

Today's Date: _____

Information for Patient Care

Patient: _____ DOB: _____ Age: _____ Sex: (M / F)
Social Security # _____ Race: _____ Ethnicity: _____
Current Address: _____ City: _____ State: _____ Zip: _____
Billing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
E-mail: _____ Would you like to receive e-news letters? (Y / N)
Employer _____ Occupation _____ Years Employed _____
Employer Address _____ City _____ State _____ Zip _____
Marital Status: S M W D Number of Children: _____
Name of Spouse: _____ Spouse's DOB: _____
Spouse's employer: _____ Spouse's cell: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
How did you hear about us? _____

Insurance Information If Patient is not Primary Card Holder

Insured's Name: _____ ID#: _____ Insured's Sex: (M / F)
Insured's Birth date: _____ Relationship to Insured: (Spouse / Child / Other)
Insured's Employer: _____ Insured's Social Security # _____

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

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable. **A \$25.00 fee will be charged for NO SHOW and LATE CANCELLED appointments.**

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Notice to our new patients: Full payment of co-payment or services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Patient's Signature: _____ Date: _____
Parent or Guardian Signature Authorizing Care: _____ Date: _____

Health Inventory

Major Complaint Today: _____
Is this the result of an accident? auto work related at home other
Have you ever been in an accident? yes no
*If you have no symptoms or complaints today and are here for wellness services, please check here: ()
How long have you had this condition? _____ What have you done for it? _____
What aggravates this condition? _____
Have you been treated for any health conditions in the past year? Yes _____ No _____
If yes, please describe _____

Have you had any previous surgeries or illnesses? _____

Do we have your permission to discuss your condition? (Yes / No)

If yes, with whom? _____ Relationship _____

Primary Care Doctor: _____

May we share your treatment at Inline Healing with your Primary Care Doctor? _____

Have you had any prior Chiropractic Care? _____ If so, what were you being treated for? _____

What medications are you currently taking? _____

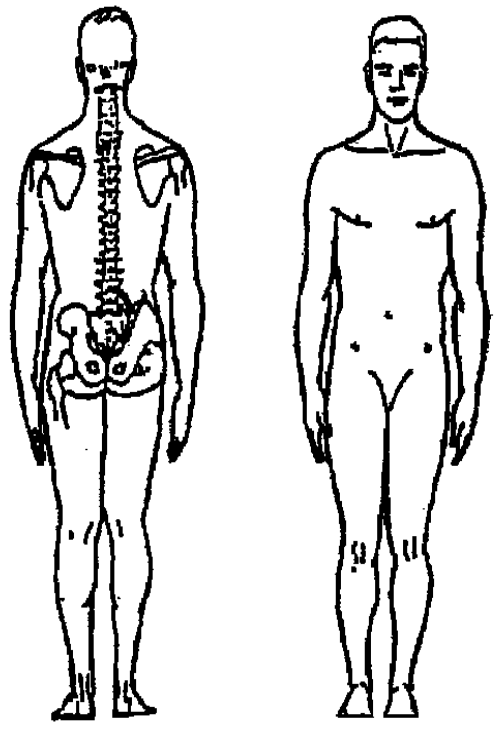
If any, what are you taking the medications for? _____

Are you or is there a possibility you are pregnant? _____

Have You Ever Suffered From:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Pain or stiffness | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Ear Noises |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Spinal curvatures | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Difficult digestion | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Difficult breathing |
| <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Kidney infection or stone |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cramps or backache | |

Tingling or numbness in: Shoulder ___ Arms ___ Elbows ___ Hands ___ Hips ___ Legs ___ Knees ___ Feet ___



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram and check the type of pain and frequency of your pain.

- | | |
|----------------|--------------------|
| _____ Pain | _____ Numbness |
| _____ Spasm | _____ Sharp |
| _____ Dull | _____ Tenderness |
| _____ Constant | _____ Intermediate |
| _____ Radiates | |

Does the pain increase or decrease when:

- | | | |
|------------|---------------|---------------|
| Sitting | () decreases | () increases |
| Standing | () decreases | () increases |
| Walking | () decreases | () increases |
| Running | () decreases | () increases |
| Stretching | () decreases | () increases |

Pain Index: Circle One

Least 1 2 3 4 5 6 7 8 9 10 Worst

How would you describe your overall health? () Good () Fair () Poor

Do you drink alcoholic beverages? () Yes () No If so, () daily () weekly () monthly

Do you use any tobacco products? () Yes () No If so, packs per day: _____

Do you consume caffeine products? () Yes () No If so, how much per day: _____

Do you exercise? () Yes () No If so, frequency and type of exercise: _____

What percentage of your time during the day do you spend: Standing _____ Lifting _____ Sitting _____

Bending _____ Working at a computer _____



FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Please review the below-listed diseases and conditions and indicate those that are recurrent health problems of a family member. Leave blank those that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar environments.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTER(S)		CHILDREN		
	Age()	Age()	Age()	Age()	Age()	Age()	Age()	Age()	Age()	Age()
Arthritis										
Asthma-Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problem										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased please list their age at death and cause:

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ **Last Name:** _____

Email address: _____ @ _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History (Record one diagnosis in your family history and the affected)				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
<i>Example: Heart Disease</i>		X		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Include regularly used over the counter medications)	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ **Date:** _____

For office use only		
Height: _____	Weight: _____	Blood Pressure: _____ / _____