Patient Intake Form

Date: ___________________________ Name: ____

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: ________________________________

If "NO" please skip to next section

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: ____

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: __________________

Briefly describe the accident, injury or illness:____

____

____

____

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom

_______________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

_______________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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List any tests, studies or medications received for this condition:

❑Tests/Studies: ______ ❑Medications: ______

Where you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? _______________________Transported by? ❑Ambulance ❑Police ❑Other: _____________________

Date Admitted: ________________ Date Released: _____________ Length of Stay: _______________

List the hospital procedures received: ____

List symptoms you are experiencing today: Choose the severity level associated with each symptom

_______________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Do you have any current work restrictions due to your current condition?

Off work: ❑Yes ❑No ❑Previously From: _____________________ To: _____________________

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) _________________________________

What type of work do you do?____

____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No ______________________

____

List any past conditions you may have had: ____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	❑

HABITS

				EXERCISE
❑Current Every Day Smoker		❑Current Some Day Smoker		❑None
❑Former Smoker		❑Never Smoker		❑Moderate
❑Drinking	Alcohol: (Cups/day): _____	❑Coffee	Cups/Day: _______	❑Daily
❑Soft Drink	Bottles or Cans/Day: _____	❑Water	Cups/Day: _______	

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No
If Yes, please indicate the following:

Medication: ______________________________
Route: Oral
Intravenous
Other: ____________________
Frequency: __________________________
Began Use: __________________________
Discontinued Use: ____________________

Medication: ______________________________
Route: Oral
Intravenous
Other: ____________________
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Began Use: ______________________________
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Intravenous
Other: ____________________
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Discontinued Use: ____________________

Medication: ______________________________
Route: Oral
Intravenous
Other: ____________________
Frequency: ______________________________
Began Use: ______________________________
Discontinued Use: _________________________

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Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: ____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: ______________________________ Allergy: ______________________________
Reaction: _____________________________ Reaction: _____________________________
Start Date: ____________________________ Start Date: ____________________________
End Date: _____________________________ End Date: _____________________________

Allergy: ______________________________ Allergy: ______________________________
Reaction: _____________________________ Reaction: _____________________________
Start Date: ____________________________ Start Date: ____________________________
End Date: _____________________________ End Date: _____________________________

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
	Back Operation		Hernia	________________	Gall Bladder
	Female Organs		Thyroid	________________	Stomach

Other ____

Have you ever had X-rays taken? ❑Yes ❑No When? ___________________ By Whom?

For what ailments were these X-rays taken?

PAST OR CURRNET SYMPTOMS

GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR NOSE/THROAT	RESPIRATORY
❑ Allergy(What) ____ ________________	❑ Belching or Gas	❑ Asthma	❑ Chest Pain
	❑ Colon Trouble	❑ Deafness	❑ Chronic Cough
❑ Bronchitis	❑ Constipation	❑ Earache	❑ Difficulty Breathing
❑ Chills (Constant)	❑ Diarrhea	❑ Ear Discharge	❑ Spitting Blood
❑ Convulsions	❑ Gall Bladder Trouble	❑ Ear Noises	❑ Spitting Phlegm
❑ Dizziness	❑ Hemorrhoids (piles)	❑ Thyroid Problems	
❑ Fainting	❑ Jaundice	❑ Frequent Colds	**GENITO-URINARY**
❑ Fatigue	❑ Liver Trouble	❑ Hay Fever	❑ Bed Wetting
❑ Headache	❑ Nausea	❑ Nasal Obstruction	❑ Blood in Urine
❑ Loss of Sleep	❑ Stomach Pain	❑ Nose Bleeds	❑ Frequent Urination
❑ Loss of Weight	❑ Vomiting	❑ Pain in Eyes	❑ Inability to Control Urine
❑ Nervousness	❑ Vomiting Blood	❑ Poor Vision	
❑ Night Sweats	❑ Heart Burn	❑ Blurred Vision	❑ Kidney Infection
❑ Numbness or Pain in arms/legs/hands	❑ Bloody Stools	❑ Sinusitis	❑ Kidney Stones
	❑ Acid Reflux	❑ Sore Throats	❑ Painful Urination
❑ Wheezing	❑ Irritable Bowel	❑ Tonsillitis	❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?

________ Last Pap Date

________ Last Menstrual Cycle

Disclosure statement: All health care fields (chiropractic, medical, dental, etc…) have the potential to help there is also a risk for injury. Chiropractic care has been extensively studied and proven to be the safest and most inexpensive form of health care. We have and will continue to take the necessary steps to keep our services as natural, safe and effective as we are capable of for you, your family and our community.

Office Financial Policy

1. PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

Payment can be made with cash, check, debit or credit card.

2. HEALTH INSURANCE

It is important that you understand that health and accident insurance policies are an arrangement between you and your insurance carrier. **YOU ALONE ARE RESPONSIBLE FOR ALL CHARGES INCURRED IN OUR OFFICE**. We expect payment in full when services are rendered until your insurance coverage is verified

Insurance companies base your coverage ability on things other than your health (ie. Your policy, national averages etc.) Our recommendations are always based on your health, your goals and our experience. Ultimately it is your investment in your health that determines what we will and will not do.

It has been our experience that insurance companies never pay for wellness care. Any and all wellness care therefore is your responsibility.

Payment of your Co-pays, deductible, and coinsurance (the portions your insurance does not pay) is expected at each visit unless other payment arrangements have been made in writing. In cases where your coverage is 100%, payment may not be required.

3. WORK COMP/ AUTO-PERSONAL INJURY

Verification of coverage is needed **before** we can file your claim for you.

All necessary information to file your claim must be provided at your first visit. You are responsible for all charges incurred in our office.

-I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims; including, but not limited to, hospital or medical service companies, insurance companies, worker compensation carriers, welfare funds, or patients employer.

-I understand all incurred costs used to collect payment are the responsibility of the patient. All extra costs will be added to my account

-I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health status.

-I authorize Excel Chiropractic and the appropriate personal to retain my debit/credit card information on file to use to keep my account current. I realize that the information will only be used with prior notice from an Excel Chiropractic team member.
-I authorize Excel Chiropractic and the appropriate personal thereof to disclose the results of my DOT examination to include but not limited to current or perspective employers, state employees, law enforcement, federal employees, or as deemed necessary by Excel Chiropractic.

Card number: ___________________________________ Exp. Date: _____________ CVC: ________ Type: Visa / MasterCard / Discover

Signature: ____ Date:____________________________

Permission to Treat a Minor (To be completed if patient is under age 18)

I, (Parent or Guardian) ____ (please print) give Excel Chiropractic permission to examine, x-ray and treat:

(Patient)____ (Print Please)

Signature: ____ Date: __________________________________