Living Well Chiropractic

Chiropractor Intake Form

Title: (Circle one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____

First Name _____ Middle Initial _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Leave Messages on: (Circle one) ☐ Home ☐ Cell ☐ Work ☐ Don't leave messages

Home Phone (_____)_____-_____ Work Phone (_____)_____-_____

Cell Phone (_____)_____-_____ Email _____

Date of Birth _____/_____/_____ Sex: ☐ Male ☐ Female

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____

If you are planning to file through insurance we will need a copy of your insurance card today to update our software!

How did you hear about our office? _____

We are excited you have chosen to visit Living Well Chiropractic and look forward to providing you with our best efforts to ensure you experience your best health!

Dr. Taylor Walter

Medical Conditions: (Circle all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Other _____	☐ Fibromyalgia	☐ Asthma	☐ Osteoporosis

Surgeries: (Circle all that apply to you)

☐ Appendectomy	☐ Cardiovascular Procedure	☐ Cervical Spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar Spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic Spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia
☐ Breast Augmentation	☐ Other _____		

Allergies: (Circle all that apply to you)

☐ Mold	☐ Seasonal	☐ Milk or Lactose	☐ Animal
☐ Chemical _____	☐ Sulfites	☐ Wheat/Glutens	☐ Other _____

Social History: (Circle all that apply to you)

Caffeine use:	☐ Never	☐ Occasional	☐ Often
Drink Alcohol:	☐ Never	☐ Occasional	☐ Often
Exercise:	☐ Never	☐ Occasional	☐ Often
Drink Water:	☐ Never	☐ <64 oz/day	☐ >64 oz/day
Cigarettes:	☐ Never	☐ <1 pack/day	☐ >1 pack/day
Sleep:	☐ Insomnia	☐ <8 hours/night	☐ 8+ hours/night

Other: _____

Family History: (Circle all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease:	☐ Parent	☐ Sibling
Hypertension:	☐ Parent	☐ Sibling
Stroke:	☐ Parent	☐ Sibling
Thyroid:	☐ Parent	☐ Sibling

Other: _____

Occupational Activities: (Circle one that best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐ Food Service Industry	☐ Executive/Legal	☐ Manufacturing	☐ Home Services
☐ Heavy Manual Labor	☐ Medium Manual Labor	☐ Light Manual Labor	☐ Housekeeper

☐ Other: _____

Patient Signature _____

Patient Name _____ **Date** _____

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular	Past	Present	No	**Neurologic**	Past	Present	No	**Allergic/ Immunologic**	Past	Present	No
Poor Circulation				Stroke				Hives			
Hypertension				Seizures				Immune Disorder			
Aortic Aneurysm				Head Injury				HIV/AIDS			
Heart Disease				Brain Aneurysm				Allergy Shots			
Heart Attack				Numbness				Cortisone Use			
Chest Pain				Severe Headaches				**Endocrine**			
High Cholesterol				Pinched Nerves				Thyroid			
Pacemaker				Parkinson's				Diabetes			
Jaw Pain				Carpal Tunnel				Hair Loss			
Irregular Heartbeat				Vertigo				Menopausal			
Swelling of legs								PMS			
Gastrointestinal				**Musculoskeletal**				**Hematologic**			
Gall Bladder Problems				Gout				Hepatitis			
Bowel Problems				Arthritis				Blood Clots			
Constipation				Joint Stiffness				Cancer			
Liver Problems				Muscle Weakness				Bruising			
Ulcers				Osteoporosis				Bleeding			
Diarrhea				Broken Bones				Fever/Chills			
Nausea/Vomiting				Joints Replaced				Sweating			
Bloody Stools				Neck Pain				Varicose Vein			
Poor Appetite				Low Back Pain							
				Upper Back Pain							
Genitourinary				**Ear, Nose, & Throat**				**Respiratory**			
Kidney Disease				Difficulty Swallowing				Asthma			
Burning Urination				Dizziness				Tuberculosis			
Frequent Urination				Hearing Loss				Shortness of Breath			
Blood in Urine				Sore Throat				Emphysema			
Kidney Stones				Nosebleeds				Cold/Flu			
Lower Side Pain				Bleeding Gums				Cough			
				Sinus Infections				Wheezing			
Eyes				**Psychiatric**				**Constitutional**			
Glaucoma				Depression				Weight Loss/Gain			
Double Vision				Anxiety				Low Energy Level			
Blurred Vision				Stress				Difficulty Sleeping			

Please list all current medications being taken: _____

_____

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

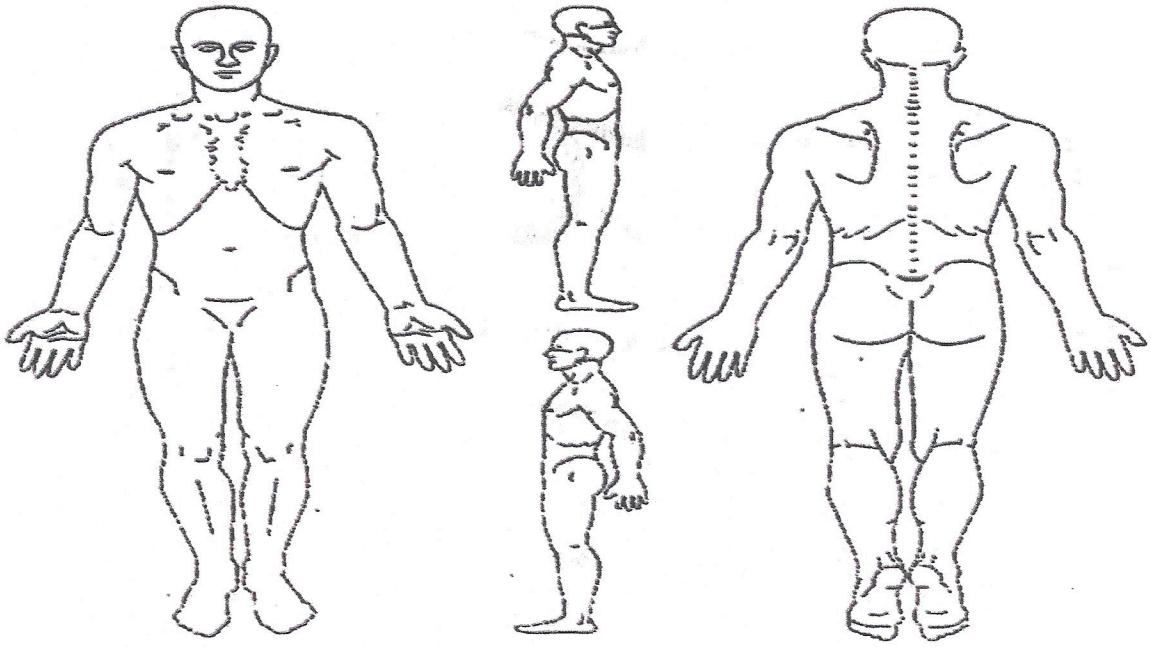
Are you Pregnant? (Check) ☐ **Yes** ☐ **No**

Patient Signature _____

Patient Name _____ **Date** _____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N = Numbness **B = Burning** **S = Sharp** **T = Tingling** **A = Dull Ache**



Average Pain Intensity:

Last 24 hours:	No pain	0	1	2	3	4	5	6	7	8	9	10	worst pain
Past week:	No pain	0	1	2	3	4	5	6	7	8	9	10	worst pain

Does anything improve your pain? ☐ Yes ☐ No **If Yes, please list:**

When did your symptoms begin? _____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐ Work related Accident ☐ Other _____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day)	☐ Frequently (51-75% of the day)	☐ Occasionally (26-50% of the day)	☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp	☐ Ache	☐ Numb	☐ Shooting
☐ Burning	☐ Tingling	☐ Throbbing	☐ Other _____

Patient Signature _____

Patient Name _____ **Date** _____

Financial Policy

Living Well Chiropractic
7439 W. 161st
Overland Park, KS 66085

CANCELLATION/NO SHOW FEE: If you call with less than 2 hours' notice or if you don't call at all, we reserve the right to bill you for the time we saved for you. No shows, missed appointments or changes in appointments made with less than a 2-hour notice will be charged a $25 fee for chiropractic treatment and $50 for chiropractic examinations, nutritional consults, and new patient visits.

SELF PAY (No Insurance): Full payment is due at the time of service

BALANCE: Failure to pay any balance due may result in your account being turned over to an outside collection agency. This action will not compromise your care.

I have read and understand the financial policy set forth by Living Well Chiropractic, and I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically by the practice.

Patient Signature_____

Date_____

HIPAA Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights 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 among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and professional certifications.

I have received or have been offered a copy of the full HIPAA policy and understand your HIPAA Notice of Privacy Practices containing a more complete and detailed description of the uses and disclosures of my health information. I understand that this office has the right to change its HIPAA Notice of Privacy Practices from time to time as necessitated by changes in HIPAA. I have the right, at any time, to contact this office at the address above to obtain a current copy of their HIPAA Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient name (print) _____ Relationship to patient_____

Signature _____ Date _____