McNeil Family CHIROPRACTIC

INTAKE FORM
(Ages 6 to Adult)

Welcome to our office…

DATE: _____

Name: _____Preferred to be called: _____
FIRST MI LAST
Address: _____ City/State/Zip Code: _____
Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____
Email address: _____
Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Children: ☐ Yes (How Many? _____) ☐ No
Occupation: _____ Employer: _____
Work Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed ☐ Disability ☐ Student ☐ Retired
Spouse's Name: _____ Phone: (___) _____
Spouse's Employer: _____
Emergency Contact: _____ Phone: (___) _____ Relationship: _____
How did you hear of our office? ☐ Phone Book ☐ Website ☐ Website ☐ Other
☐ Friend/Family member _____
Who is your primary care doctor? _____
(Please list name and facility)

Signatures & Authorizations

CONSENT FOR TREATMENT:
Any procedure intended to help, may also do harm. While chiropractic examinations and therapeutic procedures (e.g. spinal adjustment, ultrasound, electrical muscle stimulation, heat and cold application, and manual muscle therapy) are considered remarkably safe and effective, please understand that occasionally there may be some adverse reactions.

Although the chances for experiencing any of these complications are extremely small, it is the practice of this chiropractic office to fully inform and educate all of our patients. These complications include, but are not limited to: pain, swelling, discoloration, inflammation, disc Injury, sensory changes, bone fracture, nausea, soft tissue injury, stroke, dizziness, weakness and worsening of condition.

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician.
I understand that there is no guarantee or warranty for a specific cure or result. I understand that I can request further explanation regarding any and all possible risks attendant to my care.

Patient Name: _____

Patient Signature or Legal Guardian: _____ **Date:** _____

In the event that the legal guardians are unable to bring the child in, I authorize the following people to bring the child in for care:

_____	_____	_____	_____
Name	**Relationship**	**Name**	**Relationship**

--------Patient Financial Agreement--------

The undersigned patient understands that health and accident insurance policies are an arrangement between the insurance carrier and the insured patient. The patient understands that McNeil Family Chiropractic will prepare any necessary reports and forms to assist in receiving payment from the insurance company, and that any authorized payment will be paid directly to Dr. Amy Gunderson-McNeil/McNeil Family Chiropractic and will be credited to the proper account upon receipt. **However, if there is a problem where your insurance company refuses to pay for services rendered, you as the patient will be personally responsible for payment.**

・The undersigned patient agrees to allow McNeil Family Chiropractic to submit information needed to the insurance company for billing purposes.
・You as the patient agree to pay the charges in a timely manner (with-in 30 days), or on an agreed upon payment plan.
・The undersigned Patient requests, consents and agrees to any and all chiropractic treatment provided to the Patient from the Chiropractor.

Payment (Co-pays, deductibles, etc.) is due when services are rendered, unless other arrangements have been made in advance. The undersigned agrees to pay $30.00 for any returned checks.

Patient Signature: _____ **Date: _____**

Parent/Legal Guardian's Signature: _____ **Date: _____**

------No Show Policy------

Due to the high demand of our appointment times, and the fact that we often have a waiting list of people looking to get in, we cannot tolerate a missed appointment. We understand that circumstances may arise out of your control. We allow 2 missed appointments and then will refer you to another clinic to handle your care.

No showing for your first appointment will require you to leave your credit card information to reschedule. If you no show for the second time, we will charge your credit card our new patient cash rate.

I have read and understand the above statement.

Patient Signature: _____ **Date: _____**

Parent/Legal Guardian's Signature: _____ **Date: _____**

-------Routine Maintenance-------

Routine maintenance visits are a GREAT thing to keep your body functioning well and to prevent major incidences of pain.

Insurance companies DO NOT COVER maintenance visits.

If your visits are coming to a point that they are too repetitive (like once a month or every 2-4 weeks) you will be required to pay out of pocket for these visits. We offer a cash discount for payments on day of service or a variety of wellness packages to save even more. Just ask at the desk.

Patient Signature: _____ Date: _____

Parent/Legal Guardian's Signature: _____ **Date: _____**

YOUR HEALTH PROFILE

Please state your reason for coming in today:

_____

_____

How did this start? _____

When did it start? _____

Average pain intensity: Circle one (least pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Quality(s) of condition: Sharp Dull Ache Throbbing Burning Spasm Stiffness Numbness Tingling Other

Have you seen anyone for this condition? Yes _____ No

What have you done to help the condition? _____

What makes the pain worse? _____

How often do you experience your symptoms? Constantly Frequently (50-75% of the day) Intermittently (0-25% of the day)

How does your condition interfere with your:

Work: _____

Recreational activities: _____

Household responsibilities/activities of daily living: _____

Is the condition getting: Better Worse Staying the same

Have you had chiropractic care before: Yes _____ No

PATIENT MEDICAL HISTORY

Please mark if you have had the following conditions and give details:

Allergy or skin disorder _____

Arthritis or Joint Problems_____

Bladder or Kidney problems_____

Bowel problems (constipation/diarrhea)

_____

Cancer _____

Epilepsy/blackouts_____

Liver problems_____

Headaches/Migraines_____

Anxiety/Depression_____

Broken bones _____

Dislocations_____

Major Dental work_____

Major Injuries _____

Motor Vehicle Accident _____

Work Comp Injury _____

Circulation problems/blood clots_____

High or low blood pressure_____

Diabetes_____

High Cholesterol_____

Digestion problems/Food Intolerance_____

Medications (please list what and what for)

_____

_____

_____

Surgery (please list what and when)

_____

_____

Supplements

_____

_____

SOCIAL HISTORY

Do you smoke? Yes No Past smoker

For your job, are you:

Sitting Standing Mix Physically active

Occupational Stress Level: 0 1 2 3 4 5 6 7 8 9 10

Personal Stress Level: 0 1 2 3 4 5 6 7 8 9 10

Are you on any specific dietary restrictions? Yes No

Do you follow any specific diet? Yes No

What type of exercise do you do and how often?

I exercise! _____

I don't exercise ☐

Sleep Health: Sleep well Hard to fall asleep

Hard to stay asleep Wake often Toss and turn

Daily water intake: ☐Poor ☐Good ☐Excellent

Soda pop intake: _____

Caffeinated beverage intake:_____

Diet beverages (with aspartame or other sugar substitutes) _____

FAMILY HEALTH HISTORY

Please comment on any of the following issues if they pertain to your family history, and who is involved.

Arthritis _____
Joint problems or replacements_____
Bladder or Kidney problems_____
Bowel problems_____
Cancer_____
Circulation problems_____
Blood Clots_____
High or Low Blood pressure_____
High or low cholesterol_____
Heart problems_____
Stroke_____
Digestion/food intolerance_____
Epilepsy or Black outs_____
Dizziness_____
Liver problems_____
Headaches/Migraines_____
Spine problems _____

WOMEN ONLY

Are you pregnant? No ☐ Yes ☐ Due date: _____ ☐ It's possible, but not confirmed yet
How many children have you had?_____
How were your children born? Vagnial Caesarian

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____
Signature **Date**

Parent/Legal Guardian's Signature: _____ Date: _____