Patient Intake Form

Please fill out all the sections below.

If it says a field is required but it's not applicable to you, just type in "N/A"
* Required

1. First Name *

2. Last Name *

3. Email Address *

4. Sex *

Mark only one oval.

- ◯ Female
- ◯ Male

5. Address *

6. Apt *

7. City *

8. State *

9. Zip *

10. Date of Birth *

Example: January 7, 2019

11. Age *

12. Height *

13. Weight *

14. Social Security Number

15. Home Phone

16. Work Phone

17. Cell Phone *

18. Referred by *

Mark only one oval.

- Google
- Patient Referral
- Other

19. If Referred by Patient or Other, please specify:

20. Occupation *

21. Employer *

22. Marital Status *

Mark only one oval.

- Single
- Married
- Divorced
- Widowed
- Partnered

23. Spouse/Partner Name

24. Spouse/Partner Phone Number

25. Emergency Contact Name

26. Emergency Contact Relationship

27. Emergency Contact Phone Number

28. Have you ever received Chiropractic Care? *

Mark only one oval.

- ◯ Yes
- ◯ No

Chief Complaints

29. Primary complaint *

Mark only one oval.

- ◯ Neck Pain
- ◯ Mid Back Pain
- ◯ Low Back Pain
- ◯ Headaches
- ◯ Pain b/w Shoulder Blades
- ◯ Sciatica
- ◯ Other (type in below)

30. If primary complaint is other, provide details here:

_____

31. Complaint began when and how? *

_____

32. Is this a result of a work-related injury or auto accident? *

Mark only one oval.

- ◯ Yes
- ◯ No

33. Quality of the complaint/pain *

Check all that apply.

- ☐ Dull
- ☐ Aching
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Deep
- ☐ Nagging

Other: ☐ _____

34. Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? *

_____

35. Do you have any numbness or tingling in your body? Where? *

_____

36. Grade Intensity/Severity *

Mark only one oval.

- 0 (No pain)
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 (Worst Pain)

37. Frequency of complaint/ % of day *

38. Is the complaint worse at any particular time of day *

39. Does anything aggravate the complaint *

40. Does anything make the complaint better *

41. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint *

Secondary Complaints

42. Secondary complaint

Mark only one oval.

- Neck Pain
- Mid Back Pain
- Low Back Pain
- Headaches
- Pain b/w Shoulder Blades
- Sciatica
- Other (type in below)

43. If secondary complaint is other, provide details here:

44. Complaint began when and how?

45. Is this a result of a work-related injury or auto accident?

Mark only one oval.

- ◯ Yes
- ◯ No

46. Quality of the complaint/pain

Check all that apply.

- ☐ Dull
- ☐ Aching
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Deep
- ☐ Nagging
- Other: ☐ _____

47. Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?

_____

48. Do you have any numbness or tingling in your body? Where?

_____

49. Grade Intensity/Severity

Mark only one oval.

- ◯ 0 (No pain)
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10 (Worst Pain)

50. Frequency of complaint/ % of day

_____

51. Is the complaint worse at any particular time of day

_____

52. Does anything aggravate the complaint

_____

53. Does anything make the complaint better

_____

54. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint

Social & Occupational History

55. Job description *

56. Do you primarily *

Check all that apply.

- [ ] Sit
- [ ] Stand
- [ ] Perform repetitive tasks

57. Recreational activities *

58. Exercise frequency and type *

Personal Health History

For the questions below, write N/A if not applicable to you

59. Any conditions we should be aware of? *

60. Allergies *

61. Medications/Supplements and Reason *

62. Broken bones *

63. Surgeries *

64. Falls/Trauma *

65. Sports injuries *

66. Motor vehicle accidents *

67. If female, are you currently pregnant? *

Mark only one oval.

- Yes
- No

Payment Authorization

68. Who is responsible for your bill? *

Mark only one oval.

- Self *Skip to question 76*
- Health Insurance
- Worker's Comp
- Auto Insurance

Insurance Information

69. Personal Health Insurance Carrier *

70. Insurance Card ID # *

71. Insurance Card Group # *

72. Policy Holder's Name *

73. Policy Holder's DOB

Example: January 7, 2019

74. Primary Care Physician

75. Primary Care Physician Phone #

Payment Agreement

I understand that my health insurance company has agreed to pay for services in accordance with their policies and directives whereby I am bound by their decisions pursuant to these policies, directives, and procedures. I further understand that not all services may be covered by my insurance company in accordance with their aforementioned policies, directives, and procedures. Should my insurance company make such a determination that they are unwilling to pay for the services rendered, and I have opted to receive them, I agree to personally pay for the services provided by Family Chiropractic of Clark, LLC. I further understand that Family Chiropractic of Clark, LLC shall hold me personally responsible to pay for these services should coverage be denied, deemed not essential, or not a covered service. Should any collections fees be applied due to non-payment on my behalf, I understand that I am responsible for that fee in its entirety.

76. Type Patients Name *

77. Initials as signature *

78. Today's Date *

Example: January 7, 2019

HIPAA Privacy Practices

I acknowledge that I have received and/or have been given the opportunity to review the Notice of HIPAA Privacy Practices for protected health information.

79. Type Patients Name *

80. Initials as signature *

81. Today's Date *

Example: January 7, 2019

82. Consent to Treat A Minor (Parent/Guardian's Name)

83. Parent/Guardian Initials as signature

84. Parent/Guardian Today's Date

Example: January 7, 2019

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time. A discretionary visit charge will be billed if we are not given at least 24 hours advance notice. Please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

85. Type Patients Name *

86. Initials as signature *

87. Today's Date *

Example: January 7, 2019

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal: to eliminate misalignments with the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to obtain our goal. This will prevent any confusion or disappointment.

Adjustment: The specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: a state of optimal physical, mental, and social well-being, not merely the absence of disease or symptoms.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessoning of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any condition other than vertebral subluxation. However, if during the course of spinal examination 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 healthcare provided who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we provide advice regarding treatment prescribes by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I have read and understand the above statements.

All 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.

88. Type Patients Name *

89. Initials as signature *

90. Today's Date *

Example: January 7, 2019