PATIENT INTAKE FORM

PERSONAL INFORMATION :

First Name : _____ Last Name : _____

Date of Birth : _____ Age : _____ Height : _____ Weight : _____

Address : _____ City : _____

_____ State : _____

_____ Zip : _____

Phone : _____ Email : _____

Occupation : _____ Employer :_____

Emergency Contact : _____ Relationship to Contact : _____

Emergency Contact Phone Number :_____

How did you hear about us? _____

_____

REASONS FOR TODAY'S VISIT :

What brings you in today? (Primary complaint): _____

When did this start?_____

Was there a specific trauma/injury?_____

What makes the pain worse?_____

What makes the pain better?_____

How would you describe the pain? (circle all that apply): _____

Achy	*Cramping*	*Stabbing*	*Cold*
Sharp	*Numb*	*Burning*	*Heavy*
Throbbing	*Pins & Needles*	*Swelling*	*Shocks*

How would you rate your pain NOW 0 (no pain) to 10 (worst)?_____

How would you rate your pain when it is at its worst 0 (no pain) to 10 (worst)? _____

What things have you tried to help these problems? (circle all that apply):_____

Ibuprofen	*Gabapentin*	*Chiropractic*	*Aspirin*
Motrin	*Massage*	*Creams*	*Physical Therapy*
Aleve	*Steroid Injections*	*Pain Medications*	*Acupuncture*

Other:_____

If more than one concern, please list your health problems you would like to be corrected in order of importance:

1._____ 3._____

2._____ 4._____

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PAST MEDICAL HISTORY:
Have you ever suffered from any of the following, past or present? (circle all that apply). Please write in all known medical conditions.

Back Pain	*Bulging Disc*	*Cancer*	*Liver Disease*
Neck Pain	*Spinal Stenosis*	*Asthma*	*HIV*
Knee Pain	*Degenerative Disc*	*Hypertension*	*Vertigo*
Hip Pain	*Plantar Fasciitis*	*High Cholesterol*	*Thyroid Disease*
Ankle Pain	*Osteoarthritis*	*COPD*	*Stomach Ulcers*
Foot Pain	*Rheumatoid Arthritis*	*Headaches*	*Fibromyalgia*
Hand Pain	*Spondylolisthesis*	*Bleeding disorders*	*Anxiety*
Shoulder Pain	*Diabetes*	*Anemia*	*Depression*
Foot Numbness	*Heart Disease*	*Vascular problems*	*DVT (blot clots)*
Hand Numbness	*Heart Attack*	*Pacemaker/Defibrillator*	*Pulmonary Embolism*
Herniated Disc	*Stroke*	*Kidney Disease*	*Other:_____*

PAST SURGICAL HISTORY: Please list any surgeries that you have had.

_____

_____

_____

FAMILY HISTORY:

_____

_____

TRAUMAS: Please list any accidents or traumas you have suffered from.

_____

_____

ALLERGIES: Please list all allergies/sensitivities to medication, food and other items:

Allergy : _____ Reaction : _____

_____ _____

_____ _____

MEDICATIONS: List the prescription drugs you are currently taking (or you may attach a list):

Name : _____ Dose (mg or IU) : _____ Times Daily : _____

_____ _____ _____

_____ _____ _____

Are you on blood thinners? (ie. aspirin, plavix, coumadin, xarelto, Eliquis): ☐ YES ☐NO

List all nutritional supplements (vitamins, herbs, homeopathies, et c.) as above:

Name : _____ Dose (mg or IU) : _____ Times Daily : _____

_____ _____ _____

_____ _____ _____

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SOCIAL HISTORY

Do you smoke? ☐Yes ☐No If yes, how many cigarettes daily? _____

Do you drink? ☐Yes ☐No If yes, how many drinks daily? _____

Do you exercise ☐Yes ☐No If yes, how much exercise daily? _____

Acknowledgement of authenticity.
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

_____
Print Name

_____ _____
Signature of Patient, Parent or Guardian Date

Confidentiality.
This is a confidential record of your medical history and pertinent personal information. The medical provider reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

_____ _____
Signature of Patient, Parent or Guardian Date

Advanced Health Chiropractic
Advanced Health Medical, LTD.

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other therapeutic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the name of the patient below, for whom I am legally responsible) by the licensed doctors and staff at Advanced Health Chiropractic and/or Advanced Health Medical, Ltd. and/or O.O.N Medical Group, Ltd.

I have had an opportunity to discuss with the doctors of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctors named below have additionally explained the risks associated with my refusal of treatment.

Dr. Luke Stringer DC Dr. Cassandra Stringer DC Dr. Brian Vear DC

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_____ **Date** _____

Witness Signature_____ **Date** _____

FINANCIAL POLICY

We are committed to providing you with quality and affordable health care. Some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this financial policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. If you are not insured by an active plan, payment in full is expected at or prior to each visit. Knowing your exact insurance benefits is your responsibility but we will give you an estimate based on our benefits check department. Due to the many variables in the carriers "allowable" for each billing code (CPT code) we are unable to calculate an accurate estimation of your services. Many times, insurance companies allow different amounts for the same billing code within various visits of your treatment.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. Should your insurance company fully and legally adjudicate your claims in coordination of your plan documents then co-insurance, deductibles and non-covered items are due 30 days from receipt of billing unless other payment arrangements have been established.

3. Proof of insurance. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

4. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

5. Out-of-Network Claims. We shall make every reasonable effort to collect on every claim from the patient or through negotiation with the insurance company, without putting undue hardship on the patient. When a patient is first seen in our office the staff shall make reasonable efforts to collect some of the patient responsibility up front to cover some of the cost of services. Your insurance company must fully and legally adjudicate your claims in coordination with your plan documents within 30 days of receipt of the claim submitted.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

ADVANCED HEALTH

A MULTIDISCIPLINARY CLINIC