



## ADULT INTAKE FORM

Date: \_\_\_\_\_

### PERSONAL INFORMATION

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Cell Phone: (     ) \_\_\_\_\_ Alternate Phone: (     ) \_\_\_\_\_

Text Reminders: Y N Before Appointment: 1 hr 4 hrs 1 day

Email: \_\_\_\_\_ *(For updates on office hours, events, etc.)*

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Marital Status: S M D W Other Spouse's Name: \_\_\_\_\_

# of Children: \_\_\_\_\_

Children's Names & Ages: \_\_\_\_\_

Who can we thank for referring you or how did you hear about Explore? \_\_\_\_\_

\_\_\_\_\_

### REASON FOR SEEKING CARE

What is your reason for seeking care at Explore Family Chiropractic? \_\_\_\_\_

\_\_\_\_\_

When did this begin? (If applicable) \_\_\_\_\_

Are there any major injuries and/or surgeries we should know about? \_\_\_\_\_

\_\_\_\_\_

What is this affecting that is MOST important in your life? (List all that apply)

\_\_\_\_\_

Have you seen any other providers for this condition? (List all that apply)

\_\_\_\_\_

Have you seen a chiropractor before? Yes No

How long ago? \_\_\_\_\_ Clinic/Doctor Name: \_\_\_\_\_

What is your reason for the change? (If applicable) \_\_\_\_\_

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: \_\_\_\_\_

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

\_\_\_\_\_

\_\_\_\_\_

## HEALTH CONCERNS

- |   |   |
|---|---|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Fatigue/Sleep Issues     |
| <input type="checkbox"/> Digestive Troubles | <input type="checkbox"/> Dizziness                |
| <input type="checkbox"/> Nausea/Vomiting    | <input type="checkbox"/> Ringing in Ears          |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Sensitivity to Light     |
| <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Loss of Concentration    |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Memory Problems          |
| <input type="checkbox"/> Loss of Balance    | <input type="checkbox"/> Headaches                |
| <input type="checkbox"/> Neck/Back Pain     | <input type="checkbox"/> Stiffness/Flexibility    |
| <input type="checkbox"/> Pain in Arms/Legs  | <input type="checkbox"/> Sinus Troubles/Allergies |
| <input type="checkbox"/> Irritability       | <input type="checkbox"/> Cold Hands/Feet          |
| <input type="checkbox"/> Other _____        |   |

Explain any boxes checked above or add additional concerns:

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Is there anything else regarding your current condition you feel the doctor should know? \_\_\_\_\_

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## MEDICATIONS

- |   |  |
|---|--|
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Migraine/Headache |
| <input type="checkbox"/> Blood Pressure     | <input type="checkbox"/> Cholesterol       |
| <input type="checkbox"/> Pain Narcotics     | <input type="checkbox"/> ADD/ADHD          |
| <input type="checkbox"/> Muscle Relaxers    | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Other _____        |  |
| <input type="checkbox"/> Other _____        |  |
| <input type="checkbox"/> Other _____        |  |

Explain any boxes checked above: \_\_\_\_\_

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## EMERGENCY CONTACT

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_

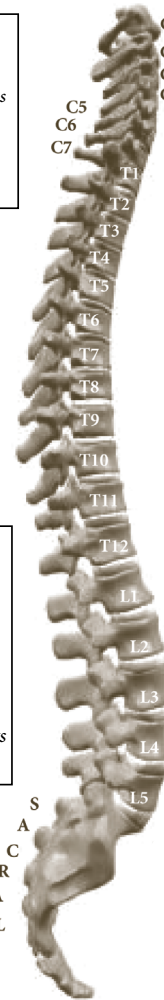
City / State / Zip: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ Relation: \_\_\_\_\_

## Did You Know...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.

- Sore Throat
  - Stiff Neck
  - Radiating Arm Pain
  - Hand/Finger Numbness
  - Asthma
  - Allergies
  - High Blood Pressure
  - Heart Conditions



- Headaches
  - Migraines
  - Dizziness
  - Sinus Problems
  - Allergies
  - Fatigue / Sleep Problems
  - Head Colds
  - Vision Problems
  - Difficulty Concentrating
  - Hearing Problems

- Middle Back Pain
  - Congestion
  - Difficulty Breathing
  - Bronchitis
  - Pneumonia
  - Gallbladder Conditions
  - Stomach Problems
  - Ulcers
  - Gastritis
  - Kidney Problems
  - Indigestion

- Constipation
  - Colitis
  - Diarrhea
  - Gas Pain
  - Irritable Bowel
  - Bladder Problems
  - Menstrual Problems
  - Low Back Pain
  - Pain or Numbness in legs
  - Reproductive Problems

## VITAMINS / SUPPLEMENTS

- |  |   |
|--|---|
| <input type="checkbox"/> Multi-Vitamin | <input type="checkbox"/> Fish Oil/Omega-3 |
| <input type="checkbox"/> Vitamin D3    | <input type="checkbox"/> Probiotics       |
| <input type="checkbox"/> _____         | <input type="checkbox"/> _____            |
| <input type="checkbox"/> _____         | <input type="checkbox"/> _____            |

Explain any boxes checked above: \_\_\_\_\_

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## STRESS QUESTIONNAIRE

Most life stresses can be grouped into 3 main categories: Physical, Chemical, and Emotional Stress.

Please check any of the following stresses you experience on a regular basis.

### Physical Stress

Physical Pain  Low Energy/Fatigue  Job/Hobbies Cause Discomfort  Tightness/Stiffness

History of Accidents/Injuries  Inability to Exercise/Perform Physical Activities  Other \_\_\_\_\_

Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Chemical Stress

Fast Food/Highly Processed Food  Medications (Prescription or OTC)  Consume Alcohol  Tobacco

Amalgam Fillings  Makeup/Lotion/Other Skin Products  Other \_\_\_\_\_

Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Emotional Stress

Work/Job  School  Health  Finances  Family  Daily Schedule/Time  Other \_\_\_\_\_

Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**What else about your health or your life do you feel is important for the doctor to know?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## QUALITY OF LIFE

Please rate your GENERAL stress level, 0-10 \_\_\_\_\_ At Work / :School \_\_\_\_\_ At Home \_\_\_\_\_

How do you think you handle your stress? \_\_\_\_\_

\_\_\_\_\_

How do you grade your physical health?  Excellent  Good  Fair  Poor

How do you grade your emotional / mental health?  Excellent  Good  Fair  Poor

How do you rate your overall \*quality of life?\*  Excellent  Good  Fair  Poor

Do you exercise regularly? If yes, how often? \_\_\_\_\_

Do you follow a special dietary regimen? \_\_\_\_\_

**Your Expectations for Chiropractic Care (check all that apply):**

Resolution of a symptom or a problem

Resolution & Prevention of a symptom or a problem

Healthier spine & Nervous system

Optimal health on all levels

Other: \_\_\_\_\_

## PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

*I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.*

Date: \_\_\_\_\_ Print Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

### FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctors' recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize Explore Family Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement charges incurred by me.
- Chiropractic care in this office deals with vertebral subluxation, and will therefore be billed under the S8990 adjustment code. While we will provide an itemized receipt upon your request, we anticipate that care will not be reimbursed by a third party carrier. This does not apply to PI, WSI, or Medicare. HSA and FLEX spending accounts may be utilized.
- I authorize the direct payment to Explore Family Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case and by any insurance company obligated to make payment to me or Explore Family Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint Explore Family Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic or payments due for services rendered on behalf of the undersigned by Explore Family Chiropractic.
- If you have any questions about our financial policies, please ask our staff. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN)*. Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our staff. Signing below means that you have received and understand this notice.

Date: \_\_\_\_\_ Signature : \_\_\_\_\_

### AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at Explore to treat my condition as deemed appropriate. At Explore Family Chiropractic we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or any staff member of Explore Family Chiropractic responsible for any errors or omissions that I may have made in the completion this form. Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### **Advanced Beneficiary Notice (ABN)**

The purpose of this form is to help you be aware of chiropractic services in this office as it relates to any medical insurance you may have. Chiropractic care in this office is not focused on diagnosis of or relief of symptoms; it is centered on the location, analysis, and correction of underlying vertebral subluxations. Because of this, all services are coded in a manner which insurance carriers view as maintenance or wellness care and most likely will not be covered. Signing below signifies that you want the services provided in this office, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion and policies as it relates to insurance coverage, not an official Medicare or other insurance carrier's stance or decision. Signing below indicates you have received and understand this notice.

Date: \_\_\_\_\_

Name (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_

Parent/Guardian Signature (if applicable) \_\_\_\_\_