Gallatin Valley Chiropractic
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Licensed Chiropractors

Patient Registration and History

Please take a moment to complete the following intake form so we may obtain all necessary information in regard to your care if you hacve any qauestions, please ask our office staff for assistance

General Information

Date ___/___/_____

Last Name_____ First Name_____ MI _____

Preferred Name (nickname)_____ Date of Birth ___ /___ /___ Age _____ ☐ Male ☐ Female

Street Address _____ City _____ State ____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Email _____

Social Security # ____-___ -____ Employer/School _____ Work Phone (____) _____

Occupation_____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Spouse/Partner's Name _____ Phone (____) _____

Emergency Contact _____ Relation _____ Phone (____) _____

How did you find out about our office?

☐ Google

☐ Referred by family/friend: _____

☐ Referred by a healthcare provider: _____

☐ Social Media post: _____

☐ Magazine/ Online news/ local happenings guide: _____

Insurance Information

Please present all insurance cards for photocopying

Current Health Insurance Coverage: ☐Health Insurance ☐ Medicare ☐ Medicaid ☐ None

Primary Health Insurance Carrier_____ Name of insured: _____

Relation to insured: _____ Insured DOB: ___ /___ /___ Health Savings acct? ☐ yes ☐ no

Is your current condition related to a workplace injury or auto accident? ☐ yes ☐ no

Patient Health Questionnaire - p. 1

Patient Name_____ Date_____

1. When did your symptoms start: _____ Describe your symptoms and how they began:

_____

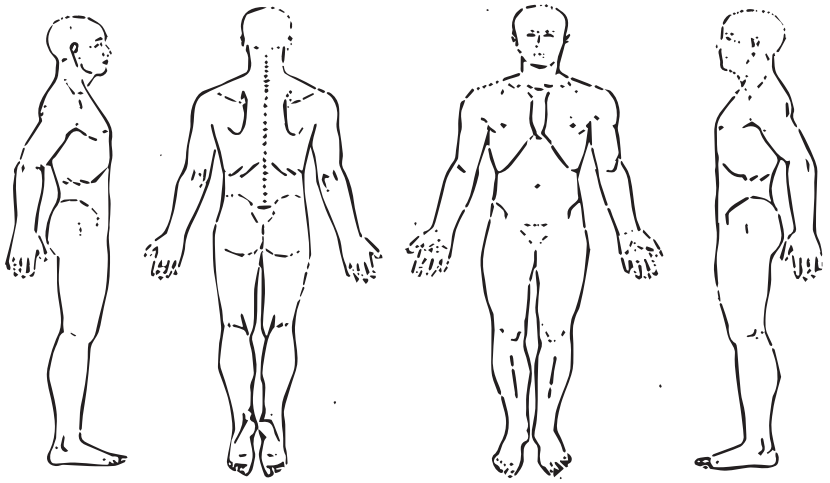
_____

2. How often do you experience your 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)

3. What describes the nature of your symptoms?
   - □sharp □ shooting
   - □dull ache □ burning
   - □numb □ tingling

4. Are your symptoms changing?
   - □ getting better
   - □ not changing
   - □getting worse

Indicate on the diagram where you have pain or other symptoms:



5. How severe are your symptoms?

	none										unbearable
a. right now:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
a. at best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
a. at worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
no complaints	mild, forgotten with activity		moderate, interferes with activity		limiting, prevents full activity		intense, preoccupied with seeking relief		severe, no activity possible

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms? □ No one □ Medical Doctor □ Other_____
   □ Other Chiropractor □ Physical Therapist

   a. when and what treatment? _____

   b. what tests have you had for your symptoms and when were they performed? □X-Rays date:_____ □ CT Scan date:_____ □ MRI date:_____ □Other date:_____

10. Have you had similar symptoms in the past? □ Yes □ No

    a. if you have recieved treatment in the past for the same or similar symptoms, who did you see? □ Other chiropractor □ Medical Doctor □ This office □ Physical Therapist

11. What is your occupation _____
    _____
    □ Professional Executive □ Laborer □ Retired
    □ White Collar/Secretarial □ Homemaker □ Other
    □ Tradesperson □ FT Student □ Unemployed

12. What do you hope to get from your visit/treatment? (select all that apply)
    □ Reduce Symptoms □ Explanation of condition/treatment □ how to prevent this from occurring again
    □ Resume/increase activity □ Learn how to take care of this on my own □ Other:_____

Patient Signature:_____ Date:_____

Patient Health Questionnaire - p. 2

Patient Name_____ Date _____

What type of regular exercise do you perform: □ none □ Light □ Moderate □ Strenuous

What is your height and weight? Height: ____ft._____in. Weight: _____lbs.

For each of the conditions listed below, place a check in the past column if you had the condition in the past. If you presently have a condition listed below, place a check in the present column.

Past	Present	
□	□	Headaches
□	□	Neck pain
□	□	Upper back pain
□	□	Mid back pain
□	□	Low back pain
□	□	Shoulder pain
□	□	Elbow/upper arm pain
□	□	Wrist pain
□	□	Hand pain
□	□	Hip/upper leg pain
□	□	Knee/lower leg pain
□	□	Ankle/foot pain
□	□	Jaw pain
□	□	Joint swelling/stiffness
□	□	Arthritis
□	□	Rheumatoid arthritis
□	□	General fatigue
□	□	Muscular incoordination
□	□	Visual disturbances
□	□	Dizziness

Past	Present	
□	□	High blood pressure
□	□	Heart attack
□	□	Chest pains
□	□	Stroke
□	□	Angina
□	□	Kidney stones
□	□	Kidney disorders
□	□	Bladder infection
□	□	Painful urination
□	□	Loss of bladder control
□	□	Prostate problems
□	□	Abnormal weigt gain/loss
□	□	Loss of appetite
□	□	Abdominal pain
□	□	Ulcer
□	□	Hepatitis
□	□	Liver/Gall bladder disorder
□	□	Cancer
□	□	Tumor
□	□	Athsma
□	□	Chronic sinusitis

Past	Present	
□	□	Diabetes
□	□	Excessive Thirst
□	□	Frequent Urination
□	□	Smoking/Tobacco Products
□	□	Drug/Alcohol dependence
□	□	Allergies
□	□	Depression
□	□	Systemic lupus
□	□	Epilepsy
□	□	Dermatitis/Eczema/Rash
□	□	HIV/AIDS

Females only:

□	□	Birth Control
□	□	Hormone Replacement
□	□	Pregnancy

Other health problems/issues

□ □ _____

□ □ _____

□ □ _____

Indicate if an immediate family member has had any of the following:

□Rheumatoid Arthritis □ Heart problems □ Diabetes □ Cancer □ Lupus □ _____

List all prescription and over the counter medications, and nutritional/herbal supplements you are taking

_____

_____

List all the surgical procedures you have had and the times you have been hospitalized:

_____

_____

Patient Signature:_____ Date _____

Doctor's Comments:

Doctors Signature_____ Date _____

Authorization and Release

Patient Name: _____

I authorize the release of any information concerning my health and health care services, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care, to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me under any insurance or pre-paid health plan.

I understand that the benefits quoted by my insurance company are not a guarantee of payment and all charges are considered at the time claims are processed. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree that I am responsible for payment of all services rendered on my behalf or my dependents. I agree to notify your office of any and all insurance changes that would affect the filing of claims or payment for the treatment I receive.

I understand that payment in full is due at the time of service unless other arrangements have been made.

Signature of patient, or patient's guardian: _____ Date: _____

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatment) and associated procedures that may include but not limited to physical examination, diagnostic testing and x-ray and physical therapy procedures.

I understand with chiropractic treatment, as with any health care procedure, there are certain risks and complications that may arise. Such complications include, but are not limited to: post treatment soreness or discomfort, soft tissue injury, dislocation, and fractures. Although exceedingly rare, some types of manipulation have been associated with injuries to 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. I wish to rely upon the doctor to exercise good judgment during the course of the treatment which the doctor deems at the time, based on the facts then known, are in my best interest.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot guarantee a cure for any symptom, condition, or disease as a result of treatment in this office. By signing below, I state that I have been informed and weight the risks involved in chiropractic treatment. (If you have any questions or concerns regarding the above, please ask your chiropractor.)

Having carefully read and considered the above, I give my informed consent to have chiropractic treatment administered.

Signature of patient, or patient's guardian: _____Date: _____

HIPAA Privacy Practice Acknowledgement

I have received or decline opportunity to read a notice of privacy practices.
Signature of patient, or patient's guardian: _____Date: _____

“No Surprises Act” Acknowledgement

I have received or decline opportunity to read a copy of estimated cost breakdown for my care.
Signature of patient, or patient's guardian: _____Date: _____

Consent to Treat a Minor (if applicable)

Having carefully read the above, as the parent or legal guardian of_____, I give my informed consent to allow chiropractic treatments to be administered to my child.

Signature of patient, or patient's guardian: _____Date:_____