# PATIENT INTAKE FORM

1920 W 250 N Ste 24, Ogden Ut 84404 801.317.4757

Date:_______________
Name:_____________________________________ Social Security #:_____________
Address:_____________________________________ City:______________________
State:_____ Zip:_________
Cell Phone:_________________________ Home:______________________
Email Address:__________________________________________________
Age:_________ Birth Date:_________________ Sex: ☐M ☐F

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Spouse:_________________________ How Many Children _________
Children's name and age:__________________________________________________

Occupation:_____________________ Employer:______________ _____
Employer Phone:_______________________________________________________
Emergency Contact Name:_____________________ Relationship:_____________
Phone:_______________
How were you referred to our office?:________________________________________

Family Medical Doctor:______________________________________________
When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care at this office?:_________________

Name of Primary Insurance Company: ______________________________________
Name of Secondary Insurance Company (if any):_____________________________
Name of Insured:__________________ Relationship to Insured:_________________
Insured DOB:___________

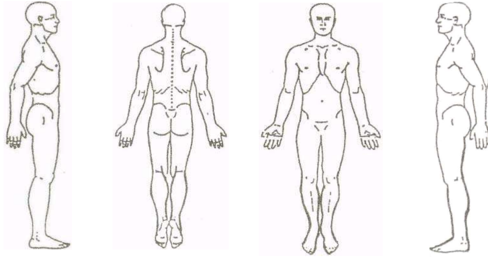
Please check any and all insurance coverage that may be applicable in this case:
☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident ☐ Medical savings Account & Flex Plans ☐ Other

Authorization and Release: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient's Signature:_______________________________________________
Date:___________________

Guardian's Signature Authorizing Care:______________________________
Date:__________________

1. **Is today's problem caused by:** ☐ Auto Accident ☐ Workman's Compensation ☐ Other
2. **Indicate on the drawings below where you have pain/symptoms:**



3. **How often do you experience your symptoms:**
   ☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
   ☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)
4. **How would you describe the type of pain?**
   ☐ Sharp ☐ Numb ☐ Dull ☐ Tingly
   ☐ Diffuse ☐ Achy ☐ Sharp with motion ☐ Shooting with motion
   ☐ Burning ☐ Shooting ☐ Stabbing with motion ☐ Electric-like with motion
   ☐ Stiff ☐ Other: _________
5. **How are your symptoms changing with time:**
   ☐ Getting worse ☐ Staying the same ☐ Getting better
6. **Using a scale from 0-10 (10 being the worst), how would you describe your problem?**
   0 1 2 3 4 5 6 7 8 9 10 (please circle)
7. **How much has the problem interfered with your work?**
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
8. **How much as the problem interfered with your social activities?**
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
9. **Who else have you seen for your problem:**
   ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
   ☐ ER Physician ☐ Orthopedist ☐ Other: _______________
   ☐ Massage Therapist ☐ Physical Therapist ☐ No one
10. **How long have you had this problem?** ________________________________________________________
11. **How do you think your problem began?** ______________________________________________________
12. **Do you consider this problem to be severe?**
    ☐ Yes ☐ Yes, at times ☐ No
13. **What aggravates your problem?** ____________________________________________________________
14. **What alleviates or reduces your problem?** ______________________________________________________
15. **What concerns you the most about your problem? What does it prevent you from doing?** ____________

    ______________________________________________________________________________________________
16. **What is your:** Height ______ Weight _______ Date of birth ____/____/____ Occupation: ______________
17. **How would you rate your overall health?**
    ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
18. **What type of exercise do you do?**
    ☐ Strenuous ☐ Moderate ☐ Light ☐ None

19. **Does your immediate family have any of the following?**

☐ Rheumatoid Arthritis ☐ Cancer ☐ Heart Problems ☐ Lupus ☐ Diabetes ☐ ALS

20. **For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, please a check in the "present" column.0.**

| Past | Present | Condition | Past | Present | Condition | Past | Present | Condition |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Headaches | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Neck Pain | ☐ | ☐ | Heart Attack | ☐ | ☐ | Excessive Thirst |
| ☐ | ☐ | Upper Back Pain | ☐ | ☐ | Chest Pains | ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Mid Back Pain | ☐ | ☐ | Stroke | ☐ | ☐ | Smoking/Tobacco Use |
| ☐ | ☐ | Low Back Pain | ☐ | ☐ | Angina | ☐ | ☐ | Drug/Alcohol Dependence |
| ☐ | ☐ | Shoulder Pain | ☐ | ☐ | Kidney Stones | ☐ | ☐ | Allergies |
| ☐ | ☐ | Elbow/Upper Arm Pain | ☐ | ☐ | Kidney Disorders | ☐ | ☐ | Depression |
| ☐ | ☐ | Wrist Pain | ☐ | ☐ | Bladder Infection | ☐ | ☐ | Systemic Lupus |
| ☐ | ☐ | Hand Pain | ☐ | ☐ | Painful Urination | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Hip Pain | ☐ | ☐ | Loss of Bladder Control | ☐ | ☐ | Dermatitis/Eczema/Rash |
| ☐ | ☐ | Upper Leg Pain | ☐ | ☐ | Prostate Problems | | | |
| ☐ | ☐ | Knee Pain | ☐ | ☐ | Abnormal Weight Gain/Loss | | | **For Females Only** |
| ☐ | ☐ | Lower Leg Pain | ☐ | ☐ | Loss of Appetite | ☐ | ☐ | Birth Control Pills |
| ☐ | ☐ | Ankle/Foot Pain | | | | | | |
| ☐ | ☐ | Jaw Pain | ☐ | ☐ | Abdominal Pain | ☐ | ☐ | Hormonal Replacement |
| ☐ | ☐ | Joint Pain/Stiffness | ☐ | ☐ | Ulcer | ☐ | ☐ | Pregnancy |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Hepatitis | | | |
| ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ | Liver/Gall Bladder Disorder | | | |
| ☐ | ☐ | Cancer | ☐ | ☐ | General Fatigue | | | |
| ☐ | ☐ | Tumor | ☐ | ☐ | Muscular Incoordination | | | |
| ☐ | ☐ | Asthma | ☐ | ☐ | Visual Disturbances | | | |
| ☐ | ☐ | Chronic Sinusitis | ☐ | ☐ | Dizziness | | | |

21. **List all prescription and over the counter medications you are currently taking:**______________________
______________________________________________________________________________

22. **List all supplements (vitamins) you are currently taking:** ______________________________
______________________________________________________________________________

23. **List all surgical procedures you have had:** ______________________________________________________
______________________________________________________________________________

24. **What activities do you do at work?**

| | | | |
|---|---|---|---|
| ☐ **Sit:** | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day |
| ☐ **Stand:** | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day |
| ☐ **Computer work:** | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day |
| ☐ **On the phone:** | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day |

25. **What activities do you do outside of work?**

______________________________________________________________________

26. **Have you had any hospitalizations?** ☐ No ☐ Yes

**If yes explain:**______________________________________________________________________

27. **Have you been seen by a chiropractor before?** ☐ No ☐ Yes
If yes, how long ago? ______________________ Did you have a good experience? _____________________

28. **Have you had significant past trauma?** ☐ No ☐ Yes

**Explain:**______________________________________________________________________

29. **Anything else pertinent to your visit today?** ____________________________________________________

30. **If the pain continues, what are you afraid you will NOT be able to do / enjoy?** _________________________
______________________________________________________________________________

## PATIENT AGREEMENTS

In consideration of treatment by the doctor the undersigned agrees as follows:

1. To pay the amount charged by the doctor for all professional treatments and services to the undersigned and/or his/her family. Payments to be made to Advanced Injury Rehabilitation, LLC DBA Pioneer Chiropractic Wellness.
2. All charges are due and payable at the time of service unless other financial agreements are made.
3. Any balance due 30 days after treatment will be subject to a 2% per month service charge (APR of 24%).
4. To pay all collection fees, settlement fees, reasonable attorney fees, and costs incurred in the event of referral to any collection agency, arbitration / mediation process, or suit. I further agree to pay all fees for collections, including a 40% agency commission fee.
5. That in the event of death, this obligation shall be binding on the estate, heirs or successors of the undersigned.

## FINANCIAL ARRANGEMENTS

1. This office will accept payment for services by cash, check (personal or business) or all major credit cards. Furthermore, in the event of a returned check there will be issued a $25 returned check fee.
2. This office has several types of financial plans available. A Chiropractic Assistant will discuss this with you upon request. Any alteration to our regular fees must be set to paper and signed by both parties to be binding.
3. I clearly understand and agree that I am responsible for the payment of all services rendered to me. I also understand that if I terminate care, any professional fees for services will become due and payable.

## CHIROPRACTIC INSURANCE

1. If you have medical insurance that covers chiropractic, your estimated portion is due and payable at the time of service. If after this office receives payment form the insurance company, and balance remains, a statement will be sent to you.
2. If an insurance payment is not received within 60 days, the full amount is due and payable by you.
3. The filing of a secondary insurance is your responsibility.

I do hereby agree to the above arrangements. I give permission for the doctor and/or his designated employees to perform chiropractic services for myself. If services are for a minor I am responsible for, the name of such minor will be listed below as the patient.

______________________________________________
Patient Name (Print)

______________________________________________ ______________________________________
Patient Signature Date

______________________________________________ ______________________________________
If a minor Parent or Guardian (circle whichever applies) Date

1920 W 250 N Ste 24, Ogden Ut 84404

Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and
Consent for Use of Health Information

Name:_______________________________________________ Date:____________

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law, and Federal Law.

The patient understands and agrees to allow this chiropractic office to use their Patient Heath lnformation for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health lnformation is going to be used in this office and your rights concerning those records. lf you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health lnformation we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The following person(s) have my permission to receive my personal health information.

_____________________________________________________________________

_____________________________________________________________________

Patient's Signature ___________________________________________

lf patient is a minor or under a guardianship order as defined by State Law:

By _______________________________________________
Signature of Parent / Guardian (circle one)