Austin Lake Chiropractic Intake Form

PLEASE PRINT

Date: _____

Circle One: Mr. Mrs. Miss Ms.

Name: _____
First Middle Last

Street Address: _____

City: _____ State: _____

Zip: _____ Phone #: _____

Identify As: Male Female Other: _____

Birth Date: _____ Age: _____

Social Security #: _____-_____-_____

Email address: _____

How did you hear about our office? _____

_____

Who is Responsible for your bill, you and:

_____ Spouse _____ Worker's Compensation

_____ Medicare _____ Medicaid

_____ Auto Ins. _____ Parents

_____ Personal Health Insurance

Carrier Name: _____

Your Occupation: _____

Your Employer: _____

Employer's Address: _____

Employer's Phone: _____

Marital Status: S M W D

Spouse's Name: _____

Spouse's Employer: _____

Current Health Condition

Primary Reason for Visit: _____

Other Doctor's seen for this condition: _____

Primary Physician?: _____ Primary Physician Phone Number: _____

When did this condition begin? _____

What makes this condition worse? _____

What relieves this condition? _____

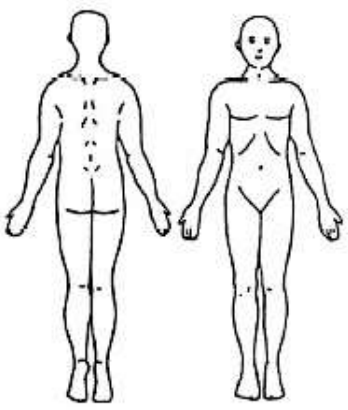
Are there others in your family with this same condition? ☐ Yes ☐ No

If Yes, Please provide their name and their relationship to you? Name Relationship

_____ _____

_____ _____

_____ _____



Please Outline on the diagram the area of your discomfort.

Diagram code: N=Numbness P=Pain X=Tenderness

B=Burning T=Tingling M=Muscle Spasm

OVER ➔

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Is this injury **Auto Related**? ☐ Yes ☐ No If auto related please indicate date of accident:_____

Is this injury **Work Related**? ☐ Yes ☐ No If disabled from work please give dates: _____

Medications you now take:	o	Nerve pills	o	Pain Killers	o	Blood Pressure	
	o	Insulin	o	Aspirin	o	Other	

Past Health History

Please check or describe

Major Surgery / Operations ☐ Appendix ☐ Tonsils ☐ Gall Bladder ☐ Hernia
☐ Heart ☐ Back ☐ Neck ☐ Leg ☐ C-Section
☐ Other : _____

Major Accidents or Falls: _____

_____

Hospitalization (other than Above): _____

_____

Have you ever been under Chiropractic Care? ☐ Yes ☐ No If Yes? Dr's Name: _____

If, Yes how would you rate your experience? **Excellent Good Bad** Date of last visit? _____

Have you been treated for any other health condition in the last year? ☐ Yes ☐ No

If Yes, Please explain: _____

Is there anything we have not asked that you should tell us? If So, what? _____

_____

How often do you floss your teeth? **Daily** **Occasionally** **Never**

How often do you wear your seatbelt? **Always** **Occasionally** **Never**

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall course of chiropractic care.

Check any of the following diseases you have had:

☐ Pneumonia	☐ Mumps	☐ influenza
☐ Rheumatic Fever	☐ Small Pox	☐ Pleurisy
☐ Polio	☐ Chicken Pox	☐ Arthritis
☐ Tuberculosis	☐ Diabetes	☐ epilepsy
☐ Whooping Cough	☐ Cancer	☐ Mental Disorder
☐ Anemia	☐ Heart Disease	☐ Lumbago
☐ Measles	☐ Thyroid	☐ Eczema

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Intake

Coffee ☐ Yes ☐ No _____ Cups/Day Cigarettes ☐ Yes ☐ No _____ #/Day

Tea ☐ Yes ☐ No _____ Cups/Day White Sugar ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No _____ Drinks/Month

Check any of the following you have had in the past 6 months:

Musculo-Skeletal

- ☐ Pain between shoulders
- ☐ Low back pain
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint pain/stiffness
- ☐ Walking Problems
- ☐ TMJ Trouble
- ☐ General Stiffness

Nervous System

- ☐ Nervousness
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

General

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

Gastro-intestinal

- ☐ Poor/excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating after meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

Genito Urinary

- ☐ Bladder Trouble
- ☐ painful/excessive urination
- ☐ discolored urine

C-V-R

- ☐ Chest Pain
- ☐ Short of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffy Nose

Male/Female

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/infections
- ☐ Breast Pain/Lumps
- ☐ Prostrate/Sexual Dysfunction

Females Only:

When was your last period? _____

Are you Pregnant? ☐ Yes ☐ No ☐ Not Sure

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Please read the statements below and initial the boxes next to the statements with which you agree:

- I have received the privacy guidelines for Advanced Chiropractic Clinic as per HIPPA requirements. ☐
- I certify that information provided to this office is up to date and correct to the best of my knowledge. ☐
- I am the authorized parent or guardian of this child, and I authorize this office to treat my child. ☐
- I authorize the release of any medical information necessary to process this and future claims submitted to my insurance carrier. ☐
- I authorize payment of any medical benefits directly to this chiropractic clinic for any services rendered to me. ☐

Signature of Patient

or authorized guardian _____ Date: _____

Austin Lake Chiropractic
Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Austin Lake Chiropractic appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Austin Lake Chiropractic, for providing chiropractic services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Austin Lake Chiropractic, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date_____

Guarantor Signature _____ Date_____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

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Consent for Treatment and Authorization to Release Information

I hereby authorize Austin Lake Chiropractic, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Austin Lake Chiropractic, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date_____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be charged a fee and/or discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Austin Lake Chiropractic. I agree to pay Austin Lake Chiropractic, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____

Motor Vehicle Insurance (PIP)

I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies.

Patient/Guarantor Signature _____ Date _____

Patient/Guarantor Signature _____ Date _____

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CONSENT TO TREAT

I am aware that during the course of treatment the doctors at Austin Lake Chiropractic may be required to touch my buttocks and hip region, my breast bone close to the breast tissue, and the pubic bone. I am also aware that at times it may be necessary to expose these areas for instrument on skin contact, and that the doctor may expose these areas minimally during treatment. Knowing this is a possibility, I authorize the doctors at Austin Lake Chiropractic to treat me now and in the future.

_____ _____

Printed Name Date

_____

Signature

_____

Parent or Guardian signature