Elite Performance Chiropractic
3530 S. Val-Vista Dr. Ste: A-111
Gilbert AZ 85297 Ph. 480-448-6842

Dr. Cary Gundlach D.C., C.C.S.P

NEW PATIENTS INTAKE FORM

(Please Print)

Legal Name: ____**Todays Date:** ___________

Address: ___________________________________ **City:** _____________________ **State:** ___________ **Zip:** _________

Home Phone: ________________________________ **Cell:** __________________________ **Carrier:** ________________

Occupation: _____________________________ **Employer:** ______________________ **Work #:**__________________

Email: _____________________________ **Marital Status** ____ **Married** _____ **Single** _____ **Divorced** ____ **Other** _____

Date Of Birth: ___/___/___ **Age:** _____ **Gender** ___ **M** ___ **F (Please Check) Social Security#** ____________________

Race (Select One) ____ **Alaska Native** ___ **American Indian** ___ **Asian** ___ **Black / African American**

____**Native Hawaiian** ___ **Other Pacific Islander** ____ **White / Caucasian** ____ **Other** ____________

Spouse Name: _______________________ **Phone:** _____________________ **Spouse Employer:** ___________________

Emergency Contact _________________________ **Phone:** ___________________ **Relationship:** ___________________

How did you hear about our clinic? ____

Have you ever received Chiropractic Care? ____ **Yes** ____ **No If yes, when?** ___________________________________

Name of most recent Chiropractor and / or Clinic:____

PAYMENT METHOD

(Please Circle) **Self-Pay / Health Insurance / Auto Insurance / Worker Comp / Personal Injury**

Please provide Insurance Card and ID **Primary Insurance**________________**Secondary Insurance** _______________

HSA Card Y / N HRA Y / N Credit Card: ___ **Visa** ___ **MasterCard** ___ **Discover** ____ **American Express** ____ **Care Credit**

Name on Card:____________________________________ **Exp Date:** ________________**CVS Code:** _____________

Card Number: ____ **Keep Card on File Y / N**

Signature of Cardholder: ____ **Date:** ___________________________

Financial Policy

I understand that I'm responsible for paying all deductibles, copayments and coinsurance, and any non-covered services at the time of service. If I receive an insurance check, I agree to bring that check to the office within 7 days. Elite Performance Chiropractic will make three attempts to collect an outstanding balance, either by phone or mail before turning the account over to a collection agency. I understand I will be assessed any and all collection fees incurred by the clinic. In addition there may be times that you will receive Insurance Checks from you Insurance Company that belong to Elite Performance Chiropractic.By Initialing you're agreeing to our financial terms **Int.** _____

Consent to Care

As a patient in this office, you have the right to know the types of treatment we could possibly use and any complication/side-effects to such treatment. The procedures performed in our clinic are usually beneficial, however unexpected issues may arise. In rare cases, underlying physical defects, deformities or pathologies, may render the patient susceptible to injury. The doctor will not provide specific treatments if he/she is aware that such care may be contraindicated. I am responsible for informing my doctors about any conditions, diseases, illnesses, etc. I agree to settle any claim or dispute against or with our clinic or personnel, were related to the prescribed care of otherwise, by binding arbitration under current malpractice terms which can be obtained by written request. I hereby allow treatment to be rendered to myself/minor by all Elite Performance Chiropractic and staff. **By Initialing you are consenting to Care/Treat:** ______

Patient Signature: ____ Date: _______________________________

If Patient is a minor (Guardian)Print Name _________________________________ **Relationship to patient:** __________________________

Guardian Signature: ____ Date: __________________________

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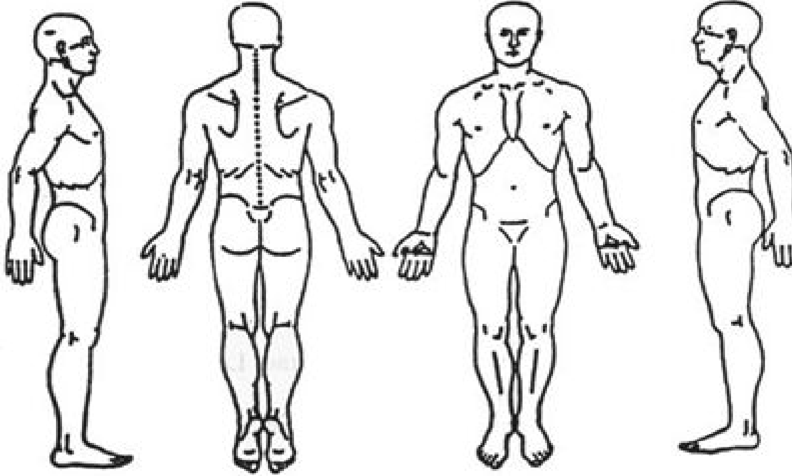
NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.



Fill out this section as accurately as possible. Mark the area with the described sensation using the appropriate **symbols** to the left of the picture.

symbols

XXX	Burning	(BU)
(((	Aching Pain	(AC)
ooo	Pins/Needles	(PI)
- - -	Numbness	(NU)
: : :	Sharp Pains	(SH)

Symptom 1 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: **1 2 3 4 5 6 7 8 9 10**
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- **When did the symptom begin?** ____
  - o Did the symptom begin suddenly or gradually? (circle one)
  - o How did the symptom begin? ____
- **What makes the symptom worse?** (circle all that apply):
  - o Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ______________________________
- **What makes the symptom better?** (circle all that apply):
  - o Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- **Describe the quality of the symptom** (circle all that apply):
  - o Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ____
- **Does the symptom radiate to another part of your body** (circle one): yes no
  - o If yes, where does the symptom radiate? __________________________________
- **Is the symptom worse at certain times of the day or night?** (circle one)
  - o Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: **1 2 3 4 5 6 7 8 9 10**
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- **When did the symptom begin?** ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ____
- **What makes the symptom worse?** (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
    ____
- **What makes the symptom better?** (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- **Describe the quality of the symptom** (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): ____
- **Does the symptom radiate to another part of your body** (circle one): yes no
  - If yes, where does the symptom radiate? ____________________________________
- **Is the symptom worse at certain times of the day or night?** (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: **1 2 3 4 5 6 7 8 9 10**
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- **When did the symptom begin?** ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ____
- **What makes the symptom worse?** (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
    ____
- **What makes the symptom better?** (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- **Describe the quality of the symptom** (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): ____
- **Does the symptom radiate to another part of your body** (circle one): yes no
  - If yes, where does the symptom radiate? ____________________________________
- **Is the symptom worse at certain times of the day or night?** (circle one)
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PAST MEDICAL HISTORY

Smoking Status: ____ Never was a smoker ____ Smoker some days (not daily)
____Smokes daily (___Packs/day or ___Cigarettes/day - for___ Years or Since ____/____/____
____Former Smoker (___Packs/day or ___ Cigarettes/day - from: Age ___ to Age___)
Allergies: ____ None Or See List Below:

DRUG / MEDICATION	FOOD	ANIMAL/POLLEN/LATEX
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Female: Are you pregnant? ____ No ____ Yes - Due Date________________ Doctor: ______________________

Date of Last Gynecological and Breast Exam:
____

Male: Date of last Prostate & Testicular Exam:
____

<u>Please indicate if you have history of any of the following (F) for family (P) personal:</u>
__/__ Lung Problems/Shortness of Breath __/__ Anticoagulant Use __/__ Bleeding ___/__ Cancer
___/__ Diabetes __/__ Heart problems/high blood pressure /chest pain __/__ Strokes/TIA's
__/__ Psychiatric Disorders __/__ Bipolar Disorder __/_ Neurological Diseases __/__ Major Depression
__/__ Headaches __/__ None of the above

CURRENT PRESCRIPTION MEDICATION ____ None or See List Below

Name of Prescription	Dose (mg, ml,etc)	Form (Tab, Caps, etc)	Duration (# times per day, wk, mo)
______________________	________________	________________	_____X per-day__________________
______________________	________________	________________	_____X per-day__________________
______________________	________________	________________	_____X per-day__________________
______________________	________________	________________	_____X per-day__________________

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CURRENT VITAMINS AND SUPPLEMENTS ____ None or See List Below

Name of Supplements	Dose (mg, ml,etc)	Form (Tab, Caps, etc)	Duration (# times per day, wk, mo)
______________________	_________________	___________________	_____X per-day___________________
______________________	_________________	___________________	_____X per-day___________________
______________________	_________________	___________________	_____X per-day___________________
______________________	_________________	___________________	_____X per-day___________________

Describe any major illnesses, injuries, falls, hospitalizations, accidents or surgeries: ______ NONE

DATE	DOCTOR	CONDITION(S)	RESULTS
_________	_________________________	_______________________	___ Full Recovery ___ Complications
_________	_________________________	_______________________	___ Full Recovery ___ Complications
_________	_________________________	_______________________	___ Full Recovery ___ Complications
_________	_________________________	_______________________	___ Full Recovery ___ Complications

Social History:

Recreation activities/hobbies: ____ Hrs per week _______________

Do you exercise ___ No ___Yes How often per week __________x In what way? ________________________

Do you consume Caffeine? ____ No ___ Yes How much? _____________ How Often? ____________________

Do you consume Alcohol? ____ No ____ Yes How much? _____________ How Often? ____________________

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CONSENT TO RELEASE RECORDS:

Under HIPAA guidelines we are not to release records to anyone without prior written consent. Below please list those that you would like to be able to request medical records on your behalf.

Name: ____ Relationship ____________________________

Name: ____ Relationship ____________________________

Name: ____ Relationship ____________________________

You have the right to your medical records up to 25 page or 2 years whichever is the greatest. In order to obtain them you will need to fill out a medical records release form. In the event that your physician would like your records do we have permission to release requested pertinent records on your behalf? **Int if yes ______.**
If, for any reason records are requested by a third party that party is required to submit a HIPAA compliant authorization in accordance to HIPPA guidelines.

MISSED APPOINTMENT POLICY
We care for our patients and one of the ways we do that is we try our best to provide you with quality time with you Dr. for treatment and for you to consult with them. When there is a no call no show or a late cancellation often patients that needed to be seen were not seen due to time set aside for you. Because we want to honor all our patients we have decided to implement this policy for everyone's benefit. If for some reason you will not make your appointment you must give 24 hour notice this includes leaving a message. After the 2 missed appointments you will be charged a $25.00 No show fee. It's important that if you are more than 10 min late to your appointment without notifying us we will consider this as missed appointment. **Please Int. __________** This indicates that you understand.

Please Write anything you would like to share here?

Please print, sign and date. Doing so is you demonstrating that you have understood all that you have read and information provided to Elite Performance Chiropractic is to the best of your abilities.

(Print)
Name: ____ **Date:** _____________________

Signature: ____ **Date:** _____________________