Adult Intake Form

Date: ____________________

Patient Information

First Name: __________________ M.I.: _____ Last Name: ________________________

Preferred Name: __________________ D.O.B: ___/___/_______ Age: _______ Sex: M / F

Marital Status: S / M / D / W / Other: ___________________ Spouse's Name: ___________

Address: ____

Street City / State / Zip

Emergency Contact: ____

Name / Relation / Best Number to Reach Them

Patient Cell: (______)-_______-_________ **(for text message appointment reminders, updates on office hours, etc.)**
Alternate Phone: (______)-_______-_________
Email: ____
Occupation: ____
Employer's Name: ____

Referral Information

Who can we thank for referring you to our office? ____
How did you hear about us? (Please check)
▢ Family/Friend ▢ Online Advertisement ▢ Newspaper:_____________ ▢ Other:_____________

Insurance Information

***Please present all insurance cards to the front desk when you first arrive for your appointment. Thank you!**

Health Information

What is your primary reason for seeking care (please circle): Wellness/Prevention Injury/Condition

If for a condition, describe: _____________________ When did this begin? ___________________

Does a certain activity increase discomfort:____

What is your pain level with this condition at worst? Please circle a number or range on a scale of 1-10. (with 1 being mild pain and 10 being intense pain)

How would you describe the pain (check all that apply):

▢ Burning ▢ Dull Ache ▢ Sharp/Stabbing ▢ Numb/Tingling ▢ Radiates to another area:_________

Other doctors seen for this condition: Y / N If yes, prior treatments received:____________________

Health and Family History

When was the last time you felt well? ____

Are there any injuries or surgeries we should know about? ______________________________

Diagnosed conditions: ____

Have you ever seen a chiropractor before: Y / N If yes, how long ago:_______________________

Do you have any anxiety/concerns about seeing a chiropractor? Y / N
If yes, please detail: ____

Sleep Quality (please circle): Poor / Fair / Good / Great Average hours per night:__________

Describe your typical diet:____

Do you have any allergies? Y / N If yes, please list: ___________________________________
Have you had your food allergies tested before? Y / N If yes, how long ago:__________________

Do you have a family history of any of the following (check all that apply):

- ▢ Cancer
- ▢ Allergies
- ▢ Diabetes
- ▢ Heart Disease
- ▢ Thyroid Disorders
- ▢ Epilepsy
- ▢ Hormone Imbalances
- ▢ Autoimmune Conditions
- ▢ Other:______________________

Stress Questionnaire

Most life stresses can be grouped into three categories: Physical, Chemical, and Emotional Stress.
Please check any of the following stresses you experience on a regular basis.

Physical Stress

▢ Physical pain ▢ Low energy/ fatigue ▢ Job/Hobbies cause discomfort ▢ Tightness/Stiffness
▢ History of accidents/ injuries ▢ Recent accident/injury ▢ Inability to exercise ▢ Desk job
▢ Other:_________________________________

Chemical Stress

▢ Fast food/ lots of processed foods ▢ Medication (Prescription or OTC) ▢ Tobacco usage
▢ Frequent alcohol consumption ▢ Amalgam fillings ▢ Non-Organic makeup/lotion/other products
▢ Other:_________________________________

Emotional Stress

Please indicate your average daily stress level on a scale of 1-10 (with 10 being intense stress): ______

Health Concerns (please check or circle all that apply)

- ▢ Anxiety / Depression
- ▢ Digestive Problems
- ▢ Hormone Problems
- ▢ Nausea / Vomiting
- ▢ Asthma / Allergies
- ▢ Sensitivity to Light
- ▢ Diabetes
- ▢ High / Low BP
- ▢ Loss of Balance / Dizziness
- ▢ Arthritis
- ▢ Neck / Back Pain
- ▢ Pain / Numbness in Arms / Legs
- ▢ Irritability
- ▢ Fatigue / Sleep Issues
- ▢ Ringing in Ears
- ▢ Loss of Concentration
- ▢ Memory Problems
- ▢ Headaches
- ▢ Stiffness
- ▢ Sinus Troubles
- ▢ Cold Hands/ Feet
- ▢ Acid Reflux / Heartburn
- ▢ Psoriasis / Eczema / Skin Issues

Is there anything else that you feel the Doctor should know?
Or any specific questions you have? _________________

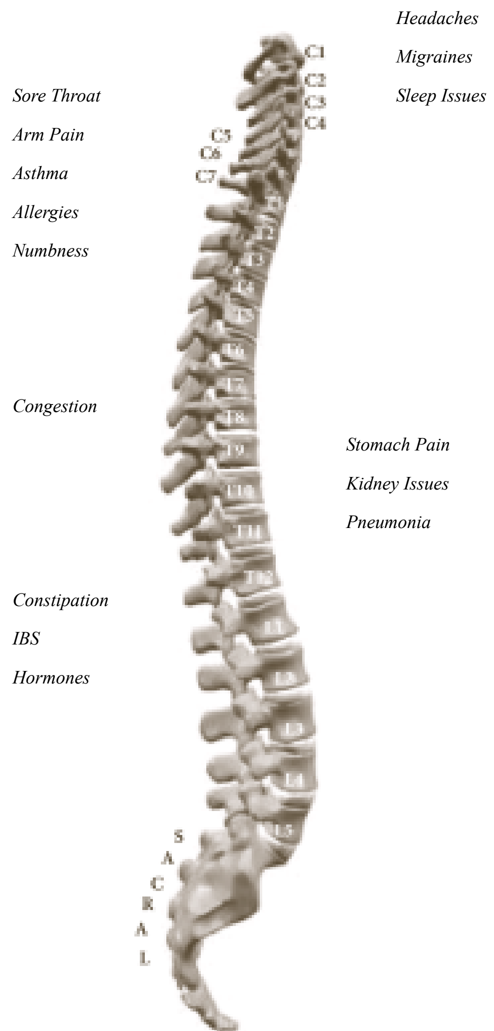
____

____

____.

Did You Know …

Each health concern relates to a specific area of the spine and nervous system. **Please circle below and/or enter the information to the left.**



Please list any medications:	Please list any vitamins / supplements:

CONSENT FORMS

Patient Consent to X-Ray

I authorize the performance of x-ray examination, which Courtley Chiropractic may consider necessary or advisable in the course of my examination and treatment.

X-Ray Consent for Women of Childbearing Age

This is to certify that, to the best of my knowledge, I am not pregnant, and that Courtley Chiropractic has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Patient HIPAA Consent Form

Protecting your privacy is important to us. Disclosure of your protected health information without authorization is limited to situations that include emergency care and law enforcement. Any other disclosures would be made only after obtaining your consent. You may request a copy of your records and they will be given to you within 30 days. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

Patient Good Faith Estimate

Standard fees for an initial visit in our office may total up to $250. *I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.*

Please send completed form to **info@courtleychiropractic.com** or turn in at the desk when you arrive for your appointment.

We are here to serve you and encourage you to ask questions during your visit with us today - We are glad you are here!

Sign:____ Date:________________

FOR OFFICE USE ONLY:

ID:	ROF:	P: Y / N Finalized:
E:	S:	F: I / C Input:

Courtley Chiropractic