INVIGORATE CHIROPRACTIC

ADULT INTAKE FORM
Today's Date:

PATIENT INFORMATION

First Name _____ MI _____ Last Name_____

DOB _____/_____/_____

Address:_____
City_____ State:_____ Zip:_____

Email: _____

Home Phone: _____ Cell Phone:_____

Cell Provider:_____ ☐**Yes!** I want to opt in for text appointment reminders

Occupation: _____
Employer:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Spouse's Name:_____

Do you have children? ☐YES ☐NO

If yes, please list names/ages:_____

How did you hear about us? ☐Screening/Event ☐Website ☐Social Media
☐Referral:_____ ☐Other: _____

HEALTH HISTORY

Health Concern (list according to severity)	Rate Severity 1=mild – 10=unbearable	When did this issue begin?	Have you had this condition in the past?	Did problem begin with injury?	Are problems constant or intermittent?
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Constant ☐ Intermittent
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Constant ☐ Intermittent
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Constant ☐ Intermittent
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Constant ☐ Intermittent
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Constant ☐ Intermittent

Have you seen other doctors for these concerns? ☐Yes ☐ No If so, which type? ☐Chiropractor ☐ Medical Doctor
☐Other _____

Additionally, list Doctor's name and approximate date of the visit:
_____

Have you ever been involved in an auto accident? ☐Yes ☐ No If yes, when?

_____

Have you ever been knocked unconscious? ☐Yes ☐ No If yes, explain:

_____

Please describe any other traumas you have undergone:

_____

_____

The human body is designed to be healthy. The primary system in the body, which coordinates health and function, is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Many of the common health challenges that adults experience have their origins during the developmental years, starting at birth. Layers of damage to the spine and nervous system occur as a result of various traumas, toxins, and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system – a condition called Vertebral Subluxation. **Please answer the following questions to give us a better understanding about your state of wellness and factors which may be contributing to vertebral subluxation and impeding your body's ability to heal. Include past and present issues.**

☐Abnormal Weight Gain
☐Abnormal Weight Loss
☐ADD/ADHD
☐Allergies
☐Arm Pain
☐Asthma
☐Back Pain - Low
☐Back Pain - Mid
☐Back Pain - Upper
☐Bladder Disorders
☐Cancer
☐Chest Pain
☐Chronic Fatigue
☐Constipation
☐Depression
☐Diabetes
☐Disc Problems
☐Dizziness
☐Ear Infections
☐Epilepsy
☐Fibromyalgia
☐Food Sensitivities
☐Gastric Reflux
☐Headaches
☐HIV/AIDS
☐Heart Disorders
☐Hip Pain
☐Infertility
☐Irritable Bowel
☐Kidney Problems
☐Knee Pain
☐Leg pain
☐Light Headedness
☐Liver Disease
☐Lupus
☐Menstrual Changes
☐Migraines
☐Neck Pain
☐Nervousness
☐Numb Arms/Hands
☐Numb Legs/Feet
☐Sciatica
☐Shoulder Pain
☐Sinus Issues
☐Sleep issues
☐Skin Issues
☐Stomach Disorders
☐Stroke
☐Throat Issues
☐Thyroid Problems
☐Tinnitus (Ear Ringing)
☐TMJ
☐Ulcers
☐Vertigo
☐Visual Disturbances
☐ OTHER_____
☐_____
☐_____
☐_____

Do any of your health concerns interfere with any of the following? ☐Work ☐Family ☐Exercise ☐Emotional Wellbeing ☐Daily Routine ☐Other: _____

Please check any condition you have currently, or have had in the past: ☐Stroke ☐Cancer ☐Heart Disease ☐Spinal Surgery ☐Seizures ☐Spinal Bone Fracture ☐Scoliosis ☐Diabetes: Type_____

Please list all hospitalizations and surgical operations you have undergone during your lifetime with the corresponding year:

_____

_____

Please list all medications you are currently taking (over the counter / prescription and dosage):

_____ _____

_____ _____

_____ _____

_____ _____

Vitamins/Supplements:

_____

Have you had any falls within the past 6 months? ☐ Yes ☐ No If yes, how many? _____

SOCIAL HISTORY

Smoking? ☐ Yes ☐ No If yes, how often? _____

Alcohol consumption? ☐ Yes ☐ No If yes, please estimate how many ounces per week? _____

Hormone altering medications (including birth control): ☐ Yes ☐ No

Pregnancies? ☐ Yes ☐ No If yes, how many? _____

FAMILY HISTORY Please list any significant health issues your family members have, if applicable.

Father: _____Mother:_____

Siblings: _____

Grandparents: _____

GOALS

What are your primary LIFE GOALS you are hoping to achieve through your visits at Invigorate Chiropractic? These can be anything…be specific! 😊

_____

_____

INVIGORATE CHIROPRACTIC

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY. PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS**. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF INVIGORATE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____

PRINT YOUR NAME HERE DATE

_____ _____

SIGNATURE YOUR AGE

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT INVIGORATE CHIROPRACTIC.

_____ _____

SIGNATURE DATE

INVIGORATE CHIROPRACTIC

PATIENT INFORMATION - MUST BE COMPLETED BEFORE SERVICES CAN BE RENDERED

NAME: _____
FIRST MIDDLE LAST

PHONE: Home: _____Cell: _____ Work: _____

SOCIAL SECURITY NUMBER: _____ MARITAL STATUS: _____

DATE OF BIRTH: _____

CONTACT IN CASE OF EMERGENCY: _____ PHONE #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

NAME OF POLICY HOLDER: _____ POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

NAME OF SECONDARY INSURANCE CARRIER: _____

NAME OF POLICY HOLDER: _____ POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

INSURANCE POLICIES AND FEE SCHEDULE

o CONSULTATION & EVALUATION – (new or established patient) – includes one or more of the following: patient history, thermography, surface electromyography, range of motion, motion and/or static palpation, orthopedic and neurological evaluation, leg check: $90
o CHIROPRACTIC ADJUSTMENT – The actual re-alignment of the vertebra performed by handheld instrument: $50
o X-RAYS – Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care: $50 cervical views*, $50 thoracic views*, $50 lumbar views*, and $60 per full spine view.
*These prices include standard AP and Lateral views; the values do not include Oblique views, Flexion/Extension Views, or other views.

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Kevin Schultz, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made. I understand that I am financially responsible for charges not covered by this assignment.

_____ _____
SIGNATURE DATE

INVIGORATE CHIROPRACTIC

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supportive, open environment.

By my signature below, I have read and fully understand the above statements.
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

SIGNATURE DATE