



intouchchiropractic

Today's Date: _____ Referred By: _____

Patient Name: _____ Male Female File# _____
Date of Birth: _____

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

Cell: _____ Home: _____ Work: _____

Email: _____ Marital Status: S M W D

Age: _____ Social Security Number: _____

Spouse's Name: _____ Name(s) of Kids: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____

Is your condition due to an accident? Yes No Auto Work At Home Other Date: _____

What is the primary stressor in your life? _____

.....
Would you like us to check your insurance benefits? Yes No (provide insurance card to front desk)

Appointment Reminders: Email Text (Cell Phone Carrier: _____)

.....
Due to changes in health insurance coverage, our policy is that payment is due at the time of service. We will provide you with an estimated insurance coverage verification on your second visit to our office. In many cases, patient self billing is the fastest way for you to receive reimbursement from your insurance company. In these cases, statements will be provided to you to submit your own bills ensuring your insurance company reimburses you directly.

.....
All charges are due when services are rendered...

Method of payment: Cash Check Credit Card CareCredit

.....
Why Chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Your doctor will weigh your needs and desires when recommending your treatment program. **Please circle which type of care fits your needs.**

RELIEF CARE

Relief care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I authorize Intouch Chiropractic to render necessary services to me and I am responsible for all charges incurred.

Patient/Guardian Signature: _____ Date: _____

Current Health History

What is your: Height: _____

Weight: _____

Primary Complaint: _____

How long have you had this problem? _____

When and how did this begin? _____

What makes it worse? _____ What makes it better? _____

What time of day is worse? Morning End of Day Night Various Times

Does it interfere with your? Work Sleep Recreation Daily Routine None

How would you describe it? Dull/Aching Sharp Stabbing Burning Tingling/Numb

Please grade the intensity (10=worst possible pain): Now: 0 1 2 3 4 5 6 7 8 9 10 Average: 0 1 2 3 4 5 6 7 8 9 10

How often do you experience this? <25% 25-50% 51-75% >75% of the time

Does this sensation travel/shoot to any areas of your body? Yes No Where? _____

Is this problem changing with time? Getting Worst Staying the Same Getting Better

Previous interventions, treatments, medications, surgery, or care you've sought for this complaint: _____

Secondary Complaint: _____

How long have you had this problem? _____

When and how did this begin? _____

What makes it worse? _____ What makes it better? _____

What time of day is worse? Morning End of Day Night Various Times

Does it interfere with your? Work Sleep Recreation Daily Routine None

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List prescription medications and doses you are currently taking:

List over-the-counter medications and doses you are currently taking:

List all surgeries and dates that you have had:

Circle any of the following you have had in the last six months:

- | | | |
|------------------|--------------------------|------------------------------|
| Headaches | Ear Aches | Sinus Congestion/Allergies |
| Numbness | Dizziness | Lung Problems/Congestion |
| Vision Problems | Heart Problems | Blood Pressure Problems |
| Ankle Swelling | Frequent Nausea/Vomiting | Prostate/Sexual Dysfunction |
| Abdominal Cramps | Constipation/Diarrhea | Poor/Excessive Appetite |
| Excessive Thirst | Discolored Urine | Excessive /Painful Urination |
| Diabetes | Cancer | Menstrual Cycle Dysfunction |

Patient/Guardian Signature _____

Date _____

Patient Consent to Physical Examination and X-Rays

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

During your examination, the doctor may determine that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patient's consent for such tests.

I understand that the doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests, x-rays and physical examinations.

Patient/Guardian Signature: _____

Date: _____

Females Only: Regarding Possibility of Pregnancy

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time that I am pregnant. If determined at a later date that I am pregnant, I do not hold the doctor, health care provider's associates, association, corporation, partnership, employees, agents and estate of this establishment accountable in any way.

Patient/Guardian Signature: _____

Date: _____

Consent for Treatment of Minors

I, being parent or guardian of _____, a minor the age of _____, do hereby authorize, request and direct Dr. Devin Young and/or Dr. Jeanett Tapia to perform an exam, x-ray and chiropractic treatment for their condition as he/she deems necessary. In addition, I give permission for the doctors to manage his/her care when I am not present to observe such care.

Patient/Guardian Signature: _____

Date: _____

Witness: _____