ELITE CHIROPRACTIC

PATIENT INTAKE FORM

DATE: ____ /____ /____

PERSONAL INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Social Security Number: _____

Address: _____

City / State / Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Email: _____

Birth Date: ____ /____ /_____ Age: _____ Sex: M F

Occupation: _____ Employer's Name: _____

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

# of Children: _____ Children's Names & Ages: _____

_____

Who can we thank for referring you or how did you hear about our office? _____

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Elite Chiropractic? _____

_____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

_____

What is this affecting that is MOST important in your life? (List all that apply) _____

_____

Have you seen any other providers for this condition? (List all that apply) _____

_____

Have you seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

What is your level of commitment to yourself and your health? 1 2 3 4 5 6 7 8 9 10

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

_____

Print Patient's Name: _____ Date: _____

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Digestive Troubles
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Hypertension
- ☐ Arthritis
- ☐ Loss of Balance
- ☐ Neck/Back Pain
- ☐ Pain in Arms/Legs
- ☐ Irritabilty
- ☐ Fatigue/Sleep Issues
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Sensitivity to Light
- ☐ Loss of Concentration
- ☐ Memory Problems
- ☐ Headaches
- ☐ Stiffness/Flexibility
- ☐ Sinus Troubles/Allergies
- ☐ Cold Hands/Feet
- ☐ Other _____

Explain any boxes checked above or add additional concerns:

_____

_____

_____

_____

_____

Is there anything else regarding your current condition you feel the doctor should know? _____

_____

_____

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Blood Pressure
- ☐ Pain Narcotics
- ☐ Muscle Relaxers
- ☐ Migraine/Headache
- ☐ Cholesterol
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Other_____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above: _____

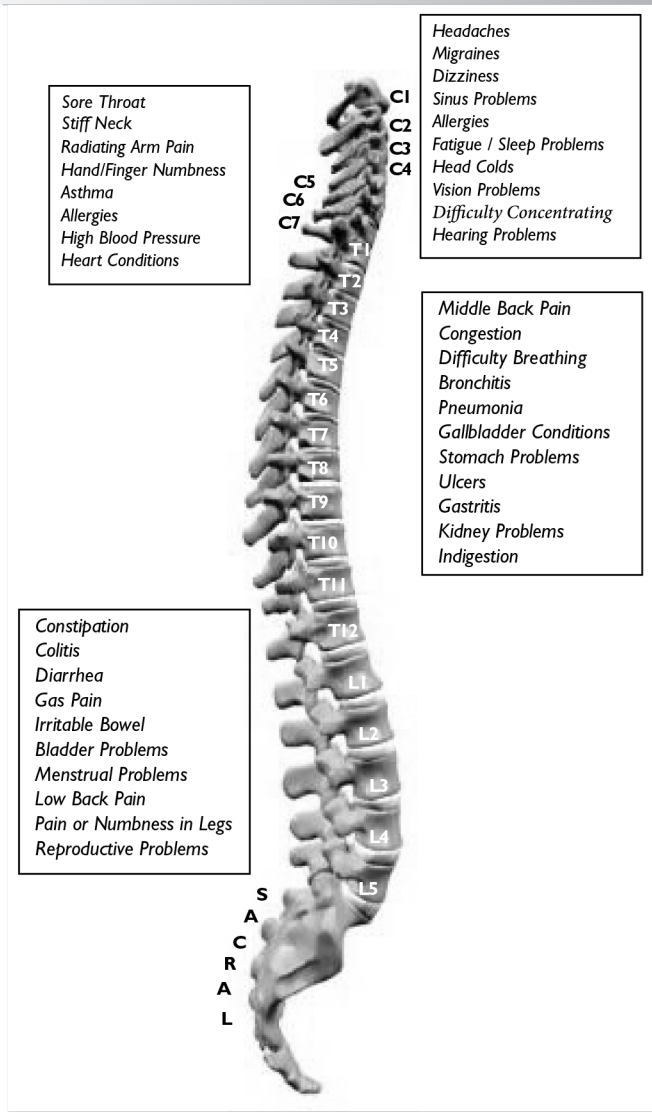
_____

_____

_____

DID YOU KNOW...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



VITAMINS / SUPPLEMENTS

- ☐ Multi-Vitamin
- ☐ Vitamin D3
- ☐ _____
- ☐ _____
- ☐ Fish Oil/Omega-3
- ☐ Probiotics
- ☐ _____
- ☐ _____

Explain any boxes checked above:

_____

_____

_____

EMERGENCY CONTACT

First Name: _____ M.I.: _____

Last Name: _____

Preferred Name:_____

Address:_____

City / State / Zip: _____

Phone: ( ) _____ Relation: _____

Print Patient's Name: _____ Date: _____

HEALTH STATUS QUESTIONNAIRE

YOUR PHYSICAL LIFE

Rate based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Presence of physical pain	1	2	3	4	5	Incidence of colds or flu	1	2	3	4	5
Feelings of tension, stiffness, lack of flexibility	1	2	3	4	5	Ability to work out or engage in activity	1	2	3	4	5
Incidence of fatigue or low energy	1	2	3	4	5	Incidence of chronic disease	1	2	3	4	5

MENTAL/EMOTIONAL STATE

Rate based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Presence of negative feelings/energy	1	2	3	4	5	Being overly worried about small things	1	2	3	4	5
Moodiness, temper, or angry outbursts	1	2	3	4	5	Difficulty thinking or concentrating	1	2	3	4	5
Difficulty falling or staying asleep	1	2	3	4	5	Feeling of depression or anxiety	1	2	3	4	5

CHEMICAL/NUTRITIONAL LIFE

Rate based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Eat a well-balanced diet	1	2	3	4	5	Eat an organic, grass fed, hormone-free diet	1	2	3	4	5
Eat a diet rich in fruit and vegetables	1	2	3	4	5	Use a lot of chemicals on your skin	1	2	3	4	5
Eat fast food or highly processed food	1	2	3	4	5	Ingestion of chemicals	1	2	3	4	5

STRESS EVALUATION

Rate based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Family	1	2	3	4	5	Work/school	1	2	3	4	5
Significant relationship	1	2	3	4	5	Day-to-day stress	1	2	3	4	5
Health	1	2	3	4	5	Finances	1	2	3	4	5

LIFE ENJOYMENT

Rate based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Experiences of relaxation, ease, or well-being	1	2	3	4	5	Compassion and acceptance	1	2	3	4	5
Interest in maintaining a healthy lifestyle, diet, etc.	1	2	3	4	5	The level of recreation in your life	1	2	3	4	5
Time devoted to things you enjoy	1	2	3	4	5	Your physical appearance	1	2	3	4	5

What else about your health or your life do you feel is important for the doctor to know?

_____

_____

_____

_____

X-RAY CONSENT FOR WOMEN OF CHILDBEARING AGE

X-ray examination of the abdomen and pelvis expose the uterus to radiation. The last ten days following onset of the menstrual cycle are generally considered safe for x-ray examination.

Date of onset of last menstrual period:_____
I am pregnant: Yes No
I had a hysterectomy: Yes No
I use an IUD: Yes No

I recognize that if I am pregnant and have radiation to the abdomen, there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this examination is important to my health. I therefore wish to have this x-ray examination performed now.

Patient signature: _____ Date: _____

Guardian signature: _____ Date: _____

Witness signature: _____ Date: _____

Print Patient's Name: _____ Date: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, your care plan must be followed.
- A $25 fee will be charged to your account for any appointments missed without a 24 hour notice of cancellation. We require a credit or debit card on file due to this policy.
- I authorize Elite Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- In order to file your claims in a timely manner (if applicable), we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
- Late payment for non-coverage, deductible, and co-payment will be subject to an 18% annual finance charge, which will be added monthly to your account.
- If you have any questions about our financial policies, please speak with our staff. If you need to make special payment.

Patient Signature: _____ Date: _____

CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic adjustments and other procedures (diagnostic x-rays if necessary) by Dr. Scott Nigbor and his staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with Dr. Scott Nigbor and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Elite Chiropractic will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Elite Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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