HOPE CHIROPRACTIC INTAKE FORM

Date_____ Referred By_____

Name (Last)_____ (First)_____MI_____
Date of Birth_____Sex: M____F____Social Security #: _____
Marital Status: Single_____Married_____Divorced_____Other _____
Address_____City_____Zip _____
Phone: Home ( )_____Cell ( )_____Work ( ) _____
Preferred Phone #: Cell____Home_____Work_____ E- Mail address: _____

Employer_____Occupation _____
Name of Emergency Contact_____Relationship_____
Number of Emergency Contact_____

Have you see a Chiropractor before? Y N Who?_____When?_____
Name of Referring Chiropractor or MD/DO_____

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____

Rate your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable

Other doctors you have seen for this condition:_____MD_____DC____DO_____DDS_____Other
Who_____
When did this condition begin?_____If accident related, date of accident _____
Which of the following is your condition interfering with? Work_____Sleep_____Daily Routine _____
Has this condition occurred before: Yes_____No _____
Is condition: Job Related? _____ Auto Accident?_____Home Injury? _____ Fall? _____
Major recent life changes _____

How Long has it been since you really felt good? Days _____ Weeks _____ Months _____ Years _____
Which of the following do you take now?(prescription and over the counter) Pain Killers _____
Muscle Relaxants_____Blood Pressure Medication _____
Other (please list) _____
Do you suffer from any other condition(s) or pains other than the one you are consulting us for? _____ If so, please describe.

_____
_____
_____
_____
_____

*__Women Only-Is there any chance that you are pregnant?_____Yes_____No__
If no, please sign here:
Patient Denies Pregnancy **X**_____

PAST HEALTH CONDITION

List Past Conditions: (Include dates and type of treatment for each condition described)

Major Surgery/Operations(Include Date and Outcome): Appendectomy _____
Tonsillectomy_____Gall Bladder _____
Hernia_____Back Surgery_____Broken Bone(S) _____
Other: _____
Comments:_____

Hospitalizations (Other than Above)

Sports Injuries

Other major accidents or falls (starting from childhood)

PLEASE CHECK ALL PRESENT SYMPTOMS

HEAD

☐ Headaches
_____Sinus _____Migraine
_____Forehead_____Temples
_____Entire head
_____Back of head
☐ Head feels heavy
☐ Loss of memory
☐ Light bothers eyes
☐ Blurred vision
☐ Loss of taste
☐ Loss of balance
☐ Dizziness
☐ Loss of hearing
☐ Pain in ears
☐ Buzzing in ears

NECK

☐ Neck pain (constant)
☐ Neck pain (with movement)
_____forward_____backward
_____turn to left_____to right
_____bend to left_____to right
☐ Pinched nerve in neck
☐ Muscle spasms in neck
☐ Grinding sounds in neck
☐ Arthritis in neck

SHOULDERS

☐ Pain in shoulder joint (R L)
☐ Pain across shoulders
☐ Bursitis (R L)
☐ Can't raise arm
_____above shoulder level
_____over head
☐ Shoulder tension
☐ Pinched nerve (R L)
☐ Muscle Spasms

ARMS & HANDS:

☐ Upper arm pain (R L)
☐ Elbow pain (R L)
☐ Tennis elbow (R L)
☐ Forearm pain (R L)
☐ Hand pain (R L)
☐ Finger pain (R L)
☐ Sensation of pins and needles
_____in arms_____in fingers
☐ Numbness in arms (R L)
☐ Numbness in fingers (R L)
☐ Fingers go to sleep
☐ Aggravated by movement
☐ Cold hands
☐ Swollen joints in fingers
☐ Sore joints in fingers
☐ Loss of grip strength

MID-BACK

☐ Mid-back pain
☐ Pain between shoulders
_____sharp stabbing
_____dull ache
☐ Pain from front to back
☐ Muscle Spasms
☐ Kidney pain

CHEST

☐ Chest pain
☐ Shortness of Breath
☐ Pain around ribs
☐ Irregular heartbeat

ABDOMEN/GI

☐ Nervous stomach
☐ Nausea
☐ Gas
☐ Constipation
☐ Diarrhea
☐ Hemorrhoids

LOW BACK

☐ Low back pain
_____lumbar
_____sacroiliac
☐ Muscle spasms

Pain is worse when:

_____working
_____bending
_____lifting
_____coughing
_____stooping
_____standing
_____lying down
_____sitting
_____walking

Pain is relieved when:

_____

HIPS, LEGS, FEET:

☐ Buttocks pain (R L)
☐ Hip joint pain (R L)
☐ Pain down leg (R L)
_____ front
_____side
_____back
☐ Pain down both legs
☐ Knee pain (R L)
☐ Leg/ foot cramps (R L)
☐ Numbness in legs (R L)
☐ Numbness in feet (R L)
☐ Numbness in toes (R L)
☐ Feet feel cold

WOMEN ONLY

☐ Menstrual pain
☐ Cramping
☐ Irregularity
☐ Abortions
☐ Hysterectomy
☐ Genital Cancer
☐ Discharge
☐ Tumors
☐ Menopausal
Method of birth control

_____

MEN ONLY

☐ Urinary frequency
☐ Difficulty starting
☐ Night urination
☐ Prostrate pain/swelling

GENERAL

☐ Nervousness
☐ Depressed
☐ Fatigue
☐ Feel Run Down
☐ Irritable
☐ Difficulty in sleeping
☐ Weight Loss
☐ Weight Gain
☐ Diabetes
☐ Hypoglycemia
Daily Intake:
Coffee _____
Tea _____
Cigarettes_____
Alcohol_____
Other_____

FINANCIAL POLICY & FEE SCHEDULE

Initial Examination & X-rays	$160.00
Additional X-rays	$ 20.00
Cervical AO X-rays	$ 60.00
Regular Adjustment	$ 65.00
One Region Adjustment	$ 30.00
Nutritional Consultation (30 Minutes)	$ 70.00
Body Composition Analysis	$ 25.00
Migun Table Session	$15.00
No-Call/No-Show Fee	$ 30.00

Payment

- Payment for services provided is expected at the time of service.
- All professional services are rendered to & charged to the patient receiving care or to the responsible adult in the case of a minor.
- This payment policy also applies to Personal Injury and Workman's Compensation cases.

Insurance

- If you are covered by insurance in any form, including Medicare, we will provide you with a diagnostic receipt that will help you receive payment from your carrier.

Medicare

- You are responsible for payment of all services at the time of service.
- Medicare Fees are set by the Federal Government and we must charge what they set.
- As required by Federal Law, we will file the mandatory forms for you each month, in an effort to have you reimbursed for covered services.

Returned Check Policy

- We will charge $30 for returned checks.

I acknowledge that I have read, understand, and accept the terms of the above Financial Policy & Fee Schedule.

Name: (Please Print) _____

Signature:_____ **Date:** _____

Cancellation Policy

It is understood that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all our patients and out of consideration for other patient's time, we have the following policies:

Cancellation ☐ Initial to confirm policy understanding and acceptance.

- 24 hour advance notice is greatly appreciated when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment.
- If you are unable to give us 24 hour advance notice, it is still important to call us as soon as possible to reschedule and avoid a "no-show" fee.

No-show Fee ☐ Initial to confirm policy understanding and acceptance.

- Anyone who misses their appointment will be considered a "no-show" and will be charged $30 for their missed appointment and future service may be denied until payment is made.
- This policy is applied universally to all missed appointments.

Arriving late ☐ Initial to confirm policy understanding and acceptance.

- Appointment times are limited in number and your time has been arranged specifically for you. To help us stay on time please plan on arriving to your appointment 5-10 minutes early.
- If you are late to your appointment, that appointment may be shortened in order to accommodate other appointments that follow yours.
- Depending on how late you arrive, it will be determined if there is enough time to start treatment and still provide you with effective care. If there is not enough time to perform an adequate treatment, you will be asked to reschedule.

WE LOOK FORWARD TO SERVING YOU!

I acknowledge that I have read, understand, and accept the terms of the above Cancellation Policy.

Name: (Please Print) _____

Signature:_____ **Date:** _____