Chiropractic Intake

Name ____________________

Address ____________________

City ____________________ Zip Code __________ E-mail ____________________

Preferred phone ____________________ ☐ Male ☐ Female Age _____ Birth date __________

Who may we thank for referring you? ____________________

Employment Information

Patient employed by ____________________ Occupation ____________________

Business address ____________________

Business phone ____________________

Emergency Information

Notify in case of emergency ____________________ Emergency phone ____________________

Primary Insurance

Person responsible for account ____________________

Relation to patient ____________________ Birth date __________ Soc. Sec. # __________

Address (if different from patient) ____________________ Home phone __________

City ____________________ Zip Code __________ E-mail ____________________

Business address (if different from patient) ____________________

Business phone ____________________

Insurance company ____________________

Phone ____________________

Group name ____________________ Group # __________ Subscriber # __________

Name of other dependents under this plan ____________________

Reason For Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? ____________________

Your reason for this visit: ____________________

Please describe your current pain and its location: ____________________

____

When did symptoms begin (date)? ____________________ Have you had similar conditions in the past? __________

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Sporadic How often do you have this pain? __________

Have you been treated by anyone else for this condition? ____________________

If so, when and where? ____________________

Activities/movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping ☐ Stiffness ☐ Swelling Other ____________________

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Health History

Please list any medication (including pain killers, vitamins, herbal supplements) you are taking: ______________________

____

Please list any serious injuries or surgeries you have had in the last 10 years:

Falls ______________________ Date __________

Head injuries ______________________ Date __________

Broken bones ______________________ Date __________

Dislocations ______________________ Date __________

Surgeries ______________________ Date __________

Sprains/Strains ______________________ Date __________

Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

- ☐ Heart attack, stroke
- ☐ Congenital heart defect
- ☐ Alcohol, drug abuse
- ☐ Fainting, seizures, epilepsy
- ☐ Shingles
- ☐ Psychiatric problems
- ☐ Difficulty breathing
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Frequent neck pain
- ☐ Jaw pain
- ☐ Wrist pain
- ☐ Shoulder pain
- ☐ Arm pain
- ☐ Leg pain
- ☐ Lower back problems
- ☐ Severe, frequent earaches
- ☐ Ringing in ears
- ☐ Severe/frequent headaches
- ☐ Diabetes, tuberculosis
- ☐ Dizziness
- ☐ Emphysema, glaucoma
- ☐ Kidney problems
- ☐ Artificial joints
- ☐ Cancer
- ☐ HIV Positive, AIDS
- ☐ Colitis
- ☐ Gout
- ☐ Numbness
  Where? __________
- ☐ Tingling
  Where? __________
- ☐ Muscle spasms
  Where? __________

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment.

Consent for Treatment: I voluntarily consent to the rendering of care including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending doctor and it is the responsibility of the staff to carry out the instructions of such doctor.

Signature of patient ______________________ Current Date __________

Signature of parent/guardian if patient is a minor ______________________ Current Date __________

How can we best serve your needs?

Please check off the following that pertain to your health-care goals so we can meet all your needs, wants and expectations.

1. Symptomatic (pain relief) care only
2. Structural care (correct and stabilize as much as possible)
3. Stretching techniques as pertaining to my condition
4. Strengthening exercises as pertaining to my condition
5. Nutritional consultation
6. Dieting information
7. Information on orthopedic support and orthotics
8. Massage therapy
9. Other:

____

____

What are/were you doing for exercise and nutrition? ______________________

____

____

____

Verifying Your Insurance Coverage

Patient Name ____

Please take a moment and call your insurance carrier and verify your insurance coverage for Chiropractic Services. Even if your carrier has not changed, your coverage may have. Below is a list of questions to ask.

Current Date _________________________

Person you spoke to __________________

Is Dr. Jane Ray an in-network provider? ☐ YES ☐ NO

What is my Chiropractic Coverage and Limitations (does my plan cover chiropractic manipulation, soft tissue therapies, electrical stimulation, hot/cold packs, etc.) in her office? (Remember, we need the in-network or the out-of-network coverage, depending on if we are providers for your carrier.)

Calendar year deductible ____________ Is any of it met yet? $ ____________

Do I have a co-pay? ☐ YES ☐ NO If yes, how much per visit? ____________

Yearly limits to coverage ____

Do I need a referral from my primary care physician? ☐ YES ☐ NO

Is acupuncture a covered benefit under my plan? ☐ YES ☐ NO

If yes, do I need pre-authorization for acupuncture? ☐ YES ☐ NO

Address to send claims:

Name ____

Address ____

City ___________________ State ____ Zip Code ___________

Please bring your insurance card with you.