



WELCOME!

Today's Date: ____/____/____

Your Name: _____ [] Male [] Female

What do you prefer to be called/Nickname: _____

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

Drivers License #: _____ State Issued: _____

Marital Status: [] Single [] Married [] Divorced [] Widowed [] Separated

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____

Mobile Phone: (____) _____

Email address: _____

Emergency Contact: _____ Phone: (____) _____

Employer: _____ Phone: (____) _____

Address: _____

Who can we thank for referring us to you: _____

May we contact him/her? [] Yes [] No

THANK YOU

NEW PATIENT INTAKE FORM

Name: _____ Date: _____

- 1) What is the reason for your visit to our office? General Injury Pre-Natal
 Auto Accident Workers Compensation Other: _____

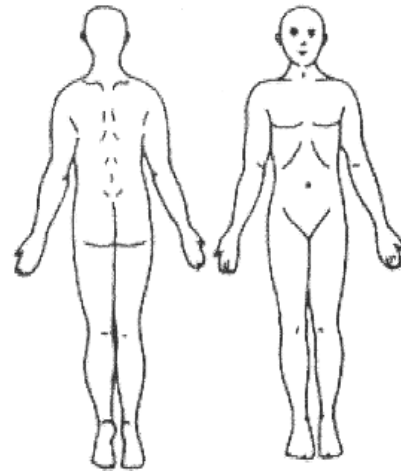
- 2) Please choose the location(s) of your area(s) of concern:
The Chiropractic Assistant will get specific information upon intake.

- | | | |
|-------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Elbow | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Jaw | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Hand | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Mid Back | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Low Back | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Hip | |

Indicate your area(s) of concern using the key to describe the *TYPE and LOCATION* of your sensations right now.

Key:

- | | |
|-------------------|---------------------------|
| A= Ache | D= Dull |
| B= Burning | SM= Sharp with motion |
| N= Numbness | SHM= Shooting with motion |
| P= Pins & Needles | STM= Stabbing with motion |
| S= Sharp | EM = Electric with motion |
| SH= Shooting | |
| ST= Stiff | |



- 3) How often do you experience your symptoms?
- | | |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the time) | <input type="checkbox"/> Occasionally (26-50% of the time) |
| <input type="checkbox"/> Frequently (51-75% of the time) | <input type="checkbox"/> Intermittently (1-25% of the time) |

- 4) How are your symptoms changing with time?
- | | | |
|--|---|---|
| <input type="checkbox"/> Getting Worse | <input type="checkbox"/> Staying the Same | <input type="checkbox"/> Getting Better |
|--|---|---|

- 5) Using a scale from 1-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (please circle)

6) Height: _____ Weight: _____ Date of Birth: _____

7) Occupation: _____

- 8) How do you rate your overall health?
- | | | | | |
|------------------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Very Good | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
|------------------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|

- 9) What kind of regular exercise do you perform?
- | | | | |
|------------------------------------|-----------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Strenuous | <input type="checkbox"/> Moderate | <input type="checkbox"/> Light | <input type="checkbox"/> None |
|------------------------------------|-----------------------------------|--------------------------------|-------------------------------|

10) Do you have an immediate family member with any of the following? Check all that apply.

- Rheumatoid Arthritis
- Heart Problems
- Diabetes
- Cancer
- Lupus
- Amyotrophic lateral sclerosis (ALS)
- Other: _____

11) Check all that applies to your health history. *Please check the appropriate column.*

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12) List ALL medications you are CURRENTLY taking. Please be specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

13) List ALL supplements you are CURRENTLY taking. Please be specific.

Supplement	Dosage	For What Condition?	How long have you been taking this?

14) List ALL surgical procedures you have had. _____

15) What activities do you perform at work?

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer Work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Drives: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Performs Manual Labor: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Reads: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Travels Frequently: | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly |

16) What activities do you enjoy? _____

17) Have you ever been hospitalized? Yes No If yes, why? _____

18) Have you been to a chiropractor before? Yes No If yes, how long ago? _____

19) How was your past chiropractic experience? Great Good Fair Mixed Poor

Other: _____

20) Who else have you seen for your problem?

- | | | |
|---|---|--|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Primary Care Physician | <input type="checkbox"/> Massage Therapist |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Neurologist | <input type="checkbox"/> No one |
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> ER Physician | <input type="checkbox"/> Other: _____ |

21) How long have you had this problem? _____

22) How do you think your problem began? _____

23) Do you consider your problem severe? Yes Yes, at times No

24a) What aggravates your problem? _____

24b) What alleviates your problem? _____

25) What concerns you the most about your problem? What does it prevent you from doing? _____

26) How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

27) How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

Have you had any significant past trauma? Yes No If yes, explain: _____

Any additional comments or concerns you wish to add: _____

By signing below, I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, and, if necessary, diagnostic x-rays. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Patient Name: _____ Date: _____

Patient Signature: _____ CA Signature: _____

DO NOT WRITE BELOW THIS LINE

What did the patient score on the revised Neck Oswestry Index? _____ Back Oswestry Index?__

ANAYLSIS: _____

DIAGNOSIS: _____

Patient Accepted: YES NO Referred Out Doctor's Signature _____

CA Instructions: _____

Please also download and complete the Back Index and Neck Index paperwork available on our website.

Who is financially responsible for your bill?

- Myself - Self Pay
 - Please give your photo ID to the front desk.
- Medicare
 - Please give your photo ID to the front desk.
 - Please ask front desk for an ABN.
- Medicaid
 - Please give your card/stickers and photo ID to the front desk.
- Worker's Compensation
 - Please give your photo ID to the front desk.
 - Please ask front desk for additional WC paperwork.
- Personal Injury (Auto)
 - Please give your photo ID to the front desk.
 - Please ask front desk for additional PI paperwork.
- Personal Health Insurance
 - Please give your insurance card and photo ID to the front desk.

Company Name: _____ Phone: _____

Policy # _____ Group # _____

Insured Person's Name: _____ Date of Birth: _____

Name of Primary Policy holder: _____ Date of Birth: _____

Relationship to you: _____ SS # of Primary: _____

By signing below:

- I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself.
- I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt.
- I understand that if I suspend or terminate my insurance, any fees for services rendered me will be immediately due and payable.
- **I understand that payment from insurance companies are an estimate only.**
- **I agree that I am financially responsible for all services incurred in this office regardless of my insurance coverage.**

Patient Name: _____ Date: _____

Patient Signature: _____ CA Verification: _____

Guardian, if minor: _____ Relationship to patient: _____

Payment Policy

As a courtesy to our patients, Garden Chiropractic (GC) offers the following billing choices.

Please initial the payment plan that applies to you & sign below.

_____ **SELF PAY**

- I will pay for all services as they are rendered on the date of my visit.
- I understand that I may contact GC for required documentation if I choose to submit my own insurance claims.

_____ **INSURANCE SUBMITTAL**

- I would like to assign my insurance benefits to GC and have you submit my insurance claims for me.
- If applicable, I understand that I am responsible for obtaining any necessary pre-authorization from my primary care physician.
- I agree to sign over to GC, within 5 business days, any insurance checks mailed to me that are owed for services received at GC.
- Although we at Garden Chiropractic (GC) will contact your insurance company to verify your benefits, we recommend that you also call in order to fully understand your plan options.
- If you are aware of any limitations on your insurance benefits, please notify us immediately to allow us to try to maximize your coverage.
- I understand that I am responsible for any balance due as billed to me by GC that results from co-payments, deductibles, or non-covered services.
- I agree to pay in full within 30 days of receipt of statement for balance due.

_____ **PERSONAL INJURY CLAIM / AUTO ACCIDENT (PI)**

- I was involved in an accident and would like to assign benefits to GC and have them submit all charges to the insurance for me.
- I will sign all liens necessary to protect your office.
- I understand that, regardless of the settlement, I am personally responsible for the entire balance.
- If GC is not paid within 30 days of the case settlement, I will personally pay the entire overdue balance.

_____ **WORKER'S COMPENSATION CLAIM (WC)**

- I was involved in an injury at work.
- I will ensure that my employer files the appropriate paperwork as needed for GC to receive compensation.
- I understand that it is in my rights as an Alaskan resident to have any bills paid that are incurred as a result of a work related injury.
- If my claim is not paid to GC within 60 days, I understand that I am responsible for the overdue balance.

By signing, I agree to the billing terms above and I understand the following:

- There is a **\$26.50** service charge on all returned checks.
- Our massage appointments require a **24 hour notice of cancellation**. With notice of less than 24 hours, I understand I will be billed a **\$50.00** 'no show' fee. NO exceptions. If I have insurance, PI or WC, the monies owed are my responsibility, NOT the insurance company's.
- If my account becomes delinquent & defaults to a collections status; I understand I will be charged a collections fee of **20%** of the entire balance due.

Printed Name: _____ Date: _____

Signature: _____ CA Verification: _____

Privacy Notice Acknowledgment

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, as it outlines the uses and limitation of the disclosure of your health information and your rights as a patient. If you have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have read, and received, if requested, a copy of *Garden Chiropractic's Notice of Privacy Practices for Protected Health Information.*

Patient Name Printed

Date

Patient Signature

Guardian signature, if minor

Relationship to Patient

A copy of our Privacy Policy may be downloaded and read or printed from our website if needed.