PATIENT INTAKE FORM

darling
CHIROPRACTIC
& MASSAGE

PATIENT INFORMATION

Patient: _____ Preferred Name: _____
LAST NAME FIRST NAME MIDDLE INITIAL

Home Phone: _____ Cell Phone: _____ Email: _____

Address: _____

City/State/Zip: _____

Birth Date:_____ Referred by: _____

Are you interested in Online Bill Pay: ☐ Yes *(Please inquire at front desk)* ☐ No

Preferred method of reminder calls: ☐ Email ☐ Text ☐ Voice call with recorded message
**By giving us your email you have agreed to receiving a monthly newsletter.*

Is this related to an Auto Accident or Workers Comp Claim? ☐ No ☐ Yes **If Yes, please see the Front Desk immediately.**

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

EMPLOYER

Company Name:_____ Phone: _____

Address: _____ City/State/Zip:_____

Occupation: _____

INSURANCE INFORMATION *(if applicable)*

Primary Insurance Name: _____ Effective Date: _____

Primary Insurance ID Number: _____ Group Number: _____

Name of Primary Insurance Holder: _____ DOB of Holder: _____

Secondary Insurance Name: _____ Effective Date: _____

Secondary Insurance ID Number: _____ Group Number: _____

Name of Secondary Insurance Holder: _____ DOB of Holder: _____

If receiving massage therapy today, please complete the following:

Massage Coverage? ☐ Yes ☐ No ☐ Unknown Referral Required? ☐ Yes ☐ No

We are unable to verify massage benefits. If insurance does not cover massage treatment, patient will be held responsible for services rendered.

Co-Pay Amount: $_____ and/or Co-Insurance Amount (%) _____

PATIENT LAST NAME / FIRST NAME	DATE

PERSONAL HEALTH HISTORY

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond appropriately, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your care we need your complete health history.

Describe what brings you in today? _____

How long have you had this condition? _____ Is it getting worse? ☐ No ☐ Yes

Does it bother your... ☐ work ☐ sleep ☐ other _____

Please specify what seems to be the initial cause? _____

Are you under the care of a physician? ☐ No ☐ Yes If yes, for what reason? _____

Date of last physical exam:_____ Where? _____

Primary Health Care Provider: _____ Telephone: _____

Have you been hospitalized in the last 5 years? ☐ No ☐ Yes If yes, please describe:_____

Have you had any mental or emotional disorders? ☐ No ☐ Yes If yes, please describe: _____

Are you currently taking any medications? ☐ No ☐ Yes

If yes, please list: _____

Do you wear: ☐ heal lifts ☐ sole lifts ☐ shoe inserts ☐ orthotics

What is the current age of your mattress? _____ Is it... ☐ comfortable ☐ uncomfortable

How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ other (please specify): _____

Have you ever...

Yes	No		If yes, please briefly explain and state the year:
☐	☐	had a broken bone?	
☐	☐	had strains or sprains?	
☐	☐	had surgery performed?	
☐	☐	been struck unconscious?	
☐	☐	had x-rays/other imaging done?	

Do you...

Yes	No		If yes, please briefly explain:
☐	☐	take minerals, herbs or vitamins?	
☐	☐	have allergies? *(Food, seasonal, medications, etc.)*	

FAMILY HEALTH HISTORY

Information about your immediate family members, brothers, sisters, parents and grandparents will give us a better understanding of your total health picture. (ie: cancer, high blood pressure, diabetes, high cholesterol...)

Relationship	Present and Past Health Problems

PATIENT LAST NAME / FIRST NAME | DATE

Please circle ○ for present condition and ✔ check for past condition.

MUSCLE/JOINT

- ☐ arthritis
- ☐ bursitis
- ☐ foot trouble
- ☐ hernia
- ☐ low back pain
- ☐ neck pain, stiffness
- ☐ pain between shoulders
- ☐ sciatica
- ☐ spinal curvature
- ☐ swollen joints

GENERAL

- ☐ allergy
- ☐ chills
- ☐ convulsions
- ☐ dizziness
- ☐ fainting
- ☐ fatigue
- ☐ fever
- ☐ headache
- ☐ loss of sleep
- ☐ loss of weight
- ☐ anxiety
- ☐ depression
- ☐ neuralgia
- ☐ numbness
- ☐ sweats
- ☐ tremors

CARDIOVASCULAR

- ☐ hardening of arteries
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ pain over heart
- ☐ poor circulation
- ☐ rapid heartbeat
- ☐ slow heartbeat
- ☐ swelling of ankles

GENITOURINARY

- ☐ bed wetting
- ☐ blood in the urine
- ☐ frequent urination
- ☐ kidney infection
- ☐ painful urination
- ☐ prostate trouble
- ☐ vomiting up blood

PAIN OR NUMBNESS IN...

- ☐ shoulders
- ☐ arms
- ☐ elbows
- ☐ hands
- ☐ hips
- ☐ legs
- ☐ knees
- ☐ feet

RESPIRATORY

- ☐ chest
- ☐ chest pain
- ☐ chronic cough
- ☐ difficulty breathing
- ☐ spitting up blood
- ☐ spitting up phlegm
- ☐ wheezing

EYE, EAR, NOSE & THROAT

- ☐ asthma
- ☐ colds
- ☐ crossed eyes
- ☐ deafness
- ☐ earache
- ☐ ear discharge
- ☐ ear noise
- ☐ enlarged glands
- ☐ enlarged thyroid
- ☐ eye pain
- ☐ failing vision
- ☐ hay fever
- ☐ hoarseness
- ☐ nasal obstruction
- ☐ nearsightedness
- ☐ nose bleeds
- ☐ sinus infection
- ☐ sore throat

SKIN

- ☐ boils
- ☐ bruise easily
- ☐ dryness
- ☐ hives or allergy
- ☐ itching
- ☐ skin eruptions (rash)
- ☐ varicose veins

GASTROINTESTINAL

- ☐ colitis
- ☐ colon trouble
- ☐ constipation
- ☐ diarrhea
- ☐ difficult digestion
- ☐ bloated abdomen
- ☐ gallbladder trouble
- ☐ hemorrhoids
- ☐ jaundice
- ☐ liver trouble
- ☐ nausea
- ☐ pain over stomach
- ☐ poor appetite
- ☐ vomiting

WOMEN ONLY

- ☐ congested breast
- ☐ cramps or backache
- ☐ excessive menstrual flow
- ☐ hot flashes
- ☐ irregular cycle
- ☐ lumps in breast
- ☐ menopause
- ☐ painful menstruation

Are you pregnant? ☐ Yes ☐ No

If yes, how many months? _____

How many children do you have? ___

Any complications during pregnancy or labor? ☐ Yes ☐ No

Please explain: _____

CONDITIONS

- ☐ alcoholism
- ☐ allergy to oils/lotions/fragrances
- ☐ anemia
- ☐ appendicitis
- ☐ arteriosclerosis
- ☐ cancer
- ☐ chickenpox
- ☐ cholera
- ☐ cold sores
- ☐ diabetes
- ☐ dipitheria
- ☐ eczema
- ☐ edema
- ☐ emphysema
- ☐ epilepsy
- ☐ fever blisters
- ☐ goiter
- ☐ gout
- ☐ heart disease
- ☐ herpes
- ☐ influenza
- ☐ lumbago
- ☐ malaria
- ☐ measles
- ☐ miscarriage
- ☐ multiple sclerosis
- ☐ mumps
- ☐ pacemaker
- ☐ pleurisy
- ☐ pneumonia
- ☐ polio
- ☐ rheumatic fever
- ☐ scarlet fever
- ☐ stroke
- ☐ tuberculosis
- ☐ thyroid fever
- ☐ ulcers
- ☐ venereal disease
- ☐ whooping cough

Habits

NONE / LIGHT / MODERATE / HEAVY

- ☐☐☐☐ alcohol
- ☐☐☐☐ coffee
- ☐☐☐☐ tobacco
- ☐☐☐☐ recreational drugs
- ☐☐☐☐ exercise
- ☐☐☐☐ sleep
- ☐☐☐☐ appetite
- ☐☐☐☐ soft drinks
- ☐☐☐☐ salty foods
- ☐☐☐☐ water
- ☐☐☐☐ sugar

PATIENT LAST NAME / FIRST NAME | DATE

PLEASE MARK AREAS OF PAIN

Using the scale below, please rate your level of pain today from zero (no pain) to ten (worst possible pain):

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Using the body chart below, indicated the region(s) of your complaint using the following symbols:

A - Aching

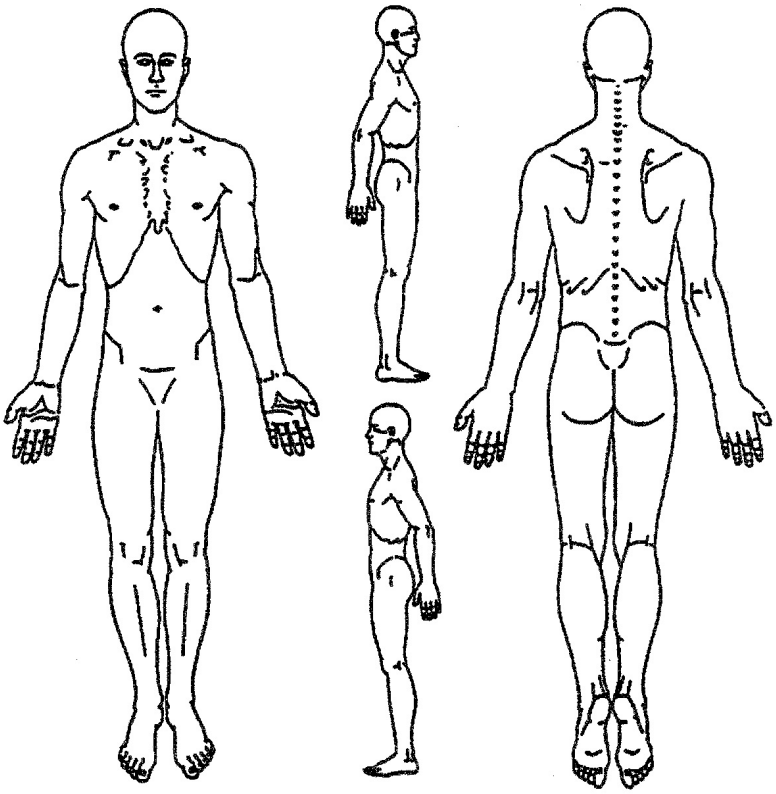
B - Burning

N - Numbness/Tingling

S - Stabbing/Sharp

T - Tightness

O - Other



FOR CHIROPRACTOR

Have you seen a chiropractor before?
☐ No ☐ Yes

If yes, how long ago? _____

_____

For what reason? _____

_____

FOR MASSAGE

Have you ever had a professional massage before? ☐ No ☐ Yes

Do you have difficulty laying on your front, back or side? ☐ No ☐ Yes

If Yes, which causes you difficulty? _____

Do you wear the following?
☐ Pacemaker ☐ Isulin Pump

Are there any areas you DO NOT want massaged?

If so, please list below: _____

_____

What type of pressure do you prefer?
☐ Light ☐ Moderate ☐ Deep ☐ Not Sure

ANY ADDITIONAL QUESTIONS OR CONCERNS?

_____

_____

_____

_____

_____

_____

PATIENT LAST NAME / FIRST NAME	DATE

PATIENT AGREEMENT ASSIGNMENT AND RELEASE

I authorize the release of any information including diagnosis and the records of any treatment rendered to me or my child during the period of such care to third-party payers and or other health practitioners. I authorize and request my insurance company to pay directly all medical benefits otherwise payable for services. I understand that I am financially responsible for all charges whether or not paid by insurance, and I have read and understand the financial policy of this office. I authorize the use of the signature on all my insurance omissions and to obtain other medical records and radiographic CT and MRI images and their corresponding report.

Signature of Insured: _____ Date: _____

FINANCIAL POLICY

Payment for copayment and supplements is due at the time rendered. Payment on the date of service is eligible for a time of service non insurance rate. You will be notified of coinsurance or other balances within 30 days of our receiving your explanation of benefits from your insurance company. There is a $40 fee for NSF checks. Accounts over 90 days past due will incur a $25 fee, unless payment arrangements are made. If you need assistance or need to make special arrangements, please talk to our billing specialist. 24 hour notice of cancellation is required. A no-show fee of $45 will be charged for 60 minute chiro and massage appointments, $65 will be charged for no-show 90 minute massage appointments.

Signature of Insured: _____ Date: _____

CONSENT TO TREAT

Chiropractic examination and therapeutic procedures including spinal adjustment, heat application, manual traction, therapeutic exercise and manual muscle therapy are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of said symptoms. More serious complications are extremely rare and their association with spinal adjustment (manipulation) is debated. These complications include injury to the neurovascular structures in the neck which may be associated with stroke and serious neurological impairment, injuries to the spinal discs, and spinal fractures. Research shows that serious complications are estimated to occur in every 1 out of 3-10 million adjustments of the neck, 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustment is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result. I have read the copy of Darling Chiropractic & Massage patient Privacy Practices.

Patient Signature: _____ Date: _____

Please be aware that there is not a guarantee of payment.
If an insurance company provides you with inaccurate information, they may not honor benefits quoted.

Thank you for choosing Darling Chiropractic + Massage.