one 1

Welcome to Dynamic Chiropractic Clinic

About you

Today's date: ___/___/_____ File #: ________________

Name: __________________________ What do you prefer to be called? : ______________

Male ___ Female___ Birth Date: ____ /____ /______ Age: ____

Mailing Address:

____

Street City State Zip Code

Home phone #: ________________________ Other Phone #: ____________________

Who can we thank for referring you?: ____

Who is your employer?: ____

Employer's address:

____

Street City State Zip Code

Occupation: ________________________ Work Phone #: ____________________

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Separated ☐Widowed ☐Partnered

Significant other's name: ______________________________________

Email address (we will never spam you): ______________________________

two 2

The reason for your visit

Please explain the primary reason for visiting our office: (Please explain what happened)

____

____

Was this the result of (**circle one**): auto accident, sports, work injury, trauma, or chronic problem?

Please describe your pain (if any) and its location:

____

____

When did this begin? (date) ____ /____ /_____ Are the problem getting worse? ☐Yes ☐No

Are your problem(s) (**circle one**) getting better, getting worse, constant, comes and goes?

Is the problem interfering with your work, sleep, daily routine? If so, please describe: ____________

____

Have you ever had this condition before? ☐ Yes ☐ No If so, please describe:

____

____

Have you sought any other treatment before this? ☐ Yes ☐ No If so, please describe: ____________

____

Is this keeping you from doing activities you love? If so, what activities?:____________________

Is this your FIRST chiropractic visit? ☐ Yes ☐ No If no, whom? Name:

____

Where? __________________________What did you enjoy most about their care? ____________

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In event of emergency

Who should we contact? ______________________________
Relation: ______________________________
Home #: ____________________ Work #: ____________________
Who is your medical doctor?: ____________________ Phone #: ____________

Health history

Are you taking any of the following medications?

Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxants ☐ Stimulants ☐ Blood thinners
Tranquilizers ☐ Insulin ☐ Other(s): ____________________

Have you had any of the following condition(s)?

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Artificial Valves
Alcohol/ Drug Abuse
Anemia
Arthritis
Artificial Bones/Joints
Asthma
Cancer
Congenital Heart Defect
Chemotherapy
Diabetes/Tuberculosis
Difficulty Breathing

☐ Heart Attack/ Stroke
☐ Emphysema/ Glaucoma
☐ Fainting/Seizures/Epilepsy
☐ Frequent Mid-Back Pain
☐ Frequent Neck Pain
☐ Heart Surgery
☐ Heart Murmur
☐ Hepatitis
☐ HIV+ / AIDS
☐ Kidney Problems
☐ Other: ______________________________

☐ Lower Back Problems
☐ Shingles
☐ Sinus Problems
☐ Indigestion
☐ Mitral Valve Prolapse
☐ Psychiatric Problems
☐ Rheumatic Fever
☐ Severe/Frequent Headaches
☐ Ulcers/Colitis
☐ Venereal Disease

Please list any other serious medical condition you have (or ever had):
____
Please list anything you may be allergic to:
____
Please list any surgeries you may have had:
____
Please list any past serious accidents with date(s):
____
Family Health History (Diabetes, High Blood Pressure, etc.):
____

Do you smoke? ☐ No ☐ Yes/ How much? _____ For how long? _____ Are you wearing: Heel lifts /Sole lifts
How old is your mattress? ______ Is it comfortable? ____________
For women: Are you taking birth control medication? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No ☐ Not sure Are you nursing? ☐ Yes ☐ No

Account Info

Person ultimately responsible for this account:

Name: ______________________________ Relation: ____________________
Billing address: ______________________________
Street City State Zip Code
SSN: ____________________ Driver's License #: ____________________
Work Phone #: ____________________ Payment method: Cash Check Credit Card
____ I authorize assignment of my insurance rights and benefits directly to the provider for services rendered.
(initial)

-------THERE IS 1 MORE PAGE OF INTAKE FORM ---------

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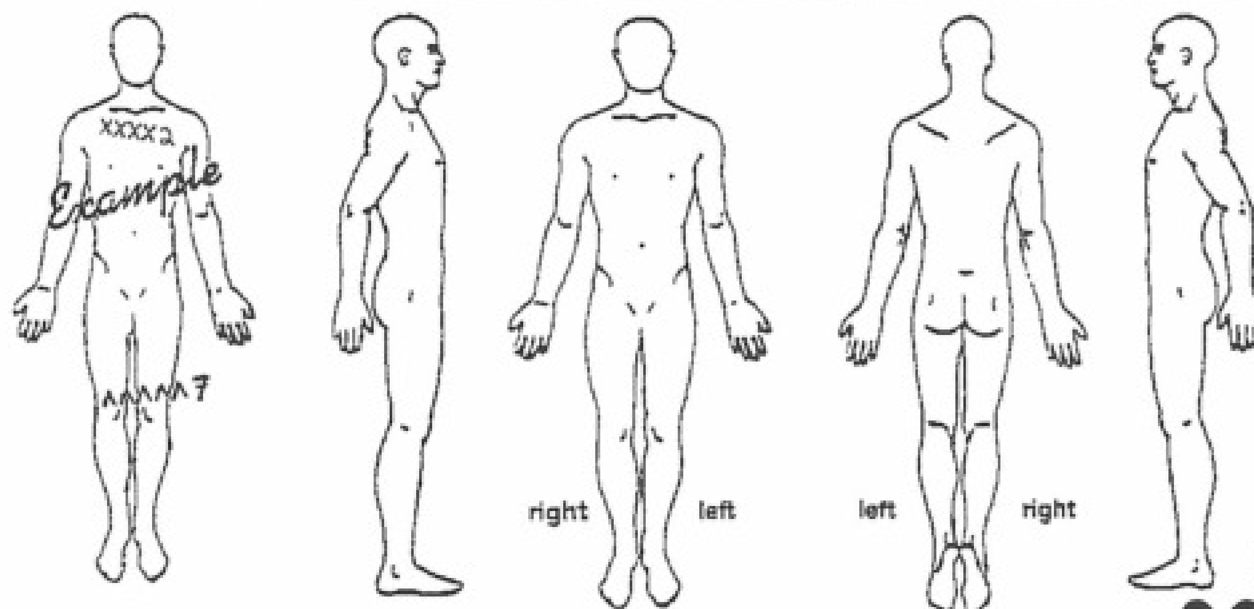
Show us where it hurts

Please show us where you are experiencing symptoms...
Indicate your degree of pain using a scale of **1** (minor discomfort) to **10** (extreme pain):

Numbness:	Pins & Needles:	Burning:	Aching:	Stabbing:
- - - - -	0000000	^^^^^^^	XXXXXXX	////////



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- We invite you to discuss with us any questions regarding your care and our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services at the time of visit, unless other arrangements have been made with the doctor. I permit this office to endorse co-issued remittance for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. If my account is not paid within 90 days of the date of service, whether the account has been charged to insurance or account and no financial arrangements are made, I will be responsible for any expenses incurred while collecting on my account. I also understand that if I terminate my care at *Dynamic* Chiropractic Clinic, any fees for professional services will be immediately due and payable, unless prior arrangements have been made. I hereby authorize the doctors at *Dynamic* Chiropractic Clinic and whomever they designate as their assistants to administer treatment as they so deem necessary. I also authorize the provider and / or managed care organization to release my information required to process insurance claims.
- I understand the above information and guarantee this form was completed to the best of my knowledge and understand that it is my responsibility to inform the office of any changes in my personal information and medical status.

Signature: ______________________________ Date: ______________________

Thank you for choosing our clinic for your chiropractic care!
The Doctors and Staff of *Dynamic* Chiropractic Clinic.