SUNSET CHIROPRACTIC INTAKE FORM

Name:_____Date:_____/_____/_____Age:_____Male/Female (circle)

Address:_____City:_____ State:_____Zip:_____

Phone: Home_____Cell:_____ Date of Birth:_____/_____/_____

Email Address:_____ Height:_____ Weight:_____

Occupation:_____ Employer's Name:_____

Single / Married / Divorced / Widowed Spouse's Name:_____

Number of Children_____ Are you currently Pregnant? Y / N

Are you currently or have you ever smoked? Y / N How many years? _____

Who may we thank for referring you? _____

What treatment(s) are you interested in? (Circle all that apply)

Chiropractic Softwave Therapy

What type of care are you interested in? (Circle one)

Relief Care (get rid of symptoms) **Corrective Care** (fix the cause of the problem) **BOTH** (relief and corrective care)

Have you had Chiropractic care before? Yes No **Is this related to an auto accident?** Yes* No

If yes, please stop here and see our reception desk to get all of the proper auto accident forms

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS	***THROAT ISSUES***	***KIDNEY PROBLEMS***	***LIVER DISEASE***	***NERVOUSNESS***
HEADACHES	***THYROID PROBLEMS***	***MID BACK PAIN***	***SHOULDER PAIN***	***EPILEPSY***
VERTIGO	***ASTHMA***	***IRRITABLE BOWEL***	***CHRONIC FATIGUE***	***DISC PROBLEM***
EAR INFECTIONS	***ULCERS***	***SCIATICA***	***LUPUS***	***INFERTILITY***
NAUSEA	***NUMBNESS IN ARMS***	***NUMBNESS IN LEGS***	***FIBROMYALGIA***	***GASTRIC REFULX***
TMJ	***NUMBNESS IN HANDS***	***NUMBNESS IN FEET***	***CHEST PAIN***	***ALLERGIES***
NECK PAIN	***MENSTRUAL DISORDER***	***LOW BACK PAIN***	***ARM PAIN***	***OTHER_____***
MIGRAINES	***HEART DISORDERS***	***HIP PAIN***	***ADD/ADHD***	_____
ANXIETY	***STOMACH DISORDERS***	***LEG PAINS***		_____
CHRONIC SINUS	***BLADDER PROBLEMS***	***KNEE PAIN***		_____

LIST YOUR TOP 3 HEALTH PROBLEMS

Health Concerns: List according to severity	**Rate of Severity 1 = mild 10 = unbearable**	**When did this episode start?**	**If you had the condition before, when?**	**Did the problem begin with an injury?**	**Are symptoms constant or intermittent?**
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

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CIRCLE ANY CONDITION YOU HAVE NOW OR HAVE HAD:

STROKE **CANCER** **HEART DISEASE** **SPINAL SURGERY** **SEIZURES** **SPINAL BONE FRACTURE** **SCOLIOSIS** **DIABETES**

List any surgical operations and year _____

_____

List ANY over the counter & PRESCRIPTION MEDICATIONS you are on:

_____

_____

AUTO ACCIDENT HISTORY: **Year** **Speed (MPH)** **Rear-ended? T-Boned?**

_____

_____

Have you ever been knocked unconscious? YES / NO **Fractured a bone?** YES / NO

If yes, please describe_____

Other trauma:_____

Activities of Daily Living

Please circle how your current condition is affecting your ability to carry out activities that are routinely part of your life.

ACTIVITY:	EFFECT:			
EXAMPLE: **Running**	**No effect**	**Painful (can do)**	**Painful (limits)**	**Unable to perform**
Sit to stand	No effect	Painful (can do)	Painful (limits)	Unable to perform
Climbing stairs	No effect	Painful (can do)	Painful (limits)	Unable to perform
Driving	No effect	Painful (can do)	Painful (limits)	Unable to perform
Sitting	No effect	Painful (can do)	Painful (limits)	Unable to perform
Standing	No effect	Painful (can do)	Painful (limits)	Unable to perform
Walking	No effect	Painful (can do)	Painful (limits)	Unable to perform
Dressing	No effect	Painful (can do)	Painful (limits)	Unable to perform
Lifting Children	No effect	Painful (can do)	Painful (limits)	Unable to perform
Sexual activities	No effect	Painful (can do)	Painful (limits)	Unable to perform
Washing/Bathing	No effect	Painful (can do)	Painful (limits)	Unable to perform
Sweeping/Vacuuming	No effect	Painful (can do)	Painful (limits)	Unable to perform
Yard work	No effect	Painful (can do)	Painful (limits)	Unable to perform
Exercise	No effect	Painful (can do)	Painful (limits)	Unable to perform
Other:_____	No effect	Painful (can do)	Painful (limits)	Unable to perform

Health Insurance Information (Must be Completed Before Services Can Be Rendered)

NAME: _____

FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER:_____

CONTACT IN CASE OF EMERGENCY:_____Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number: _____

Insurance Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is complimentary.
- **Assessment (new or established practice member)**- includes one or more of the following: thermography, orthopedic/neurological evaluation, range of motion, motion and/or static palpation, leg check $60-$150.
- **Chiropractic Adjustment**- The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $35-$60.
- **X-rays**- Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $60-$110 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Jeffrey Moody, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signature_____ **Date**_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH, AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

NAME HERE _____ SIGNATURE _____

XRAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

PLEASE NOTE: IF CLINICALLY NECESSARY X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.**
THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF SUNSET CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

PRINT YOUR NAME HERE _____ DATE _____

SIGNATURE _____ YOUR AGE _____

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT SUNSET CHIROPRACTIC.

SIGNATURE _____ DATE _____