

Adult Patient Intake Form

ABOUT YOU

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____ Dominant hand: RIGHT LEFT
Emergency Contact: _____ Relation: _____ Emergency Phone Number: _____
Home Phone: _____ Mobile: _____ Email: _____
Employer: _____ Occupation: _____
Who may we thank for your first visit?: _____
OR did you hear from us on: Google Facebook Website Groupon Other: _____

PRIMARY CARE PROVIDER

Name of primary care physician: _____ Address: _____
City: _____ State: _____ Zip Code: _____ Phone Number: _____

HEALTH INSURANCE

Subscriber Name: _____ Subscriber DOB: _____ Relationship to Patient: _____
Insurance Company: _____ Member ID: _____

CURRENT HEALTH

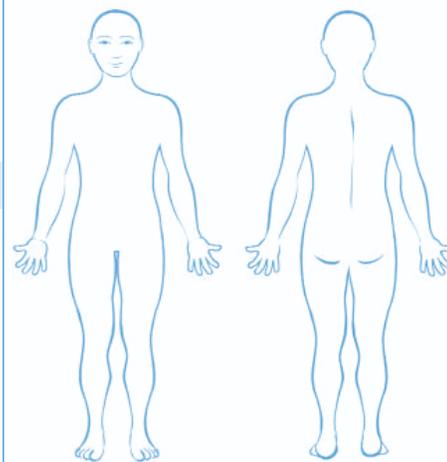
Do you smoke?: YES NO Do you drink alcohol?: YES NO
Do you wear: Heel lifts Sole lifts Inner soles Arch supports
Do you exercise regularly?: YES NO
FOR WOMEN ONLY: Are you pregnant or planning to be? YES NO

MEDICATIONS YOU TAKE: Blood Pressure
 Cholesterol Medications Blood Thinners
 Stimulants Pain Killers
 Tranquilizers Antidepressants
 Muscle Relaxers Other: _____
 Insulin _____
 Vitamins & Supplements _____

HEALTH HISTORY

<input type="checkbox"/> Severe/frequent headache	<input type="checkbox"/> Pain between shoulders	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Heart surgery/ pacemaker	<input type="checkbox"/> Pain in arms/legs	<input type="checkbox"/> Numbness
<input type="checkbox"/> Low back problems	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Allergies
<input type="checkbox"/> Digestive issues	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Surgeries
<input type="checkbox"/> Heart defects	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Loss of sleep
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Frequent neck pain	<input type="checkbox"/> High blood pressure	

Please indicate with an "X" on the body diagram where you are experiencing pain/discomfort.



REASON FOR YOUR VISIT

What health condition(s) bring you into our office?: _____
When did the conditions first begin?: _____
If job related, have you made a report of your accident to your employer?: YES NO
Have you received care for this problem before?: YES NO
If yes, please explain: _____
Have you been adjusted by a chiropractor before?: YES NO

Please rate your pain on a scale of
1 (little to no pain) to 10 (severe pain):
1 2 3 4 5 6 7 8 9 10

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt.

Signature:	Date:
Signature of guardian or spouse authorizing care:	Date:

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature:	Date:
Witness signature:	Date:

FOR THE DOCTOR

NOTES

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you.

However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

May we phone, email, or send a text to you to confirm appointments? [] YES [] NO

May we leave a message on your answering machine at home or on your cell phone? [] YES [] NO

May we discuss your medical condition with any member of your family? [] YES [] NO

If YES, please name the members allowed:	
This consent was signed by:	
Patient Signature:	Date:
Witness Signature:	Date: