GODFREY CHIROPRACTIC & WELLNESS

119 6th 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.			☐Yes ☐ No	☐Yes ☐ No	☐Constant ☐ Intermittent
2.			☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No
3.			☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No

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

___ADD/ADHD
___Allergies
___Anxiety
___Arm Pain
___Asthma
___Back Pain - Low
___Back Pain - Mid
___Back Pain – Upper
___Bladder Disorders
___Chest Pain
___Chronic Fatigue
___Constipation
___Depression
___Disc Problems
___Dizziness
___Ear Infections
___Epilepsy
___Fibromyalgia
___Food Sensitivities
___Gastric Reflux
___Headaches
___Heart Disorder
___Hip Pain
___Infertility
___Irritable Bowel
___Kidney Problems
___Knee Pain
___Leg Pain
___Liver Disease
___Lupus
___Menstrual issues
___Migraines
___Neck Pain
___Nervousness
___Numbness in Arms/Hands
___Numbness in Legs/Feet
___Sciatica
___Shoulder Pain
___Sinus Issues
___Sleep Issues
___Skin Issues
___Stomach Disorders
___Throat Issues
___Thyroid Problems
___TMJ
___Ulcers
___Vertigo
___Arthritis
___Sexual Dysfunction
___Prostate Problems
___Blood Pressure H/L
___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:

ACTIVITY:	EFFECT:			
Lifting/Carrying Objects	☐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
Twisting	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Exercise	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Household Chores	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Lifting Children	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Dressing	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Sleep	☐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
Work/Job Tasks	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Walking	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Washing/Bathing	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Yard Work	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Concentration (Reading)	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Other:_____	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Other:_____	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐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 in 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	$55.00/ $60.00	
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 _____