Chiropractic Intake Form

5191 S. Yosemite St., Suite B, Greenwood Village, CO 80111

Please complete all areas as completely and accurately as possible. ALL AREAS ARE VALID. All information is private.

Patient Contact Information

Name: ______________________________ Date: ______________

Address:______________________________City:_______________ State:______ Zip:___________

DOB ___/___/_____ Age: ____ Gender:_____________ If minor, name of parent: ______________________________

Home Phone: (______)_______________Work#(_____)_______________ Cell #(______)_________________

E-mail address: ___________________________ Employer: _______________ Occupation:________________

Married or have a life partner? Yes No Significant other's name: ____

Children's names/ages: ____

Emergency Contact: ______________________ Relationship: ____________ Phone:(_______)_____________

2nd Contact: ___________________________ Relationship: ____________ Phone:(_______)_____________

Insurance: □ Self Pay □ Health Insurance □ Auto Injury SS# _______________________

Primary: ___________________________________ Secondary: ____________________________________

How did you hear of us? Referral: _____________________________ Doctor: ___________________________

Internet: _______________________ Advertisement: __________________ Other: ______________________

Previous Chiropractic History

Have you ever received Chiropractic Care? Yes No

What age was your 1st **professional** adjustment? Birth-1yr. 2-6 yrs. 7-12 yrs. 13-18yrs. Other: _____________

Who was your last chiropractor? _____________________________ What city/state? _________________________

How often were your visits? _____________ When was your last adjustment? ____________ Reason? ___________

Current Care

On a scale of 1-10, rate your commitment to get rid of problem(s) and feel better? ________

Any concerns or fears about chiropractic? _____ If yes, what? ____

What are your goals of your chiropractic visits? 1. _________________________ 2. ___________________________

Previous History with Other Treatments

What other treatments have you tried? ____

Name(s) of any other practitioner(s) treating your condition: ____

Additional Information: ____

Patient Condition

Please describe the location of your main symptom: ____

When did this start? ____

How did it start? ____

When was the most recent episode? ____

Describe the symptoms, dull/achy, sharp/stabbing, tightness, etc. __________________________________

Do you feel symptoms down your arms or legs? ____

Does anything go numb, tingly or have weakness? Where? _____________________________________

Is this condition getting: better worse same Is it progressively getting worse? Yes No

Please rate the intensity from 1 to 10 (10=Worst) Now: _______ Average: _______ At it's worst: _______

How often do you feel symptoms? Constant (100%) Frequent (75% of the time) Intermittent (50%) Occasional (25%)

When (morning, night, after work, etc.) is it the worst? ____

What makes it better? ____

What makes it worse… sitting standing bending ? ____

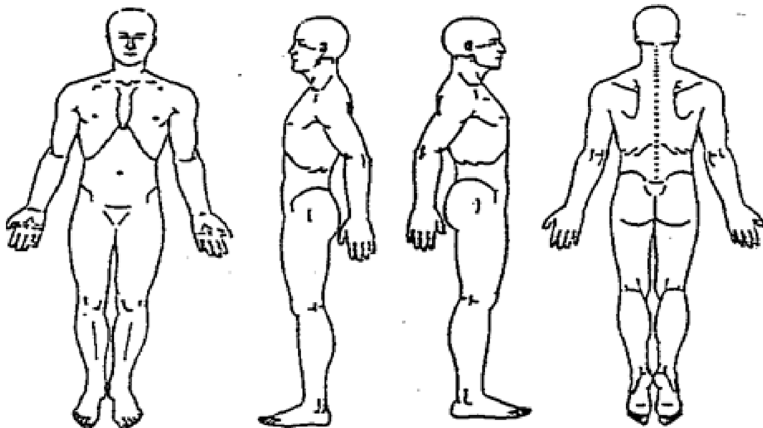
____

Does it interfere with your…… work sleep daily routine recreation? ___________________________

Additional Complaints: ____

____

Please draw where you feel symptoms:



Stress Habits

Smoking Packs/day: ___________

Alcohol Drinks/wk: ___________

Coffee/Caffeine Cups/day: ___________

Exercise Habits

Exercise per wk: None 1-3x 4-6x

Favorite activities: ________________________

Sleeping Habits

Position: Face down Face up On R / L side

How many hours? ____________

Straight through or how many wakes? _________

What causes you to wake? _________________

Global Systems Chart

Please indicate frequency of occurrence per day, week, month, or other.
Example: “Headaches: 2x daily” or “Neck Pain: 1x per month”

Cervical (Neck) Area

Headaches or Migraines: ____________
Dizziness/Lightheaded: ______________
Blurred/Loss of Vision: ______________
Sinus Congestion/Pain: ______________
Ringing in ears (Which?): ____________
Brain Fogginess: ___________________
Neck Tension/Pain: _________________
TMJ/Jaw Tension/Pain: ______________
Shoulder Tension/Pain: ______________
Elbow Tension/Pain: ________________
Wrist Stiffness/Pain: ________________
Hand Stiffness/Pain: ________________
Tingles/Numb Hands: _______________
Swollen Hands: ____________________
Cold Hands: _______________________

Thoracic Area

Difficulty Swallowing: ________________
Voice Change/Hoarseness: __________
Allergies (to what): _________________
Asthma/breathing issues: ____________
Chest pressure/Pain: ________________
Heartburn/Reflux: __________________
Gas/ Belching: _____________________
Nausea/Vomiting: __________________
Pain between sh. Blades: ____________

Lumbar/Low Back Area

Low Back Pain: ____________________
SI/Pelvis/Hip Pain: __________________
Thigh/IT Band Pain: ________________
Knee Pain (which?): ________________
Sciatica (which leg?): _______________
Calf Pain/Restless legs: _____________
Ankle or Foot Pain: _________________
Cold Feet (even w/ socks): ___________
Tingling/Numbness in legs: ___________
Constipation/Hard Stool: _____________
Diarrhea/Rectal Bleeding: ____________
Cannot fully void bladder: ____________
Dribbles when cough/sneeze: _________
Bladder wakes from sleep: ___________
Menstrual Cramping/PMS: ___________
Infertility or Impotence: ______________

Patient Health History Please check any of the following you have had:

__ Diabetes
__ Cancer
__ High/low Blood Pressure
__ Depression
__ Anxiety
__ Arthritis
__ Chronic fatigue
__ Concussion
__ Disc Herniation
__ Epilepsy
__ Heart disease
__ Thyroid Problems
__ AIDS/HIV
__ Kidney problems
__ High Cholesterol
__ Osteoporosis
__ Stroke
__ Weight Loss/Gain
__Other: ____

Accident History Everything is relevant.

Date: _____________ Front / Side / Rear Impact traveling _____________ MPH.

Any treatment? ____

Date: _____________ Front / Side / Rear Impact traveling _____________ MPH.

Any treatment? ____

Date: _____________ Front / Side / Rear Impact traveling _____________ MPH.

Any treatment? ____

Surgical History		**Current Medications**	
Year	Type/Area	Name	Purpose
_________	_____________________________	______________________	________________________
_________	_____________________________	______________________	________________________
_________	_____________________________	______________________	________________________
_________	_____________________________	______________________	________________________

Traumas (fractures, stitches, etc.)		**Supplements/Herbs**	
Year	Type/Area	Name	Purpose
_________	_____________________________	______________________	________________________
_________	_____________________________	______________________	________________________
_________	_____________________________	______________________	________________________
_________	_____________________________	______________________	________________________

Female patients: Please mark any additional conditions you've had:

Menstrual Problems / Pain Infertility Uterine fibroids Endometriosis PCOS

Start date of last period: ______________ Have you ever been pregnant? Y N # of times _________

Is there anything else which may help us to understand you and your needs which has not been discussed?

____

____

Please read the statements below and check the boxes next to those with which you agree:

□ I have been offered to view a copy of Integrative Health's HIPPA guidelines and privacy policies.
□ I certify that information provided to this office is up to date and correct to the best of my knowledge.
□ I authorize the release of any medical information necessary to process claims submitted to my insurance carrier.
□ I authorize payment of any medical benefits directly to this clinic for any services rendered to me.
□ I am the authorized parent or guardian of this child (if applicable) and authorize this office to treat my child.

Signature: ____ Date: ___________________

Signature of Parent: ____ Date: ___________________

Thank you for taking the time to provide us with this vital information. We are here to serve you!

5191 S Yosemite St, Suite B
Greenwood Village, CO 80111
Phone: 303-577-9977
www.IntegrativeHealthInc.com

_________ (initial) I, hereby understand Integrative Health Wellness Center is a wellness building that houses a variety of health professional businesses. As a patient, I realize I am not being treated by Integrative Health Inc., but the specific provider's business seen by. Integrative Health is not your health care provider and cannot be held responsible to any harm or damages to your person. I, hereby release Integrative Health Inc. from any damages that could occur to my person.

Consent For Care

_________ (initial) I, herby authorize and request the provider(s) in which I scheduled with at 5191 S Yosemite St, Ste B, to perform such examinations and therapeutic treatments as in the judgement of the provider(s). I understand I am not forced to accept medical treatment.

Authorization To Release Information

_________ (initial) I AUTHORIZE the provider(s) seen at 5191 S Yosemite Street, Ste B, to release any information required to process this claim to any insurance company or attorney involved in my case. I also authorize any insurance company or medical provider to release my medical records to the provider(s) at 5191 S Yosemite St, Ste B. The information is to be used for the purpose of preceding my claim for benefits due.

_________ (initial) I understand that my record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may request a copy of my records at any time and a fee may apply.

Payment Agreement

_________ (initial) I assume full responsibility for and agree to pay all costs, charges and expenses for goods and services furnished by provider(s) seen at 5191 S Yosemite St, Ste B, at time of service.

_________ (initial) I hereby authorize my insurance benefits to be paid directly to the provider(s) seen at 5191 S Yosemite St, Ste B. I must pay charges and services not covered by any insurer third-party and/or paid to the providers(s) seen at 5191 S Yosemite St, Ste B, for any reason within a time period deemed reasonable by the provider(s). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third party responsible for payment of the charges.

Cancellation Notice

_________ (initial) Kindly give 24 HOURS NOTICE for cancellations. Late cancellations are subject to 50% CANCELLATION FEE, no shows or cancellation with less than 2 hours before scheduled appointment are subject to a 100% CANCELLATION FEE. Cancellation fee is based on the cash rate of service. Call-backs or email reminders are a courtesy and I understand that I am responsible for my appointment and providing 24 hour notice for cancellations or reschedules.

____

Your Printed Name

_____________________________________ __________

Signature Date

5191 S Yosemite St, Suite B, Greenwood Village, CO 80111
Phone: 303-577-9977 Fax: 303-694-4341
www.IntegrativeHealthInc.com

Consent for Purpose of Treatment and Healthcare Operations

In this document, "I" and "my" refer to the patient/client

I consent to the use or disclosure of my protected health information by the provider(s) seen at Integrative Health Inc, 5191 S Yosemite St, Ste B., for the purpose of analyzing, diagnosing and providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or my treatment may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, the provider(s) seen are not required to agree to the restrictions that I may request. However, if the provider(s) agrees to a restriction that I request, the restriction is binding on the provider(s). I have the right to revoke this consent, in writing at any time, except to the extent that the provider(s) has taken action in the reliance on the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may review the Notice of Privacy Practices online on the link provided below and understand that I have the right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Integrative Health, as well as my rights and duties of the provider(s) seen at 5191 S Yosemite St, Ste B, with respect to my protected health information.

The Notice of Privacy Practices is available online at: https://www.hhs.gov/hipaa/for-individuals/index.html

____

Your Printed Name

____________________________________ ____________

Signature Date

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INSURANCE BILLING INFORMATION

Dealing with insurance can be complicated and confusing process. This information is meant to clear up any questions you might have when we are billing your insurance.

Each of providers is their own independent business and therefore contract individually with insurance. Confirm with your insurance or our front desk staff to see which providers are in-network and out-of-network with your insurance. Not all services are eligible under insurance.

The process to verify and bill insurance takes a few steps:

1. We will copy your insurance card, call and verify your benefits. We will find out if there is a deductible to be met prior to your insurance paying, or if you have a copay or co-insurance. To speed-up the verification process, contact your insurance prior to your appointment and we will honor benefits. Verification is never a guarantee of benefits. Your insurance will determine coverage upon receiving the claims.
2. When billing insurance, your provider will use specific legal codes designated to the service you received. These procedure codes, or CPT codes, have an assigned amount of time and fee attached to each. We must abide by these codes and they cannot be changed. The codes dictate the overall price at which the insurance company is charged, which is usually higher than the amount paid at time of service.
3. Once the insurance company receives the claim they will allow the full or a portion of the amount billed. For example, the insurance company gets a bill for $250.00 they may decide to allow $60.00 or deny the claim. Usually a denial it based on a variety of reasons, when possible we submit corrected claims for approval. Insurance companies ask us to allow 60-90 days to process claims.
4. If your insurance benefits state that your insurance will only cover a percentage of the charges, you may be responsible for paying the difference.
5. We will do everything we can to get your claims processed and approved, however, if insurance does not pay for your service(s), you will be responsible for the billed amount. To avoid additional charges, payment must be made in a timely manner.

Your understanding of this process is critical in our working relationship of provider and patient. Thank you for taking the time to read this letter, for further questions please inquire at our front desk.

____________________________________ ____________________
Signature Date

____
Printed Name

Name: ______________________________ Date: ______________

Notes: ______________________________