Patient Intake Form **Please Write Legibly**

Patient Legal Name: ____ □Male □ Female
Preferred Name:________________________ Date of Birth: ________________ Age: _______
Home Address: ____Apt#:_______________
City: _________________________________ State: _______________ Zip: _____________
Home Phone: ____________________________Cell Phone: ___________________________
Email: __________________________________□ Married □ Single □ □ Other: __________
Employer: __________________Occupation: _____________ Work Phone: _______________
Emergency Contact Name and Number: ____

Purpose of Visit: **DO NOT LEAVE BLANK**

Complaint(s):____
When did the symptoms start? _________________Location of Symptoms: ___________________
What caused the condition? □ Trauma □ Repetitive □ Motor Vehicle □ Work Related □ Post Surgical □ Unknown
If your injury is work or auto related, please see the front desk for additional forms
What makes the symptoms better? :____
What makes the symptoms worse? :____
Describe the nature of your symptoms: Choose all that apply
□ Sharp □ Dull Ache □Burning □Boring □Deep □Numbness/Tingling □Other:_______________
Does the pain radiate to another region of the body? □ No □ Yes,
Location:____
On a scale of 0-10, with 10 being unbearable pain, how would you rate yours? ______________________
How often do you have symptoms? □ Constant □ Frequent □ Occasional □ Intermittent
Have you suffered from this condition in the past? □ No □ Yes When: _______________________
How much have your symptoms interfered with your usual daily activities (work and home)
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely
Previous Chiropractic Care: □No □Yes Doctor's name: ___________________________________
Do you have X-Rays/MRI/CT from a previous doctor that is less than a year old? □Yes □No

Female Patients Only: Are you pregnant? □No □Yes □ Unsure

I, ________________, a patient of Chiropractic Wellness Center and affiliates, certify that to the best of my knowledge, am not pregnant. By signing here, I authorize my treating doctor to take all appropriate diagnostic x-rays. If there is even a remote chance that I may be pregnant, I will notify my doctor immediately.
Signature: ____

Insurance Information:

Insurance Company: ____________________ Insurance Policy #: __________________________
Group #: __________________ Policy Holder: ________________________ □Male □ Female
Policy Holder DOB: ________________ Relationship to Policyholder: □ Spouse □ Child □ Other
Address (if different): ____ Who is responsible for payment? □ Self □ Spouse □ Other: __________________________

****I understand Chiropractic Wellness Center bills the insurance company on my behalf and does not guarantee benefits at any time. I am responsible for any non-covered services. Initial:** __________

Patient/Parent Signature: ___________________________________**Date:** ___________________

Patient Name: ____

List Medical conditions you have and/or had: ____
List Medications you are taking and why: ____
List past surgeries: ____
List any allergies you suffer from: ____
Have you had any past Motor Vehicle Accidents (MVA), major sports injuries, or broken bones? If yes, describe:
____
List your family medical history (diabetes, cancer, heart disease, bone disorders, etc.):
____

Relative and Absolute Contraindications: ***Do you have any of the following conditions?***

❑Joint Hypermobility ❑Osteoporosis/Osteopenia ❑ Bone Tumors ❑Bleeding Disorders ❑Blood Thinners ❑Progressive Radiculopathy ❑Rheumatoid Arthritis ❑Ankylosing Spondylitis ❑Ligament Laxity ❑Joint Dislocation ❑Recent/Unstable Joints ❑Unstable/Missing Dens ❑ Spinal Cancer ❑Spinal/Joint Infection ❑Cauda Equina Syndrome ❑Vertebrobasilar Insufficiency ❑Arterial Aneurysm **❑NONE OF THE ABOVE**

PLEASE CHECK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Low Back Pain
Mid Back Pain
Pain Between Shoulders
Neck Pain
Arm Problems
Leg Problems
Swollen Joints
Stiff Joints
Sore Muscles
Weak Muscles
Walking Problems
Spasms
Broken Bones
Shoulder Pain
Bladder Trouble
Excessive Urination
Scanty Urination
Painful Urination
Discolored Urine
Vaginal Discharge

Vaginal Bleeding
Vaginal Pain
Breast Pain
Lumps on the Breast
Poor Appetite Excessive Hunger
Difficult Chewing
Difficult Swallowing
Excessive Thirst
Nausea
Vomiting Blood
Abdominal Pain
Diarrhea
Constipation
Black Stool
Bloody Stool
Hemorrhoids
Liver Trouble
Gall Bladder Problems
Weight Trouble

Numbness
Loss of Feeling
Paralysis
Dizziness
Fainting
Headaches
Muscles Jerking
Convulsions
Forgetfulness
Confusion
Depression
Insomnia
Chest Pain
Pain over Heart
Difficult Breathing
Persistent Cough
Coughing Phlegm
Coughing Blood
Rapid Heartbeat
Blood Pressure Problems

Lung Problems
Varicose Veins
Eye Strain
Eye Inflammation
Vision Problem
Ear Pain
Ear Noises
Ear Discharge
Hearing Loss
Nose Pain/Sinus issues
Nose Bleeding/Discharge
Difficult Breathing Through Nose
Sore Gums
Dental Problems
Sore Mouth/Throat
Hoarseness
Difficult Speech
Heart Problems

Patient Weight: __________ Patient Height: ___________ Habits: Cigarettes Alcohol Other: _____________

Fractures are rare occurrences and generally result from some underlying weakness of the bone which your doctor looks for during your initial consultation, your examination, and/if reviewing your x-rays. Stroke has been the subject of tremendous disagreement. The incidence of a stroke is exceedingly rare and is estimated to occur between one in one million and one in five million adjustments of the neck. The other complications are also generally described as rare.

I acknowledge that all treatment options for chiropractic conditions have been fully explained to me including over-the-counter drugs, medical care and prescription drugs, hospitalization, and surgery. It is my responsibility to complete treatment and follow recommended maintenance schedules. If I do not proceed with my treatment plan in a timely manner, maintenance plans are not followed, and/or appointments are missed, adverse results could affect my health including recurring symptoms, irreversible nerve/muscle damage, deterioration/arthritis of the spinal discs and joints, and/or inability to do common daily activities.

By signing below, I state that I have weighed the risks involved in undergoing treatment and hereby give my consent to that treatment. I understand the treatment that has been presented and the risks of not completing necessary treatment.

Patient/Parent Signature: ____ Date: _____________

Patient Name: ____**Date:**___________________

How did you hear about us? ____

Consent to Professional Treatment: I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time. **Initial ____**

HIPAA Notice of Privacy Practices: I have read the HIPAA notice provided by Chiropractic Wellness Center which describes how medical information about me may be used and disclosed and how I can get access to this information. By subscribing my name below, I acknowledge my understanding and agreement to its terms. A copy of the notice is available upon request.

Initial_____

Release of Information I hereby authorize and release the doctor to disclose all or part of the clinic's record to any person or corporation, which is or may be liable under a contract to the clinic, the patient, a family member, or employer of the patient for all or part of the clinic's charge including, but not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Initial_____

I authorize the release of information including the diagnosis, records, examination rendered to me, billing, and claims information. This information may be released to:

Name: ____ [ ] Spouse [ ] Child [ ] Other

Name: ____ [ ] Spouse [ ] Child [ ] Other

Name: ____ [ ] Spouse [ ] Child [ ] Other

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:__________________

If unable to reach me:

[ ] you may leave a detailed message [ ] please leave a message asking me to return your call

[ ] ____

The best time to reach me is (*day*)___________________ between (*time*)_________

Patient/Parent Signature: ____

Missed Appointment and Cancellation Fee Policy

There is a missed appointment fee for appointments that are not canceled or rescheduled 24 hours prior to the scheduled appointment time. This fee is not billable to your insurance company and will be your own responsibility. We understand that things happen that may interfere with your appointments so all we ask is that you please notify us if you are unable to keep your scheduled appointment so that we can better accommodate our other patients.

NO SHOW FEE POLICY

$30 Massage Appointment

$30 New Patient, Re-examination, and Report of Finding Appointments

LESS THAN 24 HOURS CANCELLATION FEE POLICY

$30 Massage Appointment

$30 New Patient, Re-examination, and Report of Finding Appointments

MEMEBERSHIP NO SHOW OR LESS THAN 24 HOUR POLICY

These appointments will count as if they were used.

Reminders

Reminders are sent via email and/or text. I understand these reminders are automated and are not guaranteed. Please send me reminders by:

- Email: ____
- Text: ____
- I do not want reminders.

Email Permission

Your Personal Health Information (PHI), including but not limited receipts, records, reports, notes, radiology, and excuse slips, may contain personal information. Chiropractic Wellness Center uses a secure email server and can send you emails containing this information. However, once the information has left our server, we cannot guarantee the security of your PHI. You have an option to choose if you would like to receive this information by email. This permission can be changed in writing at any time.

- ☐ I would like to receive emails that may contain my PHI.
- ☐ I would not like to receive emails that may contain my PHI.

I have read and accept the above 'No Show and Cancellation Fee Policy' and 'Reminders" and agree to the terms set forth regarding payment.

Patient Name: ____

Patient/Parent Signature: ____Date: ____________________

Chiropractic Wellness Center
7700 W. Eldorado Pkwy., Suite 100
McKinney, TX 75070

Telephone: (972) 540-0608

Patient Name: ____Date: _________________________

This is an **optional** form for you to allow your minor child, of **13 years or older**, to be seen without a parent or legal guardian on the premises. The authorization can be revoked at any time by the parent or Chiropractic Wellness Center. **A parent or guardian must be present for the initial visit, and as the doctor or therapist advises throughout treatment**.

I, ______________________, allow _____________________________, a minor, to be seen without a parent or guardian present for chiropractic treatments at Chiropractic Wellness Center.

-OR-

If you would like to authorize your minor child to be seen with an adult who is not a legal parent or guardian, please complete the following:

I, ____________________________, authorize the following adult(s) to accompany my child,

______________________________, while receiving treatment at Chiropractic Wellness Center.

Name: ____Relationship: ______________________________

Name: ____Relationship: ______________________________

Name: ____Relationship: ______________________________

Parent/Guardian Signature: ____