HealthWise
Family Chiropractic, P.A.

3803 Silver Lake Road NE, Unit 100
St. Anthony, MN 55421

Adult Intake Form

Patient Information:

Date: _____

Patient Name:_____ Date of Birth:_____ Age: _____ Gender:_____

Address:_____ City:_____ State: _____ Zip:_____

Phone #:_____ May we text you with clinic updates/specials?

Email Address:_____ May we email you appointment reminders?

How would you prefer to be contacted by our office? (scheduling, questions, concerns)

Email Phone Text Ok to leave detailed message?

Occupation:_____ Employed By:_____

Emergency Contact:_____ Phone:_____

Marital Status: Number of Children:_____

Name of spouse:_____ Phone:_____

How did you hear about us?

Personal Referral (name of patient): _____ (may we thank them for their referral)

Other (please specify):_____

Previous Providers:

Have you been to a chiropractor before?

If yes, who was the physician?_____

Reason for leaving:_____

Are you currently seeing any other physician or healthcare professional?

If yes, who is the provider?_____

Reason for care:_____ Date of last visit:_____

Do we have your permission to communicate with this/these provider(s) regarding your care?

Current Health and Habits:

I would describe my overall health as:

Reason you are seeking care at HealthWise Family Chiropractic:_____

What symptoms are you currently experiencing?_____

When did the symptoms begin?_____

Rate the severity of your pain (0=no pain, 10=unbearable pain!)_____

Describe your pain (check all that apply): Sharp Dull Throbbing Numbness

Shooting Aching Burning Tingling Stiffness

Has this problem occurred before? (if yes, when?)_____

Did it begin suddenly or gradually?_____

Is there anything that makes it better or worse?_____

Since it began, are the symptoms:

Have you been seen by another healthcare provider for this condition?_____

If yes, who was the physician?_____

What was the treatment?_____

What were the results?_____

Daily Habits:

How often do you exercise per week:_____ Type of Exercise: Cardio Weight Training Yoga Other

What do your daily work habits include? (include hours/day):

Sitting:_____ Standing:_____ Light Labor:_____ Heavy Labor:_____ Desk/Computer:_____

Describe any occupational stresses:_____

Do you eat fruits/vegetables? How many servings per day?_____

Do you drink caffeine? Type/cups per day?_____

Do you drink alcohol? Drinks per week?_____

Do you smoke or use tobacco? Type/how often?_____

Number of hours sleeping per night:_____ Quality of sleep:

Please list any current medications or nutritional supplements you are taking and reason for taking:

_____

_____

Past Health History:

Have you ever been hospitalized? If yes, date/reason_____

Have you ever had surgery? If yes, date/type_____

_____

Have you experienced trauma? (motor vehicle accidents, broken bones, falls down stairs, concussion/TBI, other accidents):_____

_____

Do you have any known allergies? (please explain):_____

Have you been treated for any other health condition in the past year?

If yes, please explain:_____

Family History: (check all that apply)

Back/Joint Problems	Heart Attack	High Blood Pressure	High Cholesterol
Stroke	Cancer	Diabetes	Headaches

Women Only:

Are you pregnant? (current gestational weeks) _____

Are you nursing?

Are you taking birth control pills?

Acknowledgement:

To the best of my knowledge, the information provided is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have any changes in health or insurance changes.

Signature:_____ Date:_____

Permission to Treat a Minor without Parent/Guardian present:

HealthWise Family Chiropractic must receive permission from a child's parent or legal guardian before providing non-life-threatening treatment to anyone under the age of 18. By signing below, you are giving us legal permission to treat your child in case you cannot accompany him/her to the clinic for treatment. This will remain in effect until terminated in writing.

Patient Name:_____

Parent/Guardian Printed Name:_____

Parent/Guardian Signature:_____ Date:_____

Do you have any other concerns that you would like to address with us? Please explain below. We are here to serve you as our patient, and we encourage you to ask questions! Your participation is VITAL and will help determine your results.

_____

_____

_____

Certification and Assignment:

I certify that I, and/or my dependent(s), have insurance coverage with _____ insurance company and assign directly to HealthWise Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Doctors and staff of HeathWise may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

A copy of your insurance card and valid state ID will be taken at the time of your visit.

Please note that HealthWise Family Chiropractic has never denied anyone access to chiropractic care because their circumstances prevented them from paying our stated fees. If you find yourself in this situation, please let us know so that we can arrange an individual payment plan for you.

_____ Initial

Responsible Party:

Name of person responsible for this account (if different from patient):_____

Relationship to patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Additional Therapies not Covered by Insurance:

I understand that some optional therapies (including but not limited to WellWave, Laser, or Kinesio Taping) will not be billed to my insurance plan. I understand that HealthWise will inform me when I am offered services not billed to insurance.

_____ Initial

No Show Policy:

We expect a phone call if you are unable to keep your appointment. If we do not hear from you by the time of your appointment, you will be charged a $50.00 fee for the missed appointment. Please provide us with a valid credit card. Card will not be charged unless there is a missed appointment.

Credit Card Number:_____ Expiration:____/____ CVV Code:_____

Billing Zip Code:_____ Signature:_____

Proof of Notice Provided:

I have read HealthWise Family Chiropractic's Notice of Privacy Practices, which explains how my health information may be used and disclosed, as well as, how I can get access to this information. I understand I may request a copy of this information at any time.

_____ Initial

Informed Consent for Chiropractic Treatment :

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by, the licensed doctors of chiropractic who now or in the future work at the clinic of HealthWise Family Chiropractic.

I understand that it is my responsibility to discuss with a doctor or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures, should I have any questions. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I

do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedures which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent , and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name:_____ Signature:_____

Relationship to patient:_____