New Patient Intake Form

WELCOME TO Active Family Chiropractic & Wellness

Today's Date: _____

Name: _____

Birth Date: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Occupation: _____ Employer: _____ City: _____

Marital Status: S M D W Spouse's Name: _____

Number of Children: _____ Women- Are you currently pregnant? Y N If yes, how far along? _____

Whom may we thank for referring you to our office? ☐ Website ☐ Lunch-n-Learn/Dinner ☐ Facebook Ad

☐ Person: _____ ☐ Other: _____

Experience with Chiropractic or Functional Medicine (circle)? Reason: _____ Year: _____

Primary reason for today's appointment: _____

Secondary Health Concerns/Issues: _____

How many Prescription Medications are you currently taking? _____

For what conditions? _____

Vitamins/Supplements taken regularly: _____

_____

Quality of Life Survey

Please take several minutes to answer these questions so we can help you get better. (Check as many that apply)

1 How have you taken care of your current condition in the past?

☐ Medications ☐ Emergency Room ☐ Routine Medical

☐ Exercise ☐ Nutrition/Diet ☐ Holistic Care

☐ Vitamins ☐ Chiropractic ☐ Other: _____

2 How did the previous method(s) work out for you?

☐ Bad results ☐ Some results ☐ Great results ☐ Still trying

☐ Nothing changed ☐ Did not get worse ☐ Did not work very long ☐ Confused

3 How have others been affected by your health condition?

☐ No one is affected ☐ Haven't noticed any problem

☐ They tell me to do something ☐ People avoid me

4 What are you afraid this might be (or beginning) to affect (or will affect)?

☐ Job ☐ Kids ☐ Future ability ☐ Marriage ☐ Sleep

☐ Time ☐ Finances ☐ Self-esteem ☐ Freedom

5 Are there health conditions you are afraid this may turn in to?

☐ Family health problems ☐ Heart disease ☐ Cancer ☐ Diabetes

☐ Arthritis ☐ Fibromyalgia ☐ Depression ☐ Chronic Fatigue ☐ Need surgery

→ How has your health condition affected your job, relationships, finances, family, or other activities?

(Please give examples) _____

_____

_____

_____

→ What has this cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

_____

_____

_____

→ What are you most concerned with regarding your problem?

_____

_____

→ Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

_____

_____

_____

→ What would be different/better without this problem? Please be specific.

_____

_____

→ What do you desire most to get from working with us?

_____

_____

_____

→ What would that mean to you?

_____

_____

_____

"Trust Your Gut" Wellness Evaluation

In medicine today, intestinal permeability, aka leaky gut, isn't typically diagnosed. However, that doesn't mean it's not affecting your health. Leaky Gut can not only cause digestive issues, but it can contribute to several other conditions including migraines, skin and joint conditions, hormonal and immune imbalances, and autoimmune conditions. Please take this evaluation to help our doctors determine if there are underlying factors triggering your symptoms or condition.

Please circle any that apply.

Sub-Clinical Symptoms:

Headaches and Migraines

Hormone Imbalance:

PMS
Emotional imbalance

Gastrointestinal Issues:

Abdominal bloating/cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease or other intestinal disorders

Respiratory Conditions:

Chronic sinusitis
Asthma
Allergies

Autoimmune Conditions:

Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

Developmental & Social Concerns:

Autism
ADD/ADHD

Skin Conditions:

Eczema
Skin rashes
Hives

"Trust Your Gut" Quiz

Please rate the following symptoms as they pertain to you.

0= None 1= Mild 2= Moderate 3= Severe

Constipation and/or diarrhea	0	1	2	3	Asthma, hay fever or airborne allergies	0	1	2	3
Abdominal pain or bloating	0	1	2	3	Confusion, Poor memory, or mood swings	0	1	2	3
Mucous or blood in stool	0	1	2	3	Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3	History of Antibiotic use	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3	Alcohol consumption makes you feel sick	0	1	2	3
Food allergies, sensitivities, or intolerance	0	1	2	3	Ulcerative colitis or Celiac's disease	0	1	2	3
Sinus or nasal congestion	0	1	2	3	Nausea	0	1	2	3
Chronic or frequent inflammation	0	1	2	3	Weight Trouble	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3					

Total Score: _____

Thank you for taking the time to give us detailed information about your condition.

Your specific answers help us to help you!

Patient Acknowledgement and Receipt of

Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Patient's Printed Name: _____ Date:_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Patient's Signature: _____

If patient is a minor or under a guardianship order as defined by State law:

Signature of Parent/Guardian: _____

Chiropractic Informed Consent

I will use my hand or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "popping" sound as part of the process.

There are certain complications that may occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, sprains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains, separation and/ or fracture. Rare complications may include, but are not limited to stroke. The most common complication or complaint following a spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence, I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining your for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. **If you are pregnant, you should tell the doctor when your clinical history is taken.**

Printed Name: _____

Signature: _____ Date: _____

Signature of Parent or Guardian (if minor):_____

Insurance Information

Policy Holder Information

Name on card: _____

Date of birth: _____ Relationship to patient: _____

Address (if different than patient):_____

Please check any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident

Medical Savings Account & Flex Plans Other: _____

Insurance Policy Information

Primary Insurance Company name: _____

Insurance Plan: HMO PPO Other: _____

Insurance Company phone #:_____

Policy/Member #:_____

Group #:_____

*Please let us know if you also have a secondary insurance you would like to file.

Authorization and Financial Responsibility

I authorize the release of any medical or other information necessary to process my claims. I assign directly to Active Family Chiropractic & Wellness all insurance benefits, if any, otherwise payable to me for services rendered.

I certify that the above information is correct. I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

***_____ _____**

Signature of Patient (or person acting on patient's behalf) Date