HOPE CHIROPRACTIC INTAKE FORM

Date _____ Referred By_____

Name (Last) _____ (First) _____ MI_____
Date of Birth_____ Sex: M____ F____ Social Security #: _____
Marital Status: Single _____ Married_____ Divorced _____ Other _____
Address _____ City _____ Zip _____
Phone: Home ( ) _____ Cell ( ) _____Work ( ) _____
Preferred Phone #: Cell ___ Home _____ Work _____ E- Mail address: _____

Employer _____ Occupation _____
Name of Emergency Contact _____Relationship_____
Number of Emergency Contact_____

Have you see a Chiropractor before? Y N Who? _____ When?_____
Name of Referring Chiropractor or MD/DO_____

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____

Rate your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable

Other doctors you have seen for this condition: ____ MD ____ DC ___ DO ____ DDS ____ Other
Who_____
When did this condition begin? _____ If accident related, date of accident _____
Which of the following is your condition interfering with? Work _____ Sleep _____ Daily Routine _____
Has this condition occurred before: Yes _____ No _____
Is condition: Job Related? _____ Auto Accident? _____ Home Injury? _____ Fall? _____
Major recent life changes _____

How Long has it been since you really felt good? Days _____ Weeks _____ Months _____ Years _____
Which of the following do you take now?(prescription and over the counter) Pain Killers _____
Muscle Relaxants _____Blood Pressure Medication _____
Other (please list) _____
Do you suffer from any other condition(s) or pains other than the one you are consulting us for? _____ If so, please describe.

_____

***Women Only-Is there any chance that you are pregnant? _____Yes _____No**
If no, please sign here:
***Patient Denies Pregnancy* X_____**

PAST HEALTH CONDITION

List Past Conditions: (Include dates and type of treatment for each condition described)

_____
_____
_____

Major Surgery/Operations(Include Date and Outcome): Appendectomy _____
Tonsillectomy _____ Gall Bladder _____
Hernia _____ Back Surgery _____ Broken Bone(S) _____
Other: _____
Comments:_____
_____
_____
_____
_____

Hospitalizations (Other than Above)

_____
_____
_____

Sports Injuries

_____
_____
_____

Other major accidents or falls (starting from childhood)

_____
_____
_____
_____
_____

PLEASE CHECK ALL PRESENT SYMPTOMS

HEAD
- ☐ Headaches
_____ Sinus _____ Migraine
_____ Forehead _____ Temples
_____ Entire head
_____ Back of head
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Buzzing in ears

NECK
- ☐ Neck pain (constant)
- ☐ Neck pain (with movement)
_____ forward _____ backward
_____ turn to left _____ to right
_____ bend to left _____ to right
- ☐ Pinched nerve in neck
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Arthritis in neck

SHOULDERS
- ☐ Pain in shoulder joint (R L)
- ☐ Pain across shoulders
- ☐ Bursitis (R L)
- ☐ Can't raise arm
_____ above shoulder level
_____ over head
- ☐ Shoulder tension
- ☐ Pinched nerve (R L)
- ☐ Muscle Spasms

ARMS & HANDS:
- ☐ Upper arm pain (R L)
- ☐ Elbow pain (R L)
- ☐ Tennis elbow (R L)
- ☐ Forearm pain (R L)
- ☐ Hand pain (R L)
- ☐ Finger pain (R L)
- ☐ Sensation of pins and needles
_____ in arms _____ in fingers
- ☐ Numbness in arms (R L)
- ☐ Numbness in fingers (R L)
- ☐ Fingers go to sleep
- ☐ Aggravated by movement
- ☐ Cold hands
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Loss of grip strength

MID-BACK
- ☐ Mid-back pain
- ☐ Pain between shoulders
_____ sharp stabbing
_____ dull ache
- ☐ Pain from front to back
- ☐ Muscle Spasms
- ☐ Kidney pain

CHEST
- ☐ Chest pain
- ☐ Shortness of Breath
- ☐ Pain around ribs
- ☐ Irregular heartbeat

ABDOMEN/GI
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK
- ☐ Low back pain
_____ lumbar
_____ sacroiliac
- ☐ Muscle spasms

Pain is worse when:
_____ working
_____ bending
_____ lifting
_____ coughing
_____ stooping
_____ standing
_____ lying down
_____ sitting
_____ walking

Pain is relieved when:
_____

HIPS, LEGS, FEET:
- ☐ Buttocks pain (R L)
- ☐ Hip joint pain (R L)
- ☐ Pain down leg (R L)
_____ front
_____ side
_____ back
- ☐ Pain down both legs
- ☐ Knee pain (R L)
- ☐ Leg/ foot cramps (R L)
- ☐ Numbness in legs (R L)
- ☐ Numbness in feet (R L)
- ☐ Numbness in toes (R L)
- ☐ Feet feel cold

WOMEN ONLY
- ☐ Menstrual pain
- ☐ Cramping
- ☐ Irregularity
- ☐ Abortions
- ☐ Hysterectomy
- ☐ Genital Cancer
- ☐ Discharge
- ☐ Tumors
- ☐ Menopausal

Method of birth control
_____

MEN ONLY
- ☐ Urinary frequency
- ☐ Difficulty starting
- ☐ Night urination
- ☐ Prostrate pain/swelling

GENERAL
- ☐ Nervousness
- ☐ Depressed
- ☐ Fatigue
- ☐ Feel Run Down
- ☐ Irritable
- ☐ Difficulty in sleeping
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Diabetes
- ☐ Hypoglycemia

Daily Intake:
Coffee _____
Tea _____
Cigarettes_____
Alcohol_____
Other_____

FINANCIAL POLICY & FEE SCHEDULE

Initial Examination & X-rays	$150.00
Additional X-rays	$ 20.00
Cervical AO X-rays	$ 60.00
Regular Adjustment	$ 55.00
One Region Adjustment	$ 30.00
Dr. Parry Nutritional Consultation (30 Minutes)	$ 55.00
Lifestyle Coach Consultation (45 Minutes)	$ 45.00
Body Composition Analysis (Report Only)	$ 25.00
No-Call/No-Show Fee	$ 30.00

Payment

- Payment for services provided is expected at the time of service.
- All professional services are rendered to & charged to the patient receiving care or to the responsible adult in the case of a minor.
- This payment policy also applies to Personal Injury and Workman's Compensation cases.

Insurance

- If you are covered by insurance in any form, including Medicare, we will provide you with a diagnostic receipt that will help you receive payment from your carrier.

Medicare

- You are responsible for payment of all services at the time of service.
- Medicare Fees are set by the Federal Government and we must charge what they set.
- As required by Federal Law, we will file the mandatory forms for you each month, in an effort to have you reimbursed for covered services.

Returned Check Policy

- We will charge $30 for returned checks.

I acknowledge that I have read, understand, and accept the terms of the above Financial Policy & Fee Schedule.

Name: (Please Print) _____

Signature: _____ **Date:** _____

Cancellation Policy

It is understood that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all our patients and out of consideration for other patient's time, we have the following policies:

Cancellation ☐ Initial to confirm policy understanding and acceptance.

- 24 hour advance notice is greatly appreciated when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment.
- If you are unable to give us 24 hour advance notice, it is still important to call us as soon as possible to reschedule and avoid a "no-show" fee.

No-show Fee ☐ Initial to confirm policy understanding and acceptance.

- Anyone who misses their appointment will be considered a "no-show" and will be charged $20 for their missed appointment and future service may be denied until payment is made.
- This policy is applied universally to all missed appointments.

Arriving late ☐ Initial to confirm policy understanding and acceptance.

- Appointment times are limited in number and your time has been arranged specifically for you. To help us stay on time please plan on arriving to your appointment 5-10 minutes early.
- If you are late to your appointment, that appointment may be shortened in order to accommodate other appointments that follow yours.
- Depending on how late you arrive, it will be determined if there is enough time to start treatment and still provide you with effective care. If there is not enough time to perform an adequate treatment, you will be asked to reschedule.

WE LOOK FORWARD TO SERVING YOU!

I acknowledge that I have read, understand, and accept the terms of the above Cancellation Policy.

Name: (Please Print) _____

Signature: _____ **Date:** _____