ADULT INTAKE FORM

PERSONAL INFORMATION

First Name: _____MI:_____Last:_____

Preferred Name:_____

Address:_____

City/State/Zip:_____

Cell Phone: (____)_____ Alternate Phone: (____)_____

Text Reminders: Y N Before Appointment: 1 HR 4 HRS 1 DAY

Email:_____ (For Email reminders, events, etc.)

Birthdate:_____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 how you heard about IHH Family Chiropratic?_____

_____

REASON FOR PERSONAL CARE

What is your reason for seeking care at IHH Family Chiropractic?_____

_____

When did this begin? (If applicable)_____

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

_____

_____

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

_____

Have you seen a chiropractor before? Y N

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

HEALTH CONCERNS

o Anxiety/Depression
o Digestive Troubles
o Nausea/Vomiting
o Diabetes
o Hypertension
o Arthritis
o Loss of Balance
o Neck/Back Pain
o Pain in Arms/Legs
o Irritability
o Other

o Fatigue/Sleep Issues
o Dizziness
o Ringing in Ears
o Sensitivity to Light
o Loss of Concentration
o Memory Problems
o Headaches
o Stiffness/Flexibility
o Sinus Troubles/Allergies
o Cold Hands/Feet

Explain any boxes checked above or add additional concerns:

_____

_____

_____

_____

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

_____

_____

_____

_____

did you know . . .

Each health concernrelates to a specific area of the spine and nervous system? Please circle beloww or enter the informationto the left.

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Headaches
Migraines
Dizziness
Sinus Problems Allergies
Fatigue / Sleep Problems
Head Colds
Vision Problems
Difficulty Concentrating
HearingProblems

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

Middle Back Pain
Congestion
Difficulty Breathing Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems Indigestion

MEDICATIONS

o Anxiety/Depression
o Blood Pressure
o Pain Narcotics
o Muscle Relaxers

o Migraine/Headache
o Cholesterol
o ADD/ADHD
o Diabetes

Other _____
Other _____
Other _____

VITAMINS/SUPPLEMENTS

o Multi-Vitamin
o Fish Oil/Omega-3
o Vitamin D3
o Protbiotics

Other _____
Other _____
Other _____

EMERGENCY CONTACT

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

Preferred Name: _____

Address: _____ City / State / Zip:_____

Phone: (_____)_____ Relation: _____

Most life stresses can be grouped into 3 main categories: Physical, Chemical, and Emotional Stress.
Please check any of the following stresses you experience on a regular basis.

Physical Stress

o Physical Pain o Low Energy/Fatigue o Job/Hobbies Cause Discomfort o Tightness/Stiffness

o History of Accidents/Injuries o Inability to Exercise/Perform Physical Activities o Other_____

Explain:_____

_____

Chemical Stress

o Fast Food/Highly o Processed Food Medications (Prescription or OTC) o Consume Alcohol Tobacco

o Other _____

Explain:_____

_____

Emotional Stress

o Work/Job o School o Health o Finances o Family o Daily Schedule/Time o Other

Explain:_____

_____

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

_____

X-RAY CONSENT

Patient Consent to X-Ray

I authorize the performance of x-ray examination, which IHH Family Chiropractic may consider necessary or advisable in the course of my examination and treatment.

Signed:_____ Date: _____

X-Ray Consent for Women of Childbearing Age

This is to certify that, to the best of my knowledge, I am not pregnant, and IHH Family Chiropractic has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed:_____ Date: _____

For Office Use Only

ID#: _____ V: _____

Films: _____ P: _____

ROF: _____ A: _____

Other: _____

HIPAA POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain righ ts to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan, and direct my treatment and follow-up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third-party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

Date:_____ Print Patient Name:_____ Signature: _____

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.

- If you have health insurance, IHH Family Chiropractic will bill your insurance company for the services rendered in this office. If your insurance plan does not cover certain services, you will be responsible for the charges. IHH Family Chiropractic will verify your benefits before you start care and will tell you what is covered and what is not covered, so you can make decisions about your care.

*If you do not have health insurance or chiropractic coverage, you will be responsible for paying the amount of the services you receive on the same day you receive them.

- We urge our patients to follow the doctors' 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, care must be followed.
- I authorize IHH Family 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 charges incurred by me.
- Chiropractic care in this office deals with vertebral subluxation, and will, therefore, be billed according to diagnostically appropriate procedural codes.
- If you have any questions about our financial policies, please ask our staff. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.

Date:_____ Signature: _____

AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at IHH Family Chiropractic to adjust my spine as deemed appropriate. At IHH Family Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or any staff member of IHH Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. 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. Chiropractic is a system of healthcare delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

*Date:*_____ *Signature:* _____

ADVANCED BENEFICIARY NOTICE (ABN)

The purpose of this form is to help you be aware of chiropractic services in this office as it relates to any medical insurance you may have. Chiropractic care in this office is not focused on the diagnosis of or relief of symptoms; it is centered on the location, analysis, and correction of underlying vertebral subluxations. Because of this, all services are coded in a manner which insurance carriers view as maintenance or wellness care and most likely will not be covered. Signing below signifies that you want the services provided in this office, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion and policies as it relates to insurance coverage, not an official Medicare or other insurance carrier's stance or decision. Signing below indicates you have received and understand this notice.

Date:_____

Name (Printed): _____

Signature: _____

Parent/Guardian Signature (if aplicable):_____