



**GODFREY  
CHIROPRACTIC  
&  
WELLNESS**

119 6<sup>th</sup> Avenue East  
Alexandria, MN 56308

(320) 762-8185

godfreychiroinfo@gmail.com

**ADULT INTAKE FORM**

**PATIENT INFORMATION**

First: \_\_\_\_\_ MI \_\_\_\_\_ Last: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_  Yes! I want to opt in for text reminders

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed Spouses Name: \_\_\_\_\_

Do you have children?  YES  NO If yes, please list names/ages: \_\_\_\_\_

Are you currently pregnant?  YES  NO

How did you hear about us?  Screening/Event  Online Search  Social Media  Referral Name: \_\_\_\_\_

Other: \_\_\_\_\_

**Please list the health concern that prompted your visit:**

Health Concern (list according to Severity)	Rate Severity 0 = no pain 10 = unbearable	When did this problem begin?	Have you had this condition in the past?	Did problem begin with injury?	Are problems constant or intermittent?
1.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent
2.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PLEASE MARK "C" FOR CURRENT HEALTH CONCERNS or "P" FOR PREVIOUS HEALTH CONCERNS:**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD          | <input type="checkbox"/> Disc Problems      | <input type="checkbox"/> Knee Pain              | <input type="checkbox"/> Sleep Issues       |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Leg Pain               | <input type="checkbox"/> Skin Issues        |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Stomach Disorders  |
| <input type="checkbox"/> Arm Pain          | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Lupus                  | <input type="checkbox"/> Throat Issues      |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Fibromyalgia       | <input type="checkbox"/> Menstrual issues       | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Back Pain - Low   | <input type="checkbox"/> Food Sensitivities | <input type="checkbox"/> Migraines              | <input type="checkbox"/> TMJ                |
| <input type="checkbox"/> Back Pain - Mid   | <input type="checkbox"/> Gastric Reflux     | <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Back Pain - Upper | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Nervousness            | <input type="checkbox"/> Vertigo            |
| <input type="checkbox"/> Bladder Disorders | <input type="checkbox"/> Heart Disorder     | <input type="checkbox"/> Numbness in Arms/Hands | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Chest Pain        | <input type="checkbox"/> Hip Pain           | <input type="checkbox"/> Numbness in Legs/Feet  | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Chronic Fatigue   | <input type="checkbox"/> Infertility        | <input type="checkbox"/> Sciatica               | <input type="checkbox"/> Prostate Problems  |
| <input type="checkbox"/> Constipation      | <input type="checkbox"/> Irritable Bowel    | <input type="checkbox"/> Shoulder Pain          | <input type="checkbox"/> Blood Pressure H/L |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Kidney Problems    | <input type="checkbox"/> Sinus Issues           | <input type="checkbox"/> Other: _____       |

Have you seen other doctors for these concerns?  Yes  No If so, which type?  Chiropractor  Medical Doctor  
 Other \_\_\_\_\_

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each.

**\*\*Score the pain with 0 being no pain and 10 being worst possible pain.**

Location of pain (AREA OF MAIN CONCERN): \_\_\_\_\_

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level AT ITS WORST? (How close to "10" does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

The human body is designed to be healthy! The primary system in the body, which coordinates health and function, is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Many of the common health challenges that adults experience have their origins during the developmental years, starting at birth. Layers of damage to the spine and nervous system occur as a result of various traumas, toxins, and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system – a condition called Vertebral Subluxation. Please answer the following questions to give us a better understanding about your state of wellness and factors which may be contributing to vertebral subluxation and *impeding your body's ability to heal*.

Have you ever been involved in an auto accident?  Yes  No If yes, when? \_\_\_\_\_

Please describe any other traumas you have undergone: \_\_\_\_\_

**Please check any condition you have currently, or have had in the past:**

- Stroke  Cancer  Heart Disease  Spinal Surgery  
 Seizures  Spinal Bone Fracture  Scoliosis  Diabetes: Type \_\_\_\_\_

Please list all hospitalizations and surgical operations you have undergone within the corresponding year:

Please list all medications you are currently taking:

**How would a change in your health positively impact your life?** \*Please be specific with the goals you are hoping to achieve through your care at our office. (i.e. 'I could work out again, I could play with my grandchildren, etc')

## Activities of Daily Living

Please identify how your current health concerns are affecting your ability to carry out activities that are routinely part of your life:

<u>ACTIVITY:</u>	<u>EFFECT:</u>			
<b>Lifting/Carrying Objects</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Sit to stand</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Climbing Stairs</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Driving</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Twisting</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Exercise</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Household Chores</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Lifting Children</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Dressing</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Sleep</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Sitting</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Standing</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Work/Job Tasks</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Walking</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Washing/Bathing</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Yard Work</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Concentration (Reading)</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Other:</b> _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<b>Other:</b> _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

## HIPAA Privacy Policy

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosure for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records. There will be a reasonable cost-based fee for photocopying, printing, postage, and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you. In the future, we may contact you for appointment reminders, announcements, missed appointments, and to inform you about our practice and staff. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Insurance or Private Pay Information**

*Please provide insurance card(s) to receptionist.*

Type of Insurance:     Private Ins.     State Insurance     Auto Insurance     Work Comp

Primary Insurance Carrier: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Is patient covered by another insurance?  Yes     No    **Sec. Insurance Carrier:** \_\_\_\_\_

**ASSIGNMENT/AUTHORIZATION/RELEASE:**

**Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account: \_\_\_\_\_

- I agree to be financially responsible for all the charges incurred at this clinic including my insurance deductible, co-payment, and any services rejected by my insurance company.
- Godfrey Chiropractic and Wellness will not allow a bill to be over \$250.00 dollars. If the amount due is greater than \$250.00 you will not be allowed to receive services until it is paid. Unless a payment plan is agreed upon for the balance owed, the bill will be submitted to a collection agency in 90 days.
- I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.
- I authorize this clinic to release any information pertinent to my case to any insurance company, and attorney involved in this case; and hereby releases this clinic of any consequence thereof. A photocopy of this assignment shall be considered as effective and valid as the original.

I acknowledge I have read the above and agree to the terms of each statement.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Non-Covered Services: Financial Disclosure Form**

As your Doctor of Chiropractic, I want to provide you with the best care possible. While your policy covers some chiropractic services, there may be others that I feel would help the treatment of your condition and maintenance of good health but are not covered by your health insurance coverage. If you agree to receive these services, and they are later determined to not be eligible for reimbursement through your health plan policy, your signature on this form signifies your agreement to pay for them in full. While you may choose to not obtain these services, I want to reassure you that I will only recommend care that I believe will benefit your health.

Services that we expect to not be eligible for reimbursement through your plan's chiropractic benefit, and therefore will likely be your financial responsibility should you elect to receive them, are outlined below. Your financial responsibility is limited to services received during the treatment plan as defined below:

Non-Covered Service	Cost Per Visit*	Member Initials/Date
Exam(s)	\$40	
Manipulation	\$50.00/ \$55.00	
X-ray(s)	\$43.00	

I agree to be financially responsible for all the charges incurred at this clinic including my insurance deductibles, co-payments, and any services rejected by my insurance company. In addition, Godfrey Chiropractic and Wellness will not allow a bill to be over \$250. If the amount due is greater than \$250 you will not be allowed to receive services until it is paid.

Signature \_\_\_\_\_ Date \_\_\_\_\_