intouchchiropractic

Today's Date:_____ Referred By:_____

Male Female File#_____

Patient Name:_____ 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: oEmail oText (Cell Phone Carrier: _____)

Method of payment: Cash Check Credit Card CareCredit

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.

I authorize Intouch Chiropractic to render necessary services to me and I am responsible for all charges incurred. All charges are due at time of service.

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 Worse		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
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 Worse		Staying the Same	Getting Better	

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

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 <u>last six months</u>:

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: _____