# Adult Intake Form

**Patient Information**

Date_____

First Name_____ MI_____ Last Name _____

Birthdate_____ Age_____ Gender _____ Marital Status S/M/D/W

Address _____

City/State/Zip _____

Phone number _____ Email_____

Occupation _____ Employer_____

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

Insurance Company_____

Policy #_____ Group #_____

Policy Holder (if different from above)_____

Policy Holder's Date of Birth _____ Policy Holder Employed at_____

---

**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

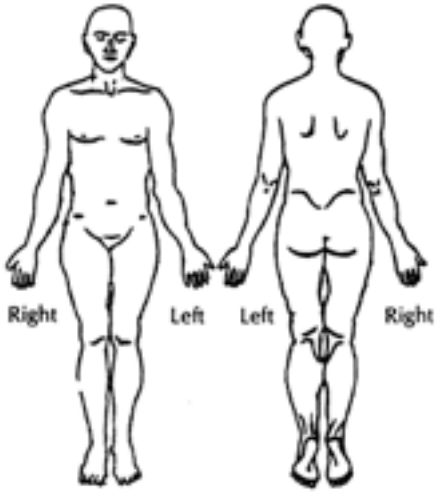
Does it affect activities of daily living? Yes/No If yes, please list _____

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

---

**Physical Stressors: childhood through adulthood**
Major Physical Traumas
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 _____
_____

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

---

**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.

---

**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 _____ Cell Phone _____

**Missed Appointment Policy**

There is now the implementation of a no-show policy for missed appointments.
The first appointment going forward (from the date signed below) where a patient misses or calls to cancel an appointment without the proper **3 HOUR NOTICE** is waived. *Emergency situations will be determined and handled on a case by case basis.*
Every appointment thereafter where no **3 HOUR NOTICE** is given, a patient is charged $25 (to be collected at the next visit). This policy is per person. For families, the charge will still be $25 per person scheduled.

Patient Signature _____ Date_____

**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<br>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:_____