Chiropractic Intake and History

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Personal Information:

Name: _____ Birth Date: _____

Address (Street, City and Zip): _____

Home Phone: _____ Email: _____

Cell Phone: _____ Best time/way to contact you: _____

Sex: **M F O:** ____ Gender: _____ Age: _____

Preferred Pronoun: _____ Height: _____ Weight: _____

Primary Care Physician name and contact information:

_____

_____

Marital Status: _____

Occupation: _____

Recreational Activities: _____

In case of Emergency, Contact:

Name: _____

Relationship to you: _____

Contact Information: _____

Insurance Information:

Is the reason that you are consulting this office the result of an injury at work or an auto accident? **Y N**

If Yes, please provide the name of the insurance company involved, contact information and claim number:

_____

Are you currently covered by health insurance? **Y N** Name of health insurance company: _____

Are you the primary policy holder? **Y N** **If No:** Name of primary: _____

Birth date of primary: _____ Address of primary: _____

Relationship to you: _____

Are you aware of whether you have a deductible or if you have a copay? If so, please list that information:

_____

Current History:

What prompted your visit here today? _____

What would you like to see change through your care in this office? _____

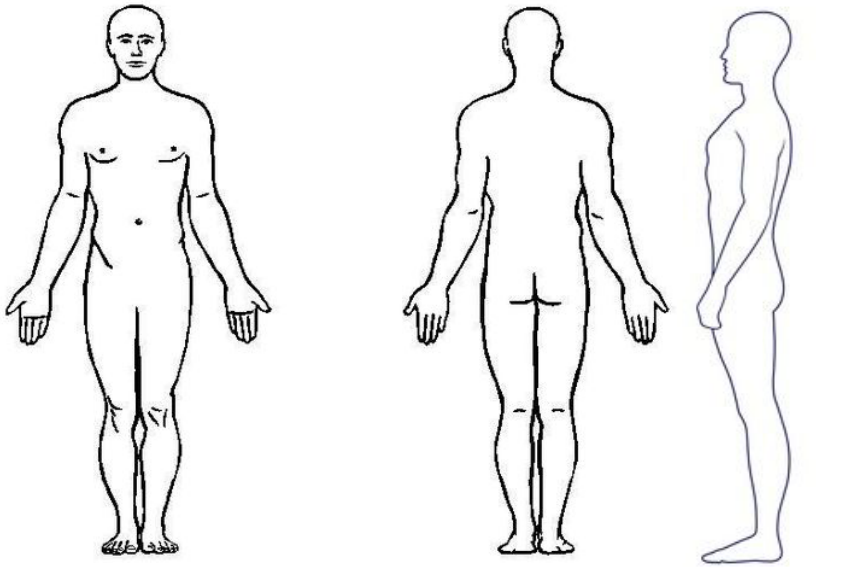
What would be different in your life if this were to change? _____

Please use the scale below to describe your state of health:

Excellent — Good — Fair — Getting Better — Getting Worse

Please mark the areas on the pictures to show where you are having symptoms.

R L Both



What does it feel like? (check all that apply)

- O Numbness
- O Dull
- O Cramping
- O Burning
- O Swelling
- O Tingling
- O Aching
- O Nagging
- O Throbbing
- O Stiffness
- O Sharp
- O Shooting
- O Stabbing
- O Hot
- O Cold
- O Other: _____

Please use the scale below to describe the intensity of your symptoms:

No Pain — Mild Pain — Moderate Pain — Severe Pain — Extreme Pain

Is there anything in your daily life that you believe is worsening your symptoms and your state of health?

_____

Is there anything in your daily life that you believe is improving your symptoms and your state of health?

_____

Are you currently receiving treatment for any of these symptoms? **Y N**

If yes, what type of treatment are you receiving? _____

What have been the results of that treatment? _____

_____

Have you received chiropractic care before? **Y N**

Is there anything you would like me to know about your experiences with chiropractic?

_____

Lifestyle and Environmental History:

Do you smoke tobacco? **Y N** If Yes, how much do you smoke? _____

How would you rate your consumption of alcohol, medications, marijuana and other drugs?

None Very Low Low Moderate High Very High

How would you rate the impact of this consumption on your life? **Negative Neutral Positive**

Do you work with any chemical fume, dust, powder or smoke for prolonged periods? **Y N** _____

Please list any medications that you are currently taking: (both prescription and over-the-counter):

Medication Name	**To Treat**	**For how long?**

Were you previously taking any medications regularly? (If yes, please list):

_____

Please mark all that apply and give details where applicable:

- O Are you currently Pregnant? **Y N** _____ Weeks
- O Exercise Regularly
- O Drive more than 60 min/day
- O Use a keyboard more than 90 min/day
- O Use a phone or tablet device more than 90 min/day
- O Sit for work
- O Perform manual labor for work

  _____
- O Perform repetitive tasks regularly

  _____
- O Have extensive dental or orthodontic work being performed _____
- O Perform caregiving activities for someone regularly
- O Experience stress that feels hard to manage
- O Experience lack of energy or fatigue
- O Have trouble sleeping
- O Have had an automobile accident

  _____

  _____
- O Have had a concussion

  _____

  _____
- O Had surgery of any kind

  _____

  _____

  _____
- O Had any complications with your birth

  _____

  _____
- O Had any complications with your health as a child

  _____

  _____

Which of the following are impacted by your current symptoms (check all that apply):

- O Sleep
- O Sit
- O Stand
- O Change Positions
- O Lift and Carry
- O Drive
- O Travel
- O Walk
- O Exercise
- O Maintain Relationships
- O Care for Self and Others
- O Perform Household Chores
- O Concentrate
- O Work
- O Engage in Usual Recreation (Kids: Play)
- O Other:

_____

_____

Comments: _____

_____

_____

Review of Systems:

Please check all that have applied to you in the past and circle those which currently apply to you.

- O Fatigue
- O General Weakness
- O Fever or Chills
- O Recent Weight Change
- O Cancer

- O Eye Disease or Injury
- O Blurred or Double Vision
- O Other Eye Problem

- O Hearing Loss or Ringing in Ears
- O Ear Infections
- O Vertigo
- O Sinus Problems
- O Nose Bleeds
- O Loss of Smell
- O Mouth Sores
- O Difficulty Swallowing
- O Swollen Glands in Neck

- O Heart Disease
- O Chest Discomfort
- O Palpitations
- O Shortness of Breath
- O Swelling in Feet, Ankles or Hands
- O High or Low Blood Pressure

- O Chronic or Frequent Coughing
- O Asthma or Wheezing
- O Blood in Sputum

- O Loss of Appetite
- O Change in Bowel Movements
- O Diarrhea or Constipation
- O Nausea or Vomiting
- O Blood in Stool
- O Abdominal Pain
- O Ulcer
- O Heartburn

- O Joint Pain, Stiffness or Swelling
- O Weakness of Muscles or Joints
- O Muscle Pain or Cramps
- O Back or Neck Pain
- O Cold Extremities
- O Difficulty Walking

- O Memory Loss or Confusion
- O Anxiety or Depression
- O Difficulty Sleeping
- O Difficulty Concentrating

- O Headaches
- O Dizziness
- O Seizures or Convulsions
- O Pins and Needles
- O Numbness
- O Tremors or Shaking
- O Paralysis
- O Stroke
- O Head Injury
- O Loss of Balance or Dexterity

- O Urinary Problems
- O Kidney Stones
- O Sexual Difficulties
- O STDs
- O Pain in Genitals
- O Menstrual Pain
- O Menstrual Irregularity
- O Miscarriages
- O Menopausal Problems

- O Skin Rash or Itching
- O Skin Lesions
- O Hair or Nail Changes

- O Glandular/Hormone Problem
- O Thyroid Disease
- O Diabetes
- O Breast Pain, Lump or Discharge
- O Excessive Thirst or Urination
- O Heat or Cold Intolerance

- O Slow to Heal after Cuts
- O Frequent Bleeding or Bruising
- O Anemia
- O Blood Transfusions
- O Enlarged or Painful Glands

- O Frequent Illness
- O Environmental Allergies
- O Food Allergies
- O Drug Allergies
- O Other Allergies

Affirmation of Purpose:

_____ I have read and received a copy of the *Statement of Purpose* from RiverSide Chiropractic.

Privacy Policy:

_____ I have read and received a copy of the *Notice of Privacy Practices* from RiverSide Chiropractic.

Is it ok to leave messages for you regarding your appointments at this office at the phone numbers you provided? **Y N** If **No**, how would you like to be contacted? _____

Cancellation Policy:

_____ I understand that 24 hours notice must be given for all cancellations except in case of extenuating circumstances or I may be billed for the missed appointment.

Financial Policy:

Payment is expected at the time that services are rendered including all copays and coinsurance unless prior arrangements have been made.

Medicare and other health insurance plans do not pay for maintenance care or wellness visits for chiropractic. On the day of service, the usual charge for a wellness visit is $45.

Medicare and medicaid do not pay for chiropractic exams or evaluations or for adjunctive therapies. On the day of service, the usual charge for a 30-minute chiropractic initial exam is $60. Other therapies that might not be covered cost between $20 - $60.

If your insurance plan does not pay for a service because it is a non-covered service, you will be responsible for that charge. Please select only ONE from the three options below by initialing in the space provided:

_____ You would like to be provided with the services that may not be covered by your insurance plan and you will be asked to pay for those services. You would also like RiverSide Chiropractic to submit a claim to your insurance company even if they are not expected to pay.
(This makes it possible for you to file an appeal with your insurance company.)

_____ You would like to be provided with the services that may not be covered and you do not want RiverSide Chiropractic to submit a claim to your insurance company.
(This means you will not be able to file an appeal with your insurance company.)

_____ You would not like to be provided with the services that may not be covered.

_____ _____ _____

Print Name Signature Date

To be completed by chiropractor:		
CC:		
O:		Q:
S:		T:
Rad:	Pro:	
Ref:	Pal:	
Notes:		
AC:		
O:		Q:
S:		T:
Rad:	Pro:	
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Rad:	Pro:	
Ref:	Pal:	
Notes:		