Gaul Family Chiropractic

PATIENT INTAKE

Today's Date: ____/____/____

Last Name: _______________ First Name: _______________ Middle Initial: ______
Preferred Name: _________________________
Birthdate: ____/____/____ **Male Female**
Address: ____
City:____________________________ State: ___________ Zip: ____________
Home Phone #: _____________________________
Cell / Other Phone #: ________________________ May we leave a message? Yes No
Email Address: ____
Emergency Contact: ____ Relation: ______________________
Home Phone #: _______________________________
Who may we thank for telling you about us? ____

Name of Medical Doctor: ________________________________ Phone #: _______________________

Occupation: ____
Employer: ____ How Long: _____________
Employer's Address: ____
Work Phone #: _________________________

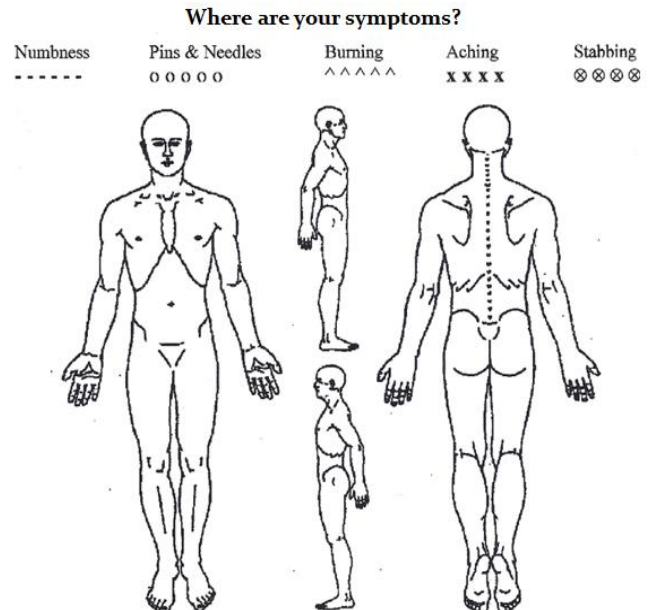
REASON FOR VISIT:
When and how did your symptoms start? ____
____
____
What is your pain **range** in the last 24 hours? (0=no pain 10=deathlike) **0 1 2 3 4 5 6 7 8 9 10**
In the last week what is your pain **range**? (0=no pain 10=deathlike) **0 1 2 3 4 5 6 7 8 9 10**
Is your condition: (*please circle all that apply*):
getting worse | staying the same | getting better | constant | frequent | occasional | comes & goes
What daily activities is your condition affecting?
____
____

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

Have you been treated for this condition?
Yes at:____
No (please circle any that apply)
Money | Time | Lack of Insurance | Distrust of providers

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

Please list any other concerns you have for your provider:
____
____



Gaul Family Chiropractic

PATIENT INTAKE FORM

Today's Date: ____/____/____

HEALTH HISTORY: Please provide as much detail as possible, use the back of this form if more space is needed to adequately describe your history.

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**

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

____

- 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, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. Chiropractic / massage treatment is rendered to provide patient relief from musculo skeletal 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. Please discuss any concerns you may have with your practitioner.
- Please provide the office with copies of the cards for all insurances you wish billed for your care.
- 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. By my signature that I have received a copy of this policy I authorize Gaul Family Chiropractic to use a copy of my signature on HICFA forms for billing for my care.
- 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 this appointment slot 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 cancelation fee. In the case of emergency please call us as soon as possible, and we will waive the fee.**
- 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. The best health services are based on a friendly, mutual understanding between provider and patient.

Signature: ____________________________________ Date ___/___/___