

Patient Intake Form

Patient Name: _____ Date: _____
Date of Birth: ____ / ____ / ____ Social Security #: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone : _____ Work: _____ Cell: _____
E-mail: _____
Employer: _____ Occupation: _____
How did you hear about us? Medical Referral Friends Name _____
 Yellow Pages Other _____

Family Information

Marital Status: S M D W

Previous Chiropractic Care?

Spouse's Name: _____ Age: ____ Yes No
Children's Name: _____ Age: ____ Yes No
Name: _____ Age: ____ Yes No
Name: _____ Age: ____ Yes No

Current Health Questions

Do you smoke? Y N How much? _____
Do you exercise regularly? Y N How Often? _____
Have you been in accidents? Car Other Y N When? _____
Do you take any Medicine? Y N List: _____

Do you take Vitamins / Supplements? Y N List: _____

Current Health Conditions/Disease you have or are being treated for, List: _____

Symptoms:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Numbness in Feet | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Tension / Stress | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Tingling Fingers | <input type="checkbox"/> Tingling Toes | <input type="checkbox"/> Cold Hands/Feet |

Other Symptoms: _____

Have you ever had surgery? Y N List: _____

Family History of: Heart Disease Arthritis Cancer Diabetes

Your Primary Care Physician? _____

Last Physical date: _____

Problem/Symptom Form

Patient Name: _____ Date: _____

Is your visit today due to an: Automobile Injury Work Injury Unknown Cause

How and when did your problem begin? _____

How is it changing with time? Getting Worse Getting Better Not Changing

Similar symptoms in the past? Y / N When? _____

Is the problem interfering with: Daily Activities Work Sleep Other: _____

Have you lost time from work? Y / N When? _____

Do you consider this problem to be severe? Y / N

Other Doctors seen for this problem: _____

Please list each Problem/Area separately - Be Specific

Problem #1. _____ (circle) (0=no pain 1 2 3 4 5 6 7 8 9 10=severe pain)

How would you describe the symptoms?

- dull sharp throbbing burning stiffness
 aching tingling stabbing cramping numbness radiating

How often do you experience these symptoms?

- Constant (76-100% of the time) Frequent (51-75% of the time)
 Occasionally (26-50% of the time) Intermittently (1-25% of the time)

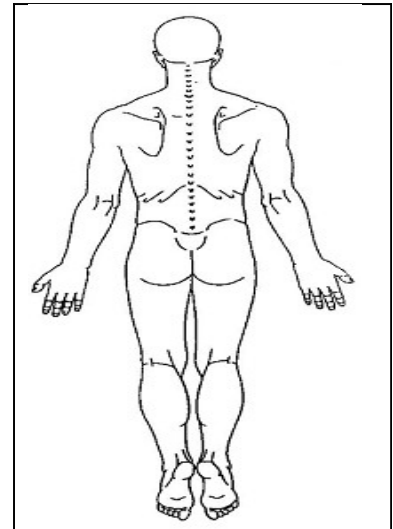
What makes it worse?

- Sitting Standing Walking Bending Coughing
 Driving Computer work Household chores Other _____

What makes it better?

- Laying Exercise Sitting Standing Rest Stretching
 Ibuprofen Heat Ice Nothing helps Other _____

Mark X where it hurts



Problem #2. _____ (circle) (0=no pain 1 2 3 4 5 6 7 8 9 10=severe pain)

How would you describe the symptoms?

- dull sharp throbbing burning stiffness
 aching tingling stabbing cramping numbness radiating

How often do you experience these symptoms?

- Constant (76-100% of the time) Frequent (51-75% of the time)
 Occasionally (26-50% of the time) Intermittently (1-25% of the time)

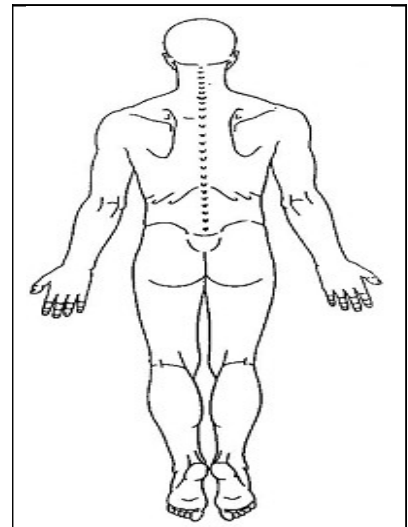
What makes it worse?

- Sitting Standing Walking Bending Coughing
 Driving Computer work Household chores Other _____

What makes it better?

- Laying Exercise Sitting Standing Rest Stretching
 Ibuprofen Heat Ice Nothing helps Other _____

Mark X where it hurts



WELCOME TO OUR OFFICE

In compliance with the Federal and State Consumer Protection and Informed Consent Laws, we present a basic outline of usual and customary procedures and fees:

Initial Examination 45.00 - 85.00 Therapy 15.00 - 60.00

Adjustments 35.00 & up X-rays 50.00 & up

IF NO INSURANCE : Payment is due when service is rendered. We gladly accept Master Card, Visa and Discover.

INSURANCE: DEDUCTIBLES, CO-PAYS AND PROCEDURES NOT COVERED ARE EXPECTED TO BE PAID FOR AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. If you fail to keep your scheduled appointment or discontinue care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any insurance claim submitted.

TREATMENT PERMISSION: I understand that I am accepted as a patient and if I agree to be treated, that I give permission to the clinic to administer treatment and perform such procedures as deemed necessary in the diagnosis and treatment of my condition. Furthermore, any risk regarding treatment will be explained to me upon my request.

PAYMENT RESPONSIBILITIES: I understand that I am personally responsible for all charges whether or not paid by any third party. I agree that all charges are payable and collectable in Polk County. An interest charge of 11/2 % monthly, 18% annually, minimum finance charge \$.50 may be charged on any unpaid balance over 60 days old. If I do not make payment after it is 90 days past due, the account may be turned over for collections and I may be charged the cost of collections. All portions of any bill sent me by this chiropractic clinic shall be assumed valid unless disputed in writing within 30 days of receiving the bill. I agree to arbitrate any disagreement, controversy, or claim which cannot be otherwise resolved to my satisfaction, arising out of or relating to any services provided by this clinic and to settle any disputed by arbitration in accordance with the rules of the American Arbitration Association, which provides dispute resolution services.

ASSIGNMENT OF RIGHT TO PAY/LIEN AGAINST BENEFITS: I hereby authorize this clinic to file my claim. I assign them my right to receive any and all payments or recoveries from any insurance company, attorney of third party for professional services rendered by this clinic. I convey a lien against any funds and authorize any direct and third party to withhold sums from any benefits, judgements,, verdicts, settlements of recoveries, and to adequately protect and to make payment for these services directly to this clinic pursuant to this assignment and lien.

ASSIGNMENT OF CAUSE OF ACTION: In the event that any insurance company or other third party that may be obligated to making payment to me or this clinic for the charges made for services, refuses to make such payment upon demand, I hereby assign, transfer and convey to this clinic the cause of action that might exist in my favor against any such company or person. I authorize this clinic to prosecute said action either in my name or their name to collect fees due for services rendered to this clinic and legal expenses and to resolve said claims as they see fit.

AUTHORIZATION TO PROCESS DRAFTS: I agree that this clinic shall be appointed as my agent to endorse drafts or to sign my name on any checks of payment of my bill for services rendered at this clinic.

LIMITED RELEASE OF MEDICAL INFORMATION: I authorize this clinic to make inquiries and to release any pertinent information to any insurance company, adjuster, medical facility, doctor, or attorney to facilitate collection under these assignments.

Our goal is to relieve your pain as quickly as possible, and then to correct the cause of your problem. If you have any question with regard to your health care or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit

SIGNATURE _____ DATE: _____