

CHIRO INTAKE FORM

| | | | | |
|-------------------------|---|--|--|---|
| Name | | Age | D.O.B DD _____ MM _____ YY _____ | Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> |
| Address | | City | Postal Code | |
| Email Address | | | Medical Doctors Name | |
| Cell Phone () | Would you like: Text Reminder <input type="checkbox"/> OR E-mail Reminder <input type="checkbox"/> | | Who can we thank for referring you? Google <input type="checkbox"/> Physician <input type="checkbox"/> Other <input type="checkbox"/> | |
| Occupation: | Employer: | Have you had chiropractic care before? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| Emergency Contact NAME: | | NUMBER: | | |

Private Insurance Info: or N/A

*If your policy allows

PLEASE NOTE ANY MODALITIES SUCH AS ACUPUNCTURE, SHOCKWAVE, IFC, ETC. ARE PERFORMED BY A CHIRO AND THEREFORE ONLY BILLABLE TO CHIROPACTOR SECTION OF INSURANCE PLANS. PLEASE ASK THE FRONT DESK ANY BILLING RELATED QUESTIONS

INSURANCE COMPANY: _____

POLICY HOLDER NAME: _____

D.O.B DD _____ MM _____ YY _____

POLICY/GROUP #: _____

YOUR RELATIONSHIP TO POLICY HOLDER:

CERTIFICATE/ID #: _____

SELF / SPOUSE / CHILD

Please indicate any recent slips, falls or motor vehicle accidents: or N/A

Date () _____ Date () _____

Did any of these accidents occur while you were working? YES NO

A. Present Complaint/Pain:

Injury: _____

When did it start? _____

Is the condition getting worse? Yes No

Home Remedies? Yes No _____

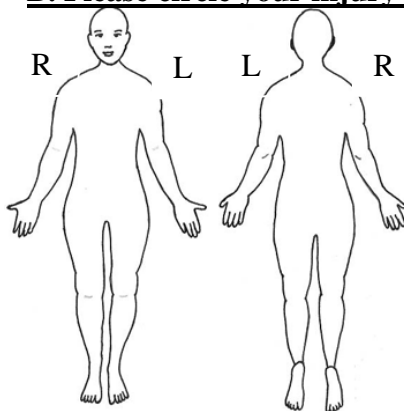
Current medications: _____

Circle your current level of pain:

(10 = most severe and 1 = least painful)

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|----|

B. Please circle your injury on the diagram and use the 'Pain Legend':



Pain Legend: (please place on diagram)

+++ Pain (dull) --- Pain (sharp)

Numbness *** Tingling (referral)

PPP Pressure

CCC Cramping

For Women:

Are you pregnant?
YES NO

C. Please indicate all relevant symptoms:

| | | | |
|--|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold feet/hands |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Loss of taste/smell | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Fever | <input type="checkbox"/> Allergies/Asthma |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Significant weight loss |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Menstrual problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Foot Pain | |

Patient Fee Schedule:

New Patient Exam \$130.00 Reassessment Exam \$100.00 ** all prices subject to change without notice

Chiropractic Treatment.....\$75.00 Chiropractic Treatment with Acupuncture.....\$85.00

I consent to the fee schedule, direct billing policies, and a physical examination by the chiropractor by signing below.

Patient Signature _____ **Date** _____