Chiropractic Intake

Dr. Jim Cox; 650 E. Tahquitz Canyon Way, #2, Palm Springs, CA 92262; T 760.898.3860; F 760.406.4016; doc@drjimcox.com

PLEASE PRINT CLEARLY

Name: ____
Last First MI

DOB: ____ / ____ / ____ Address: ______________________________
Street

Home Phone: ______________ ______________________________
City State Zip

Cell Phone: ______________ Email: ______________________________

Emergency Contact: ______________________________
Name & phone number.

Is MEDICARE your primary insurance? Y / N

If *YES*, do you have secondary insurance? Y / N

Please provide your Medicare and secondary insurance cards for copy.

☐ **If you have chiropractic coverage with any insurance other than Medicare and would like a statement provided to you for reimbursement, please check here.**

Were you involved in an auto accident? Y / N

Are your symptoms a result of an injury at work? Y / N

Chief complaint (why are you seeking treatment?) ______________________________

How did this begin? ______________________________

When did this begin? ______________________________

Has this happened before? Y / N Were you treated for this before? Y / N

Previous treatment: ______________________________

Since the problem began, it has: ☐ Improved ☐ Worsened ☐ Not changed

The problem bothers me:

☐ Occasionally (0-25% of the time) ☐ Intermittently (26-50%) ☐ Frequently (51-75%) ☐ Constantly (76-100%)

Rate your pain as you feel today: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

No pain Moderate Unbearable

Do you notice your pain mostly in the: ☐ Morning ☐ Afternoon ☐ Night

Any other associated symptoms? ______________________________

My signature, below, certifies that I am aware that all services are payable when treatment is rendered; that I understand I will be responsible for payment to any other facilities and/or health care providers that I may be referred to by Dr. Cox and any emergency transportation that may be required thereto; that the preceding questions have been answered truthfully and complete to the best of my knowledge and belief.

Patient/Guardian signature: ______________________________ Date: ______________