

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 _____

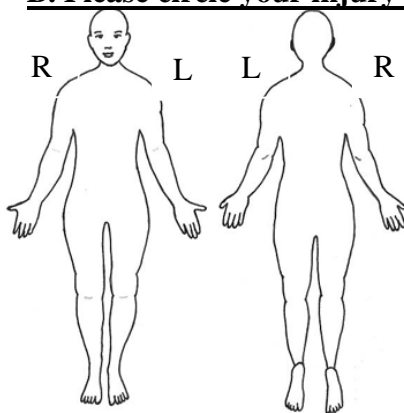
Current medications: _____

Circle your current level of pain:

(10 = most severe and 1 = least painful)

1	2	3	4	5	6	7	8	9	10
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B. Please circle your injury on the diagram and use the 'Pain Legend':



Pain Legend: (please place on diagram)

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

PPP Pressure

Numbness *** Tingling (referral) CCC Cramping

For Women:

Are you pregnant?

YES ☐ NO ☐

C. Please indicate all relevant symptoms:

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

New Patient Exam \$120.00

Reassessment Exam \$95.00

** 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** _____