

Integrity Chiropractic Health Intake Form

Please Fill Out All 3 Pages.

Patient Name: _____ Date: / / .

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

Gender: () Male () Female SSN: - - Home Phone: () - .

Work Phone: () - Birth Date: / / Spouse Name: _____

() Single () Married () Divorced () Widowed () Separated () Minor

Work Name & Address: _____

Occupation: _____

Whom Can We Thank For Referring You To Us? _____

Emergency Contact Name/Phone Number: _____ () - .

Email Address _____

Name Of Person/s Responsible For This Account: _____

Auto Accident Insurance Information (IF APPLICABLE) : _____

Insurance Company Name/Phone #: _____ () - .

Address: _____

Claim Adjuster Name/Phone #: _____ () - .

Policy/Group #: _____ Claim #: _____

Fax Phone Number: () - .

What Is The Reason For Your Visit Today? _____

When Did The Symptoms First Appear? _____

Is Your Condition Getting: ()Worse ()Better ()Staying The Same

Where Specifically Is/Are Your Pain/Problem Areas Located?_____.

Which Activities Are Difficult To Perform? ()Sitting ()Standing ()Walking
()Bending ()Twisting At The Waist ()Lying Down ()Other (describe)

How Would You Describe Your Pain? ()Sharp ()Dull ()Throbbing ()Aching
()Shooting ()Burning ()Tingling ()Crampy ()Stiff ()Swelling
()Other

Is Your Pain: ()Constant ()Frequent ()Intermittent Worse In The: ()Morning
()Evening

Have you ever been treated for this condition before? () Yes () No

If Yes, Please Indicate What Type Of Treatment You Have Had For This Condition:
()Chiropractic ()Acupuncture ()Physical Therapy ()Medical ()Surgical
()Other:

Please Rate The Severity Of Your Pain From Zero (no pain) to Ten (worst pain you have ever felt in your life!)

0 1 2 3 4 5 6 7 8 9 10

Do You Have Any Allergies? ()No ()Yes If Yes, To What?_____.

Are You Pregnant? ()No ()Yes ()Not Sure If Yes, How Many Months Along?

:

Please List Any Surgeries And Approx. Date They Occurred:_____.

_____.

_____.

Are You Currently Taking Any Medications? ()No ()Yes If Yes, What Kind And For What?_____.

Is Your Activity Level: ()Light ()Moderate ()Intense Do You Smoke? ()No ()Yes

Do You Drink Caffeinated Beverages? ()No ()Yes If Yes, How Many Per Day?_____.

Please Indicate Which Health Condition Applies To You Either (P) In The Past or (N) Now By Circling Either (P) Or (N), Or Circle Both To Indicate A Problem From The Past That Is Continuing/Chronic.

P/N Neck Pain	P/N Upper Back Pain	P/N Mid Back Pain
P/N Low Back Pain	P/N Sacroiliac Pain	P/N Shoulder Pain
P/N Arm Pain	P/N Wrist/Hand Pain	P/N Upper Leg/Hip Pain
P/N Lower Leg/Knee Pain	P/N Ankle/Foot Pain	P/N Headaches
P/N Dizziness	P/N Tinnitus (ringing ears)	P/N Fainting
P/N Swelling/Stiff Joints	P/N Visual Disturbances	P/N Convulsions
P/N Stroke	P/N Heart Attack	P/N Cancer
P/N Diabetes	P/N Depression	P/N High Blood Pressure
P/N Excessive Thirst	P/N Frequent Urination	P/N Irritable Colon
P/N HIV/AIDS	P/N Asthma	P/N Arthritis
P/N Chest Pains	P/N Abnormal Wt. Gain/Loss	P/N Irregular Menstrual Symptoms
P/N Loss Of Bladder Cont.	P/N Kidney Stones	P/N Loss Of Appetite

Please Briefly List Any Other Health Care Concerns Not Mentioned In This Questionnaire That You Feel May Have Any Bearing On The Health Care You Will Receive At Integrity Chiropractic:

I Certify that I have read and understand all information contained in this questionnaire and have answered the questions honestly and truthfully to the best of my knowledge. I further understand that providing false or misleading information may lead to mis-diagnosis and jeopardize my health. I also understand that I am ultimately responsible for fees incurred at Integrity Chiropractic regardless of insurance coverage.

CANCELLATION / NO-SHOW POLICY:

I certify that I am aware of and agree to the policy of Integrity Chiropractic that if I either do not show up for my appointment or, I cancel the appointment without the required 24 hour notice and fail to re-schedule the appointment, I will be billed for the office call in full. In the case of prepaid visits, the visit will be deducted from my account in full.

I also authorize Integrity Chiropractic/Dr. Mike Fink, D.C. to release any pertinent health care information to any third parties such as my insurance company or any other health care providers I have been referred to by Dr. Mike Fink, D.C./Integrity Chiropractic for the purpose of continuity of care provided to me by Dr. Mike Fink, D.C./Integrity Chiropractic and other health care providers I have been referred to by Dr. Mike Fink, D.C./Integrity Chiropractic and/or to expedite insurance payment of any bills incurred at Integrity Chiropractic.

I also realize and acknowledge that Dr. Mike Fink, D.C./Integrity Chiropractic reserve the right to either accept or decline me as a patient at Integrity Chiropractic.

X

Date: _____.

(Signature Of Patient Or Guardian If Patient Is A Minor)