Adult Intake Form

Patient Information

Date_____

First Name_____ MI_____ Last Name _____

Birthdate_____ Age_____ Gender _____

Address _____

City/State/Zip _____

Home Phone number _____ Cell Phone number _____

Work Phone number _____ Email_____

Occupation _____

Employer_____

Marital Status S/M/D/W Spouse _____

Name & Ages of Children _____

How did you hear about our clinic? _____If a friend, who? _____

Present Health Challenge(s)

What brings you into the office today? _____

What do you believe is the cause of this condition(s) _____

When did your symptoms begin? _____ Is it Better/Worse/No Change?

Does anything make it better? Yes/No If yes, please list _____

Does anything make it worse? Yes/No If yes, please list_____

Is the pain: ☐ Constant ☐ Come and go Rate severity of pain (0-no pain, 10-severe) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Ache ☐ Tingle ☐ Numbness ☐ Swelling
☐ Shooting ☐ Burning ☐ Stiffness ☐ Cramping

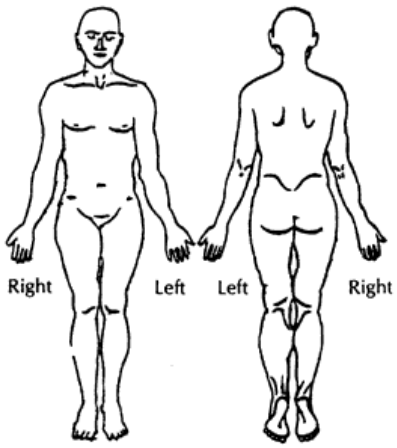
Does it affect activities of daily living? Yes/No If yes, please list _____

Have you seen anyone else for this condition? Yes/No Please list _____

Have you seen a chiropractor before? Yes/No Name of D.C. _____

Reason for that visit _____

Please mark an X on the picture of the involved areas:



Other Symptoms *(currently or in the past)*:

☐ Headache ☐ Pins/Needles in arm/legs ☐ Arm or leg pain ☐ Loss of smell or taste
☐ Fatigue ☐ Numbness in fingers/toes ☐ Cold hands/feet ☐ Depression
☐ Shortness of breath ☐ Constipation/Diarrhea ☐ Upset stomach ☐ Loss of balance
☐ Shoulder pain ☐ Ears ringing ☐ Loss of memory ☐ Chest pain ☐ Irritability
☐ Dizziness/fainting ☐ Nervousness ☐ Tension ☐ Frequent colds/flu ☐ Allergies
☐ Sinus problems ☐ Asthma ☐ Diabetes

For Women Only:

Are you pregnant? Yes/No If yes, due date: _____ Provider _____
Are you currently trying to get pregnant? Yes/No If yes, for how long have you been trying _____
Are you nursing? Yes/No Are you taking birth control? Yes/No
Do you experience painful periods? Yes/No Do you have irregular cycles? Yes/No

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Goals for My Care

People see chiropractors for a variety of reasons. Your Doctor will weigh your needs and desires when recommending your chiropractic care treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

____RELIEF CARE: symptomatic relief of pain or discomfort.
____CORRECTIVE CARE: Correcting and relieving the cause of the problem as well as the symptoms.
____WELLNESS CARE: Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care, regardless if symptoms are present or not.

Lifestyle & Past Health History Affecting Chiropractic Care

The primary system in the body which coordinates health is the CENTRAL NERVOUS SYSTEM. The vertebrae (bones of the spinal column) surround and protect the delicate NERVOUS SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the spine and nerve system.

The information below will help us to see the types of PHYSICAL, EMOTIONAL, & CHEMICAL stressors you have been subjected to and *how they may relate to your present spinal, nerve, and health status.*

Physical Stressors: childhood through adulthood

<u>Major Physical Traumas</u>

Have you had an accident or injuries in your life related to the following? (Check all that apply.)
☐Automobile ☐Motorcycle ☐Bicycle ☐Sports ☐Playground ☐Abuse

If yes, please describe the type of injury and date _____
_____
_____

<u>Minor Physical Traumas</u>

Sleep Position ☐Side ☐Back ☐Stomach Hours of sleep _____ Quality of sleep_____

How would you grade your physical health? ☐ Good ☐ Fair ☐ Poor

Do you exercise regularly? If yes, type of exercise(s) and how often _____

Emotional Stressors

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N
Work or School	Y	N	Divorce/separation	Y	N
Lifestyle change	Y	N	Abuse	Y	N
Financial	Y	N	Illness	Y	N

Chemical Stressors

Chemical stress can occur when a substance that is toxic to the body is breathed, injected, orally taken, or placed on the skin, e.g. food allergies, drug reactions, exposure to chemicals in the air, etc.

Were you vaccinated? Yes No Any adverse reactions _____
Do you smoke? Yes No # or pack per day _____

Have you been exposed to any of the following on a regular basis, past or present?

Toxic chemicals	Y	N	Secondhand smoke	Y	N
Drug therapy	Y	N	Radiation	Y	N
Chemotherapy	Y	N	Other _____		

Please list all medications _____

How would you rate your diet/nutrition? ☐ Good ☐ Fair ☐ Poor
Do you take vitamins or supplements? Yes No If yes, please list _____
Do you have any food or other allergies? _____
Beverage(s) most consumed_____ Water consumed _____ ounces/day
Do you drink: ☐ caffeine/coffee, how much_____ ☐ alcohol, how much_____

Consent to Treat/Payment Authorization

1.) I authorize the healthcare providers at Olson Chiropractic Health Center to administer treatment as deemed necessary for care of the patient named above. I certify that, if I am not the patient, I am the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made to the results that may be obtained from the treatment.

2.) I certify that I have read and understand the information provided to me on this date to the best of my ability. The questions asked verbally and in writing have been or will be accurately answered. I understand that providing incorrect information can be dangerous to my health.

3.) I authorize this office to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office any benefits for our services that may otherwise be payable to me. I understand that my insurance carrier may pay less than the actual bill for services. All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient/parent/responsible party is responsible for any unpaid balances.

Co-payments will be made at the time of service. I request that payment of authorized Medicare, Medicaid, or other insurance company benefits be made to the care providers of Olson Chiropractic Health Center for any services furnished to me by the office. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

Olson Chiropractic Health Center has my permission to contact me the following ways:

☐ Can leave message on my home answering machine ☐ Can call my cell phone

☐ May make reminder call for appointments ☐ Can call me at work

Patient Signature _____ Date_____

Emergency Contact

Name_____ Relationship_____

Work Phone _____ Home Phone _____

Patient Demographics Form for Insurance Patients

First Name: _____ **MI** _____ **Last Name** _____

Street Address: _____ City, State _____ Zip _____

Mailing Address (if different) _____ City, State _____ Zip _____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Home Phone _____ Work Phone _____

Cell Phone _____ Employed at _____

Email Address _____ Marital Status Married Single Divorced Widowed Separated Child

Spouse's Name _____ Employed at _____

Cell Phone _____ Work Phone _____

Emergency Notification Name _____ Relationship _____

Phone _____ Referring Doctor _____

Primary Insurance Company _____

Address _____

Policy # _____ Group # _____

Policy Holder (if different than above)_____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Effective Date _____ Employed at _____

Work Address _____ Work Phone _____

Secondary Insurance Company _____

Address _____

Policy # _____ Group # _____

Policy Holder (if different than above)_____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Effective Date _____ Employed at _____

Work Address _____ Work Phone _____

Please note any additional Insurance Coverage _____

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to be made directly to the physician or supplier of services rendered. Our office cannot accept responsibility for collecting an insurance claim or for negotiating disputed claims. You are responsible for payment within ninety (90) days from date of service. Insurance reimbursement is a contract between you and your insurance company. In consideration of the services rendered to me by this physician, I am obligated to pay said office in accordance with the physician's credit and policy terms.

Advance Beneficiary Notice (ABN)

Date: _____ Patient: _____

Insurance: _____

This is a notice that your insurance company may not pay for all of the services that you receive during your visit to our office.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.

Supplies and Services	**Reason(s) Insurance May Not Pay**	**Estimated Cost**
Chiropractic exam visit, adjustments, or therapies	Not a covered expense Benefits exceeded	$30-$125

_____**YES,** I want to receive these services. If my insurance carrier denies payment, I am completely responsible for payment in full. I understand that I can appeal this decision for nonpayment by my insurance carrier.

_____**No,** I have decided not to receive these services.

By signing this notice, you have received and understand this notice. You agree to take financial responsibility for the cost of the supplies and services listed above should your insurance company deny coverage for the listed items.

Guarantor Signature: _____ Date: _____