Gaul Family Chiropractic

PATIENT INTAKE

Today's Date: ____/____/____

First Name _____ Middle Initial: ____ Last Name: _____
Preferred Name: _____
Address: _____City: _____State: ____ZIP_____
Phone #: _____
Other Phone #: _____ May we leave a message? **Y N**
Birthdate: ____/____/____ **Male Female**
Email Address: _____
Emergency Contact: _____ Relation: _____
Phone #: _____
Who may we thank for telling you about us? _____

Name of Medical Doctor: _____ Phone #: _____

Occupation: _____
Employer: _____ How Long: _____
Employer's Address: _____
Work Phone #: _____

REASON FOR VISIT:_____
When did your symptoms start? _____
How did your symptoms start? _____
What is your pain **range** in the last 24 hours? (0=no pain 10=deathlike) **0 1 2 3 4 5 6 7 8 9 10**
In the last week what is your pain **range**? (0=no pain 10=deathlike) **0 1 2 3 4 5 6 7 8 9 10**
What daily activities is your condition affecting?
_____
_____

Have you had this/similar conditions in the past? **Y N**
If so, please explain: _____
_____

Have you treated for this condition or used self-care?
Yes: _____
_____

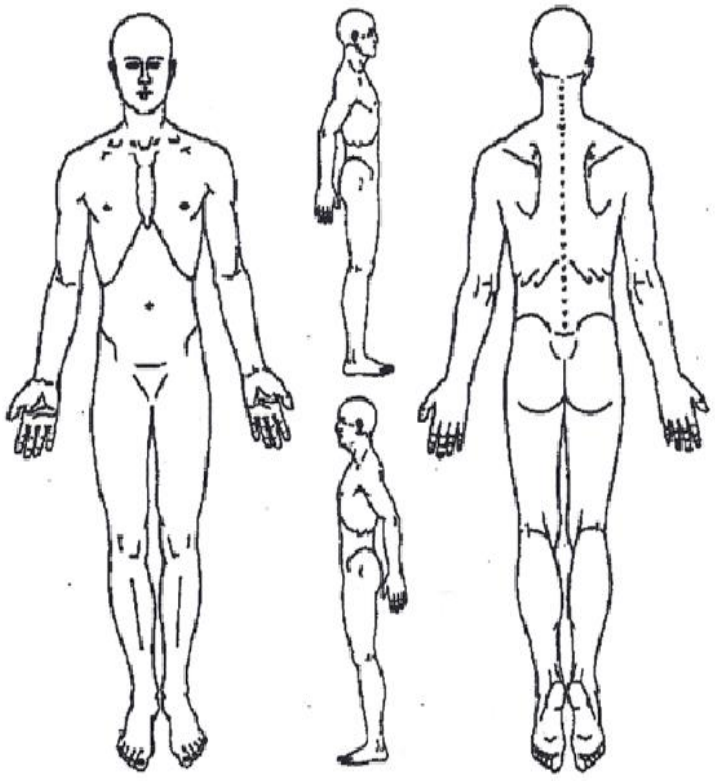
No (please circle any that apply)
Time | Money | Lack Insurance | Distrust Providers

How often have you been treated for this condition?
_____
How much change have you seen on your condition?
_____

Please list other concerns you wish to discuss today:
_____
_____
_____

Please show us where your symptoms are using the letters below:

N = Numbness **P** = Pins & Needles **B** = Burning **A** = Aching **S** = Stabbing



Gaul Family Chiropractic

PATIENT INTAKE FORM

Today's Date: ___/___/___

HEALTH HISTORY: Please use the back of this form or provide copies if more space is needed.

Current Height: _____ Current Weight: _____

Health Issues: _____

Medications: _____

Allergies: _____

List all Surgeries & dates: _____

_____

Serious Traumas & dates: _____

_____

Family Health History: _____

Supplements / Vitamins? _____

Exercise / Recreational activities? _____

_____

Special diet? _____ Since: ___/___/___

Do you wear: **Heel lifts** **Sole lifts** **Insoles** **Arch supports** **Other Support:** _____

What are your goals for treatment here? **Acute Pain Relief** **Chronic Pain Relief** **Lifestyle Change**

Other: _____

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest, and any other expenses incurred in collecting your account allowable by Colorado Law.
- Please provide the office with copies of policy for all insurances you wish billed for your care, we may bill your insurance as a courtesy but are bound by the parameters of your policy if applicable.
- I hereby authorize assignment of my insurance rights and benefits directly to the provider (Gaul Family Chiropractic) for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if accepted at this office).
- I authorize the provider and or managed care organization to release any information needed during diagnosis and treatment or to process insurance claims.
- Patients under 18: parent/guardian please initial for permission to treat on this visit and future visits. _____
- I authorize Gaul Family Chiropractic to use a copy of my signature on HICFA forms for billing for my care.
- I authorize the staff to perform any necessary services needed during exam, diagnosis, and treatment.
- Chiropractic /massage treatment is rendered to attempt to provide patient relief from musculoskeletal issues in the human body. Results are completely based upon patient condition and may vary from patient to patient. There are potential risks of side effects with manual medicine including but not limited to muscle or joint soreness, stroke, fracture, sprain, or strains.
- I understand my health information is protected under the HIPAA Act. Upon request I will be furnished a full copy of my rights under the HIPAA Act and how this office follows this act.
- **We ask for scheduled appointments to be cancelled or rescheduled by the end of business day prior to your scheduled appointments. This allows us to offer appointments to other patients who may have an immediate need to care. If you do not show up for your scheduled appointment or fail to provide sufficient notice as listed, you will be charged a $25 missed appointment fee. In the case of emergency there is no charge, but please call us as soon as possible.**
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge.
- I understand it is my responsibility to inform the office of any changes to the information I have provided.
- We invite you to discuss with us any questions regarding our services and your treatment. The best health services are based on a friendly, mutual understanding between provider and patient.

Signature: _____ Date ___/___/___

Guardian/Parent(if applicable)_____