ChiroHealth of Rockford
6769 Courtland Drive
Suite 100
Rockford, Michigan 49341
(616) 863-9482 Office
(616) 863-9486 Facsimile

Patient Intake Form

Welcome to the office of ChiroHealth. Please fill out this **Patient Intake Form** completely and to the best of your knowledge. Let our staff know if you have any questions. When complete, return this **Intake Form** along with the **Office Policy** and **HIPPA Form** with appropriate signatures and initials filled in.

Patient Information

Personal Information

*First Name: _____

Middle Name: _____

*Last Name: _____

*Gender: ◯ Female ◯ Male

*Date of Birth: _____

Social Security #: _____

Height: _____ Feet _____ Inches

Weight: _____ lbs.

Marital Status: ◯ Single ◯ Married ◯ Other

Spouse's Name: _____

Number of Children: _____

Emergency Contact: _____

Relationship: _____

Phone: _____

Contact Information

*Email: _____

(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice)

*Home Phone: _____

*Cell Phone: _____

Work Phone: _____

* Address Line 1: _____

Address Line 2: _____

*City: _____

* State: _____

*Zip/Postal Code: _____

How did you hear about our office? ◯ Friend/Family ◯ Internet ◯ Community Event

Name: _____ ◯ Insurance List ◯ Drive By ◯ Other

Employment Information

Regular Work Status: ◯ Full Time ◯ Part Time ◯ Unemployed ◯ Retired ◯ Student

Employer Name: _____

Employer Address: _____

Employer City: _____

Employer State: _____ Employer Zip: _____

Occupation: _____

Insurance & Payment for Care

How do you plan to pay for care? ◯ Personal Insurance ◯ Third-Party Insurance ◯ No Insurance, Self-Pay

Name of Person(s) Responsible for Payment: _____

Responsible Party Phone: _____

Primary Insurance

Insurance Name: _____

Phone: _____

Address: _____

City: _____

State: _____ Zip: _____

ID/Policy #: _____

Group #: _____

Insured's Name: _____

Insured's Date of Birth: _____

Secondary Insurance

Insurance Name: _____

Phone: _____

Address: _____

City: _____

State: _____ Zip: _____

ID/Policy #: _____

Group #: _____

Insured's Name: _____

Insured's Date of Birth: _____

Authorization/Consent to Treat

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

* ☐ **I agree with this statement of authorization**

Name of the Patient: _____

(please print)

Signature of Patient, Parent or Legal Guardian (if a minor):

_____

Date: _____

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Health Questionnaire

Patient Name: _____ **Date:** _____

What is the purpose of your visit today? ◯ Wellness ◯ Complaint ◯ Injury ◯ Other

What type of complaint do you have? ☐ Acute ☐ Chronic ☐ Recurring ☐ Sub-Acute ☐ No Musculoskeletal Complaints

Where is your Chief Complaint? _____
(this is your primary area of pain/discomfort only, additional complaints are below)

How did this injury, pain or discomfort originate? _____

When did this condition begin? (use date if known) _____

Was this condition caused by a FALL, INJURY or ACCIDENT? ◯ No ◯ Yes: (explain) _____

_____

What is the frequency of your pain? ◯ Constant ◯ Frequent ◯ Occasional ◯ Intermittent

What is the quality of discomfort? ☐ Aching ☐ Annoying ☐ Burning ☐ Deep ☐ Diffuse ☐ Dull ☐ Heavy ☐ Intolerable
☐ Pulling ☐ Sharp ☐ "Shock Like" ☐ Stabbing ☐ "Stiffness" ☐ Throbbing ☐ "Tightness" ☐ Tingling ☐ Other

If the discomfort radiates, where does it travel to? _____

Is this complaint getting better, worse, or staying the same? ☐ Improved ☐ Worsened ☐ Relief that lasted awhile ☐ Same

What would you rate your pain? (0-10 with 10 being extreme) _____

What are your symptoms relieved by? ☐ Nothing ☐ Cold Packs ☐ Exercise ☐ Heat Packs ☐ Massage ☐ Chiropractic
☐ Over the Counter Meds ☐ Physical Therapy ☐ Prescription Meds ☐ Rest ☐ Stretching ☐ Work ☐ Other

What aggravates the symptoms? ☐ Nothing ☐ Almost any movement ☐ Bending ☐ Carrying
☐ Changing positions ☐ Climbing Stairs ☐ Coughing/Sneezing ☐ Driving ☐ Sleeping ☐ Getting out of car ☐ Getting out of bed
☐ Getting up from laying ☐ Getting up from sitting ☐ Household chores ☐ Lifting ☐ Looking over shoulder ☐ Pulling ☐ Pushing
☐ Reaching ☐ Running ☐ Sitting ☐ Squatting ☐ Standing ☐ Stretching ☐ Turning ☐ Twisting ☐ Walking ☐ Working
☐ Yard Work ☐ Other

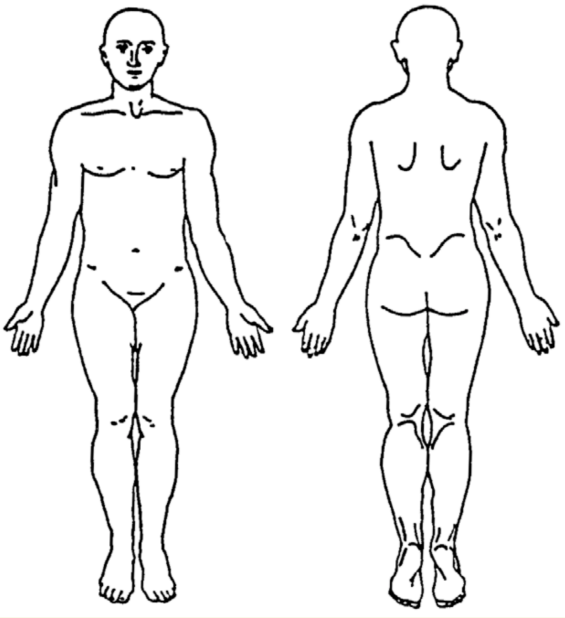
Have you had any past episodes of this complaint? ◯ No
◯ Yes: (explain) _____

Have you received any past care for this current complaint? ◯ No
◯ Yes: (explain) _____

Any diagnostic images or tests for this complaint? ◯ No ◯ Yes

Do you have any additional complaints? ◯ No ◯ Yes

*Please mark your areas of pain
(Can be finished while at the office)



Complaint #2

Acute, chronic, or recurring? _____

Where is this complaint located? _____

Rate your pain ? (0-10) _____

Complaint #3

Acute, chronic or recurring? _____

Where is the complaint located? _____

Rate your pain? (0-10) _____

Personal Health History

Name of Primary/Family Physician: _____

Address: _____

Phone: _____

Date of last physical exam: _____

Please check ALL of the health conditions below that apply to you currently or in the past.

☐ Osteoarthritis ☐ Whiplash ☐ Headaches ☐ Migraines ☐ Rheumatoid Arthritis ☐ Disc Herniation ☐ Joint Pain

☐ Osteoporosis ☐ Fibromyalgia ☐ Asthma ☐ Diabetes ☐ Anemia ☐ Cancer/Tumor ☐ Depression/Anxiety

☐ High Blood Pressure ☐ Heart Disease/Stroke ☐ Epilepsy/Seizures ☐ Genetic Disorders ☐ Infertility ☐ Constipation

Please list any other medical conditions: _____

Please check ALL conditions that run in your family. (father, mother, sister, brother)

☐ Cancer ☐ Anemia ☐ Diabetes ☐ Heart Problems/Stroke ☐ High Blood Pressure ☐ Genetic Disorders ☐ Arthritis

Please list any other medical conditions: _____

WOMEN ONLY: **Currently Pregnant?** ◯ No ◯ Yes **Painful/Abnormal Menstrual Cycle?** ◯ No ◯ Yes

Menopause? ◯ No ◯ Yes **Do you have children?** ◯ No ◯ Yes: Vaginal ◯ or C-Section ◯

Fractures (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date):

_____

_____

Surgeries and/or Hospitalizations (List and Date):

_____

_____

List of current prescription medications, over the counter medications, and supplements. (Including frequency and dosage if known)

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

***** You may provide us with a photocopy of your medications

Social History:

Do you exercise? ◯ No ◯ Yes **Times per week?** ___ **Intensity?** ☐ Light ☐ Moderate ☐ Strenuous

Do you currently smoke tobacco of any kind? ◯ No ◯ Yes **How often?** ◯ Everyday ◯ Intermittent

Do you drink alcohol? ◯ No ◯ Yes **How many drinks per week?** _____

Do you drink caffeine? ◯ No ◯ Yes **How many drinks per day?** _____

Do you take pain killers? ◯ No ◯ Yes **How often?** ◯ Daily ◯ Weekly ◯ Monthly ◯ Rarely

Describe your overall health right now? ◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

What is your current stress level? ◯ Mild ◯ Moderate ◯ High

Have you seen a chiropractor in the past? ◯ No ◯ Yes **Date of last chiropractic adjustment:** _____

What are your specific therapeutic goals? ☐ Sleep thru the night ☐ Decrease swelling ☐ Improve range of motion ☐ Lift

☐ Improve strength ☐ Improve flexibility ☐ Decrease stiffness ☐ Relieve pain ☐ Walk without limitation ☐ Return to sports

☐ Work without limitations ☐ Other: (explain) _____

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OFFICE POLICIES

NO-SHOW/CANCELLATION POLICY

We understand that life and emergencies happen, but we do ask that if you cannot keep your appointment, please call us within 24 hours to cancel and reschedule your appointment. You can leave a message on our answering machine and one of our team members will gladly reschedule your appointment for you. If you do not show up for your appointment, and did not call ahead to Cancel (NO-CALL/NO-SHOW), you will be charged a $25 NO-CALL/NO-SHOW Missed appointment fee.

PLEASE READ BELOW FOR ALL CHARGES.....

No-Show Policy-Chiropractic Adjustment Appointments $25

A No-Show appointment fee of $25 will be charged to you for any missed Chiropractic appointments.

First offense-No charge, graceful warning

Second (+) offense- $25

No-Show Policy-Scheduled Massage Therapy Appointments $25

A No-Show appointment fee of $25 will be charged to you for any missed Massage appointments.

First offense-No charge, graceful warning

Second (+) offense- $25

***Our office allows you 5 minutes before and after your massage to talk to your therapist, undress/redress, and get yourself on/off the table. This means a 30 minute massage is 20 minute hands on therapy. A 60 minute massage is a 50 minute hands on therapy. A 90 minute massage is an 80 minute hands on therapy. A 120 minute massage is a 110 minute hands on therapy. This allows your therapist to customize your session as they deem appropriate. Please note it also helps keep our scheduled appointments to run on time.*

In addition, if you are scheduled for both a Chiropractic appointment and a Massage appointment, you will be charged a $25 fee for both, for a total of $50.

FINANCIAL POLICY

Payment is due at the time of service. The amount due for services will depend on whether you have insurance, are self-pay, or are going through a Third Party Administrator. See below for further information regarding insurance, self-pay and Third Party Administrator. The accompanying adult to a minor patient is responsible for payment. For your convenience, we accept credit card, cash, and checks.

***Insurance:** Our services are rendered to you, not your insurance company. In most cases we will call to verify your insurance benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. We will bill your insurance plan and collect any copy, co-insurance, or deductible due by you at the time of service. Any non-covered service fees will also be collected at the time of service. If your health plan determines a service to be "**not covered**" or is **not an eligible expense under your plan**, you will be responsible for the complete charge or remaining balance of the non-covered service(s). Payment is due upon receipt of the explanation of benefits from your insurance company. It is uncommon, but pre-authorization from your insurance company or PCP may be required for your plan. Please contact our office or your insurance company to verify your plan benefits. If required, an authorization may be able to be processed by our office or you may need the authorization from your PCP.

***Self Pay (No Insurance):** Full payment is due at the time of service.

Personal injury/Auto Injury/Worker's Comp (Third Party Administrators): Please advise our office on your first visit whenever you have one of these listed claims. We will work with any insurance company(s)/attorneys involved, but please remember that you are ultimately responsible for your bill if payment cannot be obtained from another party within a reasonable time. If you, your attorney or the insurance company does not cooperate in protecting the doctor's interest, we will not await payment and may declare the entire balance due and payable immediately.

Special Arrangement: We have never denied anyone the benefits of chiropractic care because of their inability to pay our published fees. If financial hardship exists, it requires an Individual Consideration Contract. Please speak with the front desk staff.

Balance: Failure to pay any balance due may result in your account being turned over to an outside collection agency. This action will not compromise your care.

* ChiroHealth offers a time of service discount of 10% for Self Pay patients as well as for services that are a non-covered benefit when we bill Insurance. This discount does not apply to nutritional supplements, customized orthotics or supplies. For additional discounts, please ask one of our team members about CHIROHEALTH USA, which can help you save even more for Self Pay patients and non-covered services for Insurance patients.

I have read and understand the financial policy set forth by ChiroHealth, and I agree to be bound by its terms. I understand that my insurance is an arrangement between myself and my insurance company. I request ChiroHealth prepare customary forms at no charge so I may obtain insurance benefits. I understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care prescribed to me by the doctors of ChiroHealth, fees will be due and payable immediately. I understand and agree that such terms may be amended periodically by the practice.

Patient Name: _____
Please print

Financially Responsible Party: _____
Please print

Patient/Financially Responsible Party: _____ Date: _____

ChiroHealth HIPAA Form

Patient's Name: _____

Patient's SSN: _____ Date of Birth: _____

SPECIFIC AUTHORIZATIONS- *INITIAL ALL THAT APPLY*

(☐) I give permission to **ChiroHealth Rockford** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards and any information about treatment(s). If **ChiroHealth Rockford** contacts me by phone; I give them permission to leave a phone message on my answering machine or voicemail.

(☐) I give **ChiroHealth Rockford** permission to use and disclose my protected health information to the entities of my choosing, some of which may or may not be listed below.

APPROVED ENTITIES FOR PERSONAL HEALTH INFORMATION

Name: _____ Relationship: _____

Approved type(s) of information: (☐) Diagnosis (☐) Treatments (☐) Appointments (☐) Financial Records

Name: _____ Relationship: _____

Approved type(s) of information: (☐) Diagnosis (☐) Treatments (☐) Appointments (☐) Financial Records

Name: _____ Relationship: _____

Approved type(s) of information: (☐) Diagnosis (☐) Treatments (☐) Appointments (☐) Financial Records

Name: _____ Relationship: _____

Approved type(s) of information: (☐) Diagnosis (☐) Treatments (☐) Appointments (☐) Financial Records

_____

Signature of Patient or Personal Representative

_____

Date

RIGHT TO REVOKE HIPAA AUTHORIZATION

- You have the right to revoke this authorization, in writing, at any time. Please send such requests to:
  ChiroHealth Rockford
  Attn: Office Manager
  6769 Courtland Dr. Ste. 100
  Rockford, MI 49341
  Phone: 616-863-9482
  Fax: 616-863-9486
- You may refuse to sign this HIPAA authorization. If you refuse to sign this authorization it will not affect your ability to obtain treatments.
- Upon request, a copy of this authorization will be provided to you.
- I have read / received the information about the Health Insurance Portability and Accountability Act. **Initials:** _____