EQUILIBRIUM CHIROPRACTIC

EVALUATION INTAKE FORM

Patient's Legal First Name _____ Last _____ M.I. _____

SSN _____ Sex: M or F DOB _____ Minor: Y or N

Address _____ City _____ State _____ Zip _____

(Mailing) Employer/School _____ *E-Mail _____

*Mobile Phone _____ Msg Ok? Y or N

Alt Phone _____ Msg Ok? Y or N

**Text & E-Mail reminders are automatically sent out prior to your appointment unless you request to opt out of this service.

Referring MD _____ Body Area/DX _____

Previous Patient? Y or No X-Rays Or MRI's? Y or N - If yes, where were they taken? _____

_____

Private Insurance _____ Phone _____

ID# _____ Group# _____

Subscriber _____ DOB _____ Relation to Patient _____

Secondary Insurance _____ Phone _____

ID# _____ Group# _____

Subscriber _____ DOB _____ Relation to Patient _____

_____

Is your injury related to an Accident? Yes____ or No____

Worker Comp Ins _____ Phone _____

Claim# _____ -OR- SSN _____

Accident Employer _____ Phone _____

Accident State _____ Date of Injury _____ Open Claim? Y or N

_____

Auto Insurance _____ Phone _____

Claim# _____ -OR- SSN _____

Accident State _____ Date of Injury _____ Open PIP? Y or N

Primary Driver _____ Attorney _____

_____

Emergency Contact _____ Phone _____

Relation to Patient _____ **Permission to release Health/Billing info to contact? Y or N

_____

I understand that I am responsible for all charges incurred during treatment. I attest that all the above is correct to the best of my knowledge and agree to inform Equilibrium Chiropractic of any changes to this information.

_____ _____

Signature (Responsible Party) Date

EQUILIBRIUM CHIROPRACTIC

Consent for Treatment

I, the undersigned, herby request evaluation and treatment by Equilibrium Chiropractic and consent to adjustments and other procedures by the Chiropractor and/or anyone working in this office authorized by the Chiropractor. I understand the results are not guaranteed, nor do I, expect the Chiropractor to be able to anticipate and explain all risks and complications. I wish to rely on the Chiropractor to exercise judgement during the course of the procedure which the Chiropractor feels are in my best interest at the time, based upon the facts then known.

Permission to Treat a Minor

I certify that I am the parent or legal guardian of the patient named below. I herby authorize the chiropractor at Equilibrium Chiropractic to treat the patient named below without my being present in the facility.

Patient Name_____ DOB_____

Parent/Legal Guardian Name _____

Relationship to Patient_____ DOB_____

_____ _____

Signature (Responsible Party) Date

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that Equilibrium Chiropractic is a health care provider and that it will use or disclose my health information for treatment, billing and healthcare operation. I have seen a copy of the notice of privacy practices that describe how my health information is used and shared. I understand that I have the right to request restrictions on uses and disclosures of my health information for treatment, payment and healthcare operations purposes.

I acknowledge receipt of a copy of the Notice of Privacy Practices from Equilibrium Chiropractic.

Initials _____

No Show Policy

I understand that Equilibrium Chiropractic has specifically reserved an appointment time for me. If I do not show up for that reserved appointment, I will be charged a fee of $25.00. I understand that these charges are NOT COVERED BY MY INSURANCE and will be my responsibility to pay.

Practice & Financial Policies

I herby authorize my health insurance company to make payment directly to Equilibrium Chiropractic, LLC for any benefits I may receive. I realize this may not represent the full payment for services rendered and that I will be responsible for the balance due. I authorize the release of any information necessary to process my insurance claims and facilitate payment of my account by a third party.

I am aware that any insurance benefits quoted to me are NOT a guarantee of payment and that I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES INCURRED DURING TREATMENT. Information provided by my insurance is not a guarantee of payment.

_____ _____

Signature (Responsible Party) Date

EQUILIBRIUM CHIROPRACTIC

Patient's
Legal Name _____ Today's Date_____

Date of Birth_____ Height_____ Weight_____

1. Where are the symptoms located that have brought you to our office? Please list and rate each symptom individually on the scale provided.

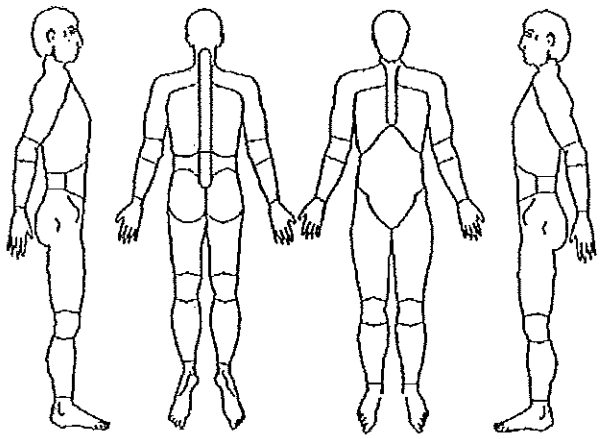
_____ (1=no pain) (10=unbearable pain)

_____ (1=no pain) (10=unbearable pain)

_____ (1=no pain) (10=unbearable pain)

_____ (1=no pain) (10=unbearable pain)

Using the pictures of the body, please circle all affected areas. Please indicate pain = (xxx), numbness = (ooo), tingling = (+++), and weakness = (- - -)



Right Back Front Left

2. How long have these complaints been present? _____

_____

_____

3. What do you think caused your complaints? _____

_____

_____

4. Did the complaints begin ☐ Suddenly or ☐ Gradually?

5. The pain/complaints are what % of your day?

☐ Constant (76-100%) ☐ Frequent (51-75%)

☐ Occasional (26-50%) ☐ Intermittent (0-25%)

DOCTOR'S NOTES

6. Do you feel these complaints are getting progressively worse? ☐ No or ☐ Yes,

please describe _____

_____

7. The symptoms are worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ N/A

8. Complaints are due to: ☐ Sports Injury ☐ Work Injury ☐ Auto Accident ☐ Other

9. Have you had prior similar complaints? ☐ No or ☐ Yes, please describe ___

_____

_____

10. Does the pain radiate? ☐ No or ☐ Yes? If yes, please mark below:

RIGHT ☐ Upper Arm ☐ Forearm ☐ Hand ☐ Thigh ☐ Calf ☐ Foot
LEFT ☐ Upper Arm ☐ Forearm ☐ Hand ☐ Thigh ☐ Calf ☐ Foot

11. Type of pain? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

12. What makes the pain/complaints worse? Please mark all that apply.

☐ Bending	☐ Sitting	☐ Standing	☐ Walking	☐ Lying Down	☐ Pushing/Pulling w/ Hands
☐ Coughing	☐ Sneezing	☐ Driving	☐ Lifting	☐ Cold/Damp	☐ Reaching Out/Up/Down
☐ Other	☐ Yard Work	☐ Gardening	☐ Working	☐ Twist/Turning	☐ General Activity

13. What makes the pain/complaints better? Please mark all that apply.

☐ Ice ☐ Medication _____
☐ Heat ☐ Rest
☐ Stretching ☐ Other _____

DOCTOR'S NOTES

_____
_____
_____

14. Are there any other symptoms that you feel are related to your pain/complaints?

_____

_____

15. Do your pain/complaints interfere with:

☐ Nothing at this time ☐ Sleep ☐ Activities of work ☐ Activities of daily living

Please describe _____

_____

16. What treatment have you received for your current condition?

☐ None ☐ Chiropractic ☐ Physical Therapy ☐ Surgery ☐ X-Rays/MRI

Providers? _____ Treatment? _____

17. Have you ever had chiropractic care in the past? ☐ No or ☐ Yes, with whom & how long _____

18. Please check all those conditions below which apply to your personal health history:

☐ Anemia	☐ Elbow Pain	☐ Jaw Pain	☐ Polio	☐ Anxiety
☐ Ankle Pain	☐ Epilepsy	☐ Joint Stiffness	☐ Prostate Problems	☐ Thyroid Problems
☐ Arm Pain	☐ Eye/Vision Problems	☐ Knee Pain	☐ Shoulder Pain	☐ Pneumonia
☐ Arthritis	☐ Fainting	☐ Leg Pain	☐ Sig. Weight Change	☐ Miscarriage
☐ Asthma	☐ Fatigue	☐ Low Back Pain	☐ Sleep Apnea	☐ Currently Pregnant
☐ Back Pain	☐ Foot Pain	☐ Menstrual Problems	☐ Spinal Cord Injury	☐ Kidney Disease
☐ Broken Bones	☐ Genetic Spinal Disorder	☐ Mid Back Pain	☐ Sprain/Strain	☐ Mononucleosis
☐ Cancer	☐ Hand Pain	☐ Minor Heart Trouble	☐ Stroke/Heart Attack	☐ Allergies
☐ Chest Pain	☐ Headaches	☐ Multiple Sclerosis	☐ Stomach Problems	☐ Mumps
☐ Chicken Pox	☐ Hearing Problems	☐ Neck Pain	☐ Tumor	☐ Ulcerative Colitis
☐ Depression	☐ Hepatitis	☐ Neurological Disorder	☐ Ulcer(s)	☐ Rheumatoid Arthritis
☐ Diabetes	☐ High Blood Pressure	☐ Pacemaker	☐ Wrist pain	☐ Other
☐ Dizziness	☐ Hip Pain	☐ Parkinson's Disease	☐ Osteoporosis	

19. Have you been treated by a physician for any condition this past year? MD_____ Condition_____

20. Are you pregnant? ☐ No or ☐ Yes, due-date_____

21. When was your last physical exam? _____ Were there any unhealthy findings? ☐ No or ☐ Yes, please describe_____

22. Have you ever been involved in an auto accident? ☐ No or ☐ Yes, when? _____
Were you treated? ☐ No or ☐ Yes, by whom _____

23. List other past significant injuries or falls with dates _____

24. List any surgeries/hospitalizations with dates_____

25. Describe exercise levels: ☐ Never ☐ Seldom ☐ Occasional ☐ Frequent, what type_____

26. Describe your daily work activities_____

27. How much tobacco do you use? _____/packs per day Alcoholic drinks _____/per week Caffeine drinks _____/per week