NEW PATIENT INTAKE FORM

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name_____ Date____/____/____ S/S____-____-____
First MI Last

Address_____ City_____ State____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Birth Date____/____/____ Height_____ Weight_____ e-mail address:_____

Sex: ☐ Female ☐ Male Status: ☐ Minor ☐ Married ☐ Single ☐ Other

Your Employer_____ Occupation_____

Business Address_____ City_____ State____ Zip_____

Spouse/ Parent's Name_____ Phone_____

Who may we thank for referring you to us?_____

Person to contact in case of an emergency_____ Phone_____

HEALTH HISTORY

Do you currently have or have you previously had any of the following symptoms:

☐ Headaches	☐ Tension	☐ Ringing/ Buzzing in Ears
☐ Neck Pain	☐ Irritability	☐ Loss of Memory
☐ Neck Stiffness	☐ Mood Swings	☐ Loss of Smell
☐ Mid Back Pain	☐ Sleeping Problems	☐ Loss of Taste
☐ Low Back Pain	☐ Fatigue	☐ Upset Stomach
☐ Arm Pain	☐ Depression	☐ Constipation
☐ Leg Pain	☐ Chest Pain	☐ Diarrhea
☐ Pins and Needles in Arms	☐ Shortness of Breath	☐ Urinary Problems
☐ Pins and Needles in Legs	☐ Cold Sweats	☐ Heartburn
☐ Numbness in Fingers	☐ Fever	☐ Ulcers
☐ Numbness in Toes	☐ Fainting	☐ Allergies
☐ Cold Hands	☐ Dizziness	☐ Menstrual Pain
☐ Cold Feet	☐ Loss of Balance	☐ Menstrual Irregularity
☐ Nervousness	☐ Light Sensitivity with Eyes	☐ Hot flashes

Have <u>YOU</u> (○) or <u>A FAMILY MEMBER</u> (☐) ever been diagnosed with any of the following conditions:

○ ☐ AIDS/HIV	○ ☐ Heart Disease	○ ☐ None
○ ☐ Cancer	○ ☐ Diabetes	○ ☐ Unknown
○ ☐ High Blood Pressure	○ ☐ Stroke	○ ☐ Other_____

724 S. 8th St.
Griffin, Ga. 30224

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:
(chief complaint)

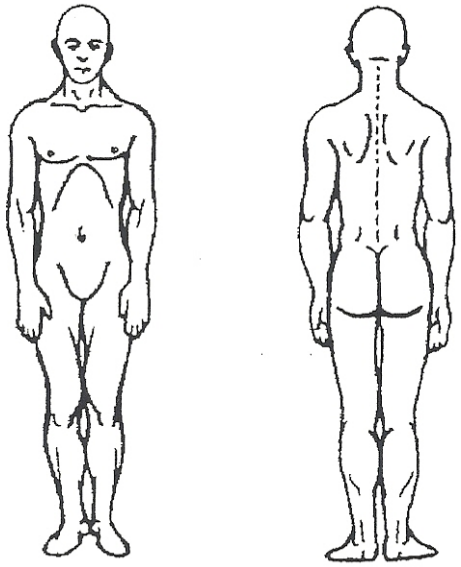
1) _____ 2) _____ 3) _____ 4) _____

0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= !!!
Shooting	= XXX
Other_____	= ***



How often do you notice your symptoms? ❒ Constantly ❒ Frequently ❒ Occasionally

Does anything relieve your pain?_____

What activities are difficult to perform? ❒Sitting ❒Standing ❒Walking ❒Bending ❒Lying Down

Please describe any other activities that are restricted due to this injury?_____

_____

Is the condition getting worse? ❒ No ❒ Yes

Have you had this problem before? ❒ No ❒ Yes, When?_____

Have you ever been diagnosed with a Subluxation? ❒ No ❒ Yes, When? _____

Have you had x-rays before? ❒ No ❒ Yes, When? _____ What areas? _____

I am currently taking the following medications for the following reasons: ❒ None

_____

_____

Surgical History: _____ ❒ None

For Women Only: Is there a possibility that you may be pregnant? ❒ No ❒ Yes

Which best describes your health goals: ❒pain relief only ❒correct entire problem ❒ wellness/ preventative care

DATE: ___/___/___ **SIGNATURE:** _____

PARENT/GUARDIAN: _____

Ellis Chiropractic Clinic

FINANCIAL AGREEMENT

atients are responsible for full payment at the time of service. We accept cash, ersonal checks, and credit/debit cards. Returned checks are subject to a $25.00 e.

INSURANCE/CONTRACT SERVICES/THIRD PARTY

ther options are available if your care is covered by Group Health Insurance, Vorker's Compensation, Managed Care Provider, Medicare or Personal Injury.

ll deductibles and co-payments MUST BE MET at the time of service. In the vent of a third party claim, payment is due upon services rendered. We will pply you with statements, reports, or other documents to help you receive imbursement for your treatment.

e will not become involved in disputes with your insurance company regarding eductibles, co-pays, covered charges, secondary insurance, usual and customary es, etc. other than to supply factual information. Please be aware that you have a greement with your insurance company and they do NOT recognize us as part of at agreement.

after 45 days the payment has not been issued, it will be your responsibility to y your account and then ask reimbursement from your insurance carrier. Any lances left unpaid by your insurance company are billed monthly and are nsidered past due 10 days after the invoice date, UNLESS special arrangements ve been made in advance.

ave read and understand this agreement and I do not have any questions garding the payment policy of Ellis Chiropractic Clinic.

Ellis Chiropractic Clinic

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic test, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial, and seldom cause any problems. In rare cases, underlying physical defects, deformities and pathologies may render the patient susceptible to injury. The doctor will not give a chiropractic adjustment or health care if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means and without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. It is important to understand what to expect from Chiropractic health care services.

I have read and understand the information above.

Patient's Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

If you have health insurance, PLEASE READ AND SIGN the following authorization/assignment of benefits.

I authorize the release of any medical information to process my insurance claims. I authorize the request of payment of medical benefits directly to my physician. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

Patient's Signature _____ Date _____