in activity 1 2 3 4 5
Incidence of fatigue or low energy 1 2 3 4 5
Incidence of chronic disease 1 2 3 4 5

Mental/Emotional State Rate

Based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Presence of negative feelings/energy 1 2 3 4 5
Being overly worried about small things 1 2 3 4 5
Moodiness, temper, or angry outbursts 1 2 3 4 5
Difficulty thinking or concentrating 1 2 3 4 5
Difficulty falling or staying asleep 1 2 3 4 5
Feeling of depression or anxiety 1 2 3 4 5

Chemical/Nutritional Life Rate

Based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Eat a well-balanced diet 1 2 3 4 5
Eat an organic, grass fed, hormone-free diet 1 2 3 4 5
Eat a diet rich in fruit and vegetables 1 2 3 4 5
Use a lot of chemicals on your skin 1 2 3 4 5
Eat fast food or highly processed food 1 2 3 4 5
Ingestion of chemicals 1 2 3 4 5

Stress Evaluation Rate

Based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Family 1 2 3 4 5
Work/school 1 2 3 4 5
Significant relationship 1 2 3 4 5
Day-to-day stress 1 2 3 4 5
Health 1 2 3 4 5
Finances 1 2 3 4 5

Life Enjoyment Rate

Based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Experiences of relaxation, ease, well-being 1 2 3 4 5
Compassion and acceptance 1 2 3 4 5
Interest in maintaining a healthy lifestyle 1 2 3 4 5
The level of recreation in your life 1 2 3 4 5
Time devoted to things you enjoy 1 2 3 4 5
Your physical appearance 1 2 3 4 5

X-RAY CONSENT FOR WOMEN OF CHILDBEARING AGE

Date of onset of last menstrual period: _____
I am pregnant: Yes No I had a hysterectomy: Yes No I use an IUD: Yes No

I recognize that if I am pregnant and have radiation to the abdomen, there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this examination is important to my health. I therefore wish to have this x-ray examination performed now. Patient signature: _____Date:_____

Guardian signature: _____ Date: _____

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature:_____ Relationship to Patient: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

• We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.

• I authorize Redmond Roots Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.

• I authorize the direct payment to Redmond Roots Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me or Redmond Roots Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint Redmond Roots Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic for payments due for services rendered on behalf of the undersigned by Redmond Roots Chiropractic.

• In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it doesn't. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.

• Advanced Beneficiary Notice of NON-Coverage (ABN). Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our front desk. Signing below means that you have received and understand this notice.

Date: _____ Signature: _____

AUTHORIZATION FOR CARE

I hereby authorize doctors and staff at Redmond Roots Chiropractic to treat my condition as deemed appropriate. At Redmond Roots Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Redmond Roots Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: _____ Signature: _____