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: ____ (my Son / Daughter)

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.) are 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:_____________________**

-------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:______________________**

YOUR HEALTH PROFILE

As a full spectrum chiropractic office we focus on your ability to be healthy. Our goals are first to address the issues that brought you to the office, and second, to offer you the opportunity for improved health potential and wellness-services in the future. On a daily basis, we experience physical, chemical and emotional stress that can accumulate and result in a serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

YOUR CHILDHOOD YEARS

Research shows that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

			Please explain any "Yes" answers (include dates where appropriate)
Did you have any childhood illness?	Yes	No	______________________________
Did you have any serious falls as a child?	Yes	No	______________________________
Did you play youth sports?	Yes	No	______________________________
Did you take/use any drugs?	Yes	No	______________________________
Did you have any surgeries?	Yes	No	______________________________
			______________________________
Have you fallen/jumped from a height over three feet (i.e. crib, bunk bed, trees)?	Yes	No	______________________________
Were you involved in any car or ATV accidents as a child?	Yes	No	______________________________
Was there any prolonged use of medicine such as antibiotics or an inhaler?	Yes	No	______________________________
Did you suffer any other traumas (physical or emotional)?	Yes	No	______________________________
Were you vaccinated?	Yes	No	______________________________
As a child, were you under regular Chiropractic care?	Yes	No	______________________________

YOUR ADULT YEARS

			Please explain any "Yes" answers (include dates where appropriate)
Do you have a physical job?	Yes	No	______________________________
Do you sit a computer for long periods?	Yes	No	______________________________
Do/did you smoke or drink alcohol?	Yes	No	______________________________
Have you had any surgeries?	Yes	No	______________________________
			______________________________
			______________________________
Have you been in a car or ATV accident?	Yes	No	______________________________
Do/did you participate in adult sports?	Yes	No	______________________________

On a scale of 1 – 10 describe your stress level (1 = none / 10 = extreme): Occupational_________ Personal__________

On a scale of Poor-Good-Excellent describe your:

Diet:________________ Any specific diet followed?______________________________

Exercise:_____________ What do you do?______________________________

Sleep:_______________ Sleep well / Hard to get to sleep / Hard to stay asleep / Wake often

General Health:_______________

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Briefly describe you chief area of complaint and how you believe it started.
____
____
How long have you been experiencing this complaint?____
If you are experiencing pain, is it... _____Sharp _____Dull _____Comes & goes _____Travels _____Constant

Average pain intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
Past Week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Since the problem started it is... _____About the Same _____Getting Better _____Getting Worse
What makes it worse?____
It interferes with... _____Work _____Sleep _____Walking _____Sitting _____Hobbies _____Leisure _____Other
What are you doing to help the problem? Ice / Heat / Stretching / Pain Meds / Essential Oils / Topical Pain Creams / Other____________________________________
Other Doctors seen for this problem (please list):
Chiropractors____
Medical Doctors____
Others____

Please put (P) Past, (C) Current or (B) Both for all symptoms you have ever had, even if they do not seem related to your current problem.

____Headache	____Pins & Needles	____Fainting	____Neck Pain
____Fatigue	____Loss of Smell	____Back Pain	____Loss of Balance
____Dizziness	____Fever	____Ringing in Ears	____Nervousness
____Numbness in Fingers	____Numbness in Toes	____Loss of Taste	____Stomach Upset
____Pins & Needles in Arms	____Depression	____Irritability	____Tension
____Sleeping Problems	____Neck Stiff	____Cold Hands	____Cold Feet
____Diarrhea	____Constipation	____Buzzing in Ear	____Hot Flashes
____Cold Sweats	____Ulcers	____Problem Urinating	____Heartburn
____Menstrual Irritability	____Menstrual Pain	____Mood Swing	____Eyes Sensitive to Light

List any medications you are now taking & what are you taking them for:______________________________________
____
List any supplements/vitamins you are taking:____

FAMILY HEALTH PROFILE

Please list any significant health issues to your grandparents, parents and siblings.
____
____

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**