

Chiropractic Intake



Name: _____ Male Female Today's Date: _____

Date of Birth: ____ / ____ / ____ Age: _____ Height: _____ Weight: _____ SS #: _____

Marital Status: Married Single Divorced Widowed Student Status: Full time Part Time Non-student

Race: American Indian or Alaska Native Asian Black Caucasian Pacific Islander Other Declined

Ethnicity: Hispanic Non-Hispanic Declined Preferred Language: _____

Home Address: _____
Street / P.O. Box City State Zip Code

E-Mail: _____ How did you hear about us? _____

Employment Status: Full Time Part Time Occupation: _____ Work Phone: _____

Are you: Working without restrictions Working With Restrictions Not working/ off since: _____

Home Phone: _____ Cell Phone: _____ Primary Care Doctor: _____

Are you seeing us for an injury from: Auto Work Sports Injury No Injury Other: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Insurance Information: Please bill: Auto Insurance Workman's Comp. Health Insurance Self Pay

General Consent Form: The undersigned hereby consents to evaluation and treatment rendered by the licensed Doctors of Chiropractic in this office, licensed massage therapists, licensed acupuncturist, and their assistants according to the applicable standards of care. It is understood that options exist for treatment and that any/all treatments have risks and benefits. I do not expect the doctor or therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor or therapist to exercise judgment during the course of the procedure which the doctor or therapist feels at the time, based on the facts given, is in my best interest. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested by the therapist or doctor and that as a patient, I have a responsibility to ask any questions that I may have regarding treatment. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment. I understand that I have a responsibility to communicate honestly with the Doctors and therapists and to notify them of any changes to my health status. The information in my chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimal disclosure necessary as related to your care. Please see the Notice of Privacy Practices for more detailed information. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Financial Awareness and Consent: I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, including Medicare, private insurance and other health plans to Scott Family Health. I understand that all plans are different and I may have one or more of the following that I am responsible for: referral from PCP/ deductible/ co-pays/ percentage owed for each date of service. When billing any workman's compensation claims or auto accident claims please note that *before treatment is rendered* all billing information including, but not limited to claim number and the address of where the claims need to be sent must be presented at *the time of service*. When billing health insurance I understand that I must present my insurance card at the time of service. Scott Family Health has the right to not treat any patient if all required information is not provided. I understand that any accounts that are 90 days overdue are subject to collection proceedings, regardless of case type. Please be aware that a \$20.00 fee will be assessed for any check returned for non-sufficient funds. *** Payment for treatment is required at the time of service. ** If you have a deductible on your insurance plan, our cash rates for Chiropractic treatments are due at the time of service for each visit (\$95.00 for the initial visit, and \$50.00 for subsequent visits--subject to change). Remaining charges applied to your deductible will be billed to you after claims are processed by your insurance company. **Massage Therapy and Acupuncture:** PLEASE NOTE: Most insurance companies do not cover massage and acupuncture. We are willing to bill only *qualifying* health insurance plans for massage and acupuncture services. Acupuncture charges are \$90.00 for the initial visit and \$75.00 for subsequent visits (subject to change). Massage charges are \$45.00 for a half hour and \$70.00 for an hour (subject to change). Chiropractic 'Payment at the time of service' discount:** I understand that I may pay for my treatment in full at the time of service and will receive any and all treatments for a flat rate of \$95.00 for the initial visit and \$50.00 for subsequent visits (subject to change). If I choose to have my insurance company billed, all services will be itemized and will exceed these discounted rates.

Release of Records: I authorize Scott Family Health to release all health records necessary for my treatment and/or evaluation. I also authorize Scott Family Health to release any protected health information required to secure payment.

Cancellation policy: Please be considerate of our clinic and other patients and provide, when possible, 24 hours notice to cancel or reschedule your appointment. Please be aware that any patients arriving late for their scheduled appointment may be required to wait until the next available opening or reschedule their appointment for a later time/ date. Also note that you will be responsible for an office visit of \$35.00 for an hour massage, (subject to change) \$22.50 for a half hour massage, (subject to change) and \$37.50 for an acupuncture session (subject to change) for failure to cancel or reschedule your appointment within 24 hours of your scheduled appointment. The massage & acupuncture schedules are very limited, therefore we strictly enforce this policy.

Patient/ Responsible party's signature: _____ Date: ____ / ____ / ____
(if patient is under 18 years of age)

*Scott Family Health includes Dr. Trenton Scott, Dr. Gina Scott, Dr. Scott Hessler, Ashley Johnson, Michah Stephens, Tanya Hemberger and Michelle Hykes.

What is your **major** complaint? _____

When did your condition develop? _____

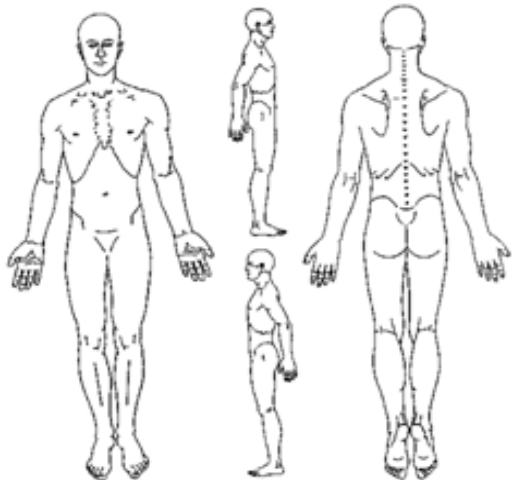
How did your condition develop? _____

Has your condition been getting better, worse or staying the same? _____

What makes your condition better? _____ What makes it worse? _____

Please mark on the diagram to explain and locate the areas of complaint.

A= ACHE B=BURNING C=STABBING N=NUMBNESS P=PINS & NEEDLES O=OTHER



Do you currently or in the past have had:
(Please mark all that apply.)

Complaint: _____ **When & # of Episodes:** _____

- Back pain or stiffness _____
- Neck pain or stiffness _____
- Shoulder pain _____
- Hip pain _____
- Foot pain or trouble _____
- Swollen or painful joints _____
- Cold hands or feet _____
- Numbness or pain in the arms, hands or fingers _____
- Numbness or pain in the legs, feet, or toes _____

TESTS: Please list the most recent date and location taken, if known.

X-Ray of any area of the spine: _____ **EKG:** _____ **MRI/ CT:** _____

Other pertaining to condition you are seeing us for: _____

HABITS: Do you...	Yes	No	If yes, please describe:
Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	How many packs per day? _____
Consume Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	How many drinks per day? _____ Per week? _____
Consume coffee or tea?	<input type="checkbox"/>	<input type="checkbox"/>	How many cups per day? _____
Take street drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise?	<input type="checkbox"/>	<input type="checkbox"/>	How often? (Daily, Weekly, or Monthly) _____ Type: _____

MEDICINES: Please list all currently used medicines. Include prescription and non prescription drugs, vitamins, and herbs.

ALLERGIES: Please list all known allergies, especially to medicines. _____

TREATMENT you are receiving or have received:

Medical Care: _____

Chiropractic Care: _____

Massage Therapy: _____

Other: (Please specify). _____

MALES ONLY: Do you have: Changes in urine stream Prostate Trouble Lump in testicles

FEMALES ONLY: Do you have: Menstrual Problems Breast Lumps or pain Tubal Infections Problems conceiving

History of miscarriages * **ARE YOU CURRENTLY OR POSSIBLY PREGNANT?** ___ **HOW MANY WEEKS?** ___

Please list: **HOSPITALIZATIONS, OPERATIONS, AUTO ACCIDENTS OR WORK INJURIES, Evaluations & Treatment/YEAR**

Do you currently or have you had:
(Please mark all that apply.)

- | | Current | Past |
|------------------------------------|--------------------------|--------------------------|
| NEUROLOGICAL | | |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Tremor | <input type="checkbox"/> | <input type="checkbox"/> |
| Speech problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Trouble concentrating | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Muscle weakness or paralysis | <input type="checkbox"/> | <input type="checkbox"/> |
| Memory loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Direct head trauma | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of consciousness | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor coordination | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness in groin | <input type="checkbox"/> | <input type="checkbox"/> |

MUSCULOSKELETAL

- | | | |
|---------------------------------------|--------------------------|--------------------------|
| Hernia | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis or gout | <input type="checkbox"/> | <input type="checkbox"/> |
| Bursitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Fractured bones | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain fails to improve with rest | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain greater than 4 weeks | <input type="checkbox"/> | <input type="checkbox"/> |
| History of osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |

CARDIOVASCULAR

- | | | |
|---|--------------------------|--------------------------|
| Passing out | <input type="checkbox"/> | <input type="checkbox"/> |
| High cholesterol or triglycerides | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease or murmur | <input type="checkbox"/> | <input type="checkbox"/> |

CONSTITUTIONAL

- | | | |
|--|--------------------------|--------------------------|
| History of trauma | <input type="checkbox"/> | <input type="checkbox"/> |
| Infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Unexplained weight loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Unusual fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness/ Poor balance | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in appetite | <input type="checkbox"/> | <input type="checkbox"/> |
| Fevers/ Night Sweats | <input type="checkbox"/> | <input type="checkbox"/> |
| Low or High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent infection | <input type="checkbox"/> | <input type="checkbox"/> |
| History of cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdominal pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Use of corticosteroids | <input type="checkbox"/> | <input type="checkbox"/> |
| Use of anticoagulants/ blood clots | <input type="checkbox"/> | <input type="checkbox"/> |
| Use of birth control pills | <input type="checkbox"/> | <input type="checkbox"/> |
| Intravenous drug use | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |

Do you currently or have you had:
(Please mark all that apply.)

- | | Current | Past |
|----------------------------|--------------------------|--------------------------|
| RESPIRATORY | | |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic cough | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing | <input type="checkbox"/> | <input type="checkbox"/> |

URINARY

- | | | |
|------------------------------------|--------------------------|--------------------------|
| More frequent urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain or blood with urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney or bladder infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney stones | <input type="checkbox"/> | <input type="checkbox"/> |

ENT

- | | | |
|-----------------------------|--------------------------|--------------------------|
| Sinus Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> |

GASTROINTESTINAL

- | | | |
|--|--------------------------|--------------------------|
| Recurrent abdominal pain/ nausea | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Heartburn | <input type="checkbox"/> | <input type="checkbox"/> |
| Diarrhea or constipation | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemorrhoids | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of bowel or bladder control | <input type="checkbox"/> | <input type="checkbox"/> |
| Vomited Blood | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody or black stools | <input type="checkbox"/> | <input type="checkbox"/> |

ENDOCRINE

- | | | |
|-----------------------|--------------------------|--------------------------|
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver trouble | <input type="checkbox"/> | <input type="checkbox"/> |

INTEGUMENTARY/ALLERGIC

- | | | |
|-----------------------|--------------------------|--------------------------|
| Skin Conditions | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> |

HEMATOLOGIC

- | | | |
|-------------------------------------|--------------------------|--------------------------|
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding or bruising tendency | <input type="checkbox"/> | <input type="checkbox"/> |

PSYCHIATRIC

- | | | |
|----------------------------|--------------------------|--------------------------|
| Sleep Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervous Tension | <input type="checkbox"/> | <input type="checkbox"/> |
| Irritability | <input type="checkbox"/> | <input type="checkbox"/> |
| Mood Swings/ Changes | <input type="checkbox"/> | <input type="checkbox"/> |

FAMILY HISTORY: Do you or **any member of your family** have any of the following? Please indicate who has the condition.

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psychological Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Spine or back disorder | <input type="checkbox"/> Other |

ANY OTHER SERIOUS ILLNESSES NOT MENTIONED HERE: _____