Chiropractic Intake

8791 Wolff Ct. Suite 140
Westminster, CO 80031
PH: 303-427-2414
FX: 303-427-5719

Name:_____ DOB:_____ Age: _____ Sex: M / F

Address:_____ City:_____ ST:_____ ZIP: _____

Home Phone:_____ Mobile Phone:_____ Preference: ☐H ☐C

Email Address:_____
(By providing your email you consent to being added to our mailing list for announcements)

Employer:_____Occupation:_____

Emergency Contact:_____

Relationship:_____ Contact Phone:_____

Do you have Medicare? _____ (If yes, please provide your card)

How did you hear about our office? (Who referred you)_____

Automated Reminders (Choose one)
☐Text: **Mobile Phone Provider**:_____☐ 1 Day Prior ☐ 2 Days Prior
☐Email

What type of treatment are you looking for? (Check all that apply)

- ☐ Quick Fix. I want the minimal amount of care to “patch up the symptoms” of my problem.
- ☐ Problem Fix. I want to resolve the symptoms and go on to “fix the cause” of my problem.
- ☐ Optimal. I want to take care of my current problems then go on to “achieve optimal health”.

Please describe the current condition that brings you to our office: _____
_____
_____

When did the condition start: _____

Onset of the condition was (circle one): Sudden Gradual Associated w/ an event

The event:_____

Is the condition getting worse? ☐ Yes ☐ No

Is this condition interfering with your: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Other:_____

Have you received treatment for this problem? ☐ Yes ☐ If Yes, please describe: _____

_____

Any other health concerns:_____

_____

Have you ever been in an auto accident: ☐ Never ☐ Past Year ☐ Past 5 years ☐ Over 5 years

Please describe: _____

Check all that apply: PAST (P) OR CURRENT (C)

Musculoskeletal System	**P**	**C**	**G/I Tract**	**P**	**C**	**Nervous System**	**P**	**C**
Low Back Pain			Excessive Hunger			Muscle Jerking		
Mid Back Pain			Difficulty Swallowing			Confusion		
Pain b/w Shoulders			Excessive Thirst			Forgetful		
Neck Pain			Nausea			**Cardio-Vascular**		
Arm Problems			Abdominal Pain			Chest Pains		
Shoulder Pain			Blood			Pain over Heart		
Leg Problems			Black Stool			Difficulty Breathing		
Ankle/Foot Pain			Hemorrhoids			Persistent Cough		
Wrist/ Hand Pain			Liver Problems			Rapid Heart Rate		
Swollen Joints			Gall Stones			Slow Heart Rate		
Painful Joints			Weight Fluctuation			Varicose Veins		
Stiff Joints			Acid Reflux/ Heart Burn			Known Heart Problems		
Sore Muscles			**Genito- Urinary System**			Known Lung Problems		
Weak Muscles			Fullness of Bladder			**Eye/Ear/Nose**		
Walking Problems			Urinary Difficulty			Vision Problems		
Spasms			Frequent Urination			Ear Pain		
Broken Bones			Painful Urination			Ear Tubes		
TMJ (Jaw Pain)			Stones			Tinnitus/ Ringing		
Teeth Grinding			**Nervous System**			Sinus Pain		
Female System			Convulsions			Seasonal Allergies		
Irregular Menstruation			Irritability			Nose Bleeds		
Hot Flashes/ Night Sweats			Impatience			Sore Throat		
Breast Pain/ Lumps			Depression			Hoarseness		
Pain During Cycle			Insomnia			Dry Mouth		
Miscarriage			Fainting			Bad Breath		
Pregnancy			Paralysis			Bad Taste		
G/I Tract			Numbness			**Infections (Write In)**		
Constipation			Tingling					
Diarrhea			Dizziness					
Poor Appetite			Headaches					

Medications: Please list your current medications including “over the counter” medications and nutritional supplements.

Name of Medication:	Dose:	Reason for taking:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Allergies:

Food: _____

Seasonal: _____

Environmental: _____

Medications: _____

Have you had any surgeries or extended hospitalizations within the last 5 years?:

_____

_____

Family History: Identify any conditions that a family member has now or has had in the past (**G=Grandparent, M=Mother, F=Father, S=Sibling)**

Alcoholism/ Drug Abuse		Goiter		Seizures/ Fainting	
Anemia		Gout		Stroke	
Cancer:		Heart Disease		Tumors	
Cold Sores		Pneumonia		Ulcers	
Deep Vein Thrombosis		Rheumatic Fever		Vaccination Reaction	
Diabetes		Miscarriage		Eczema	
Diverticulitis/ IBS				Genetic Disorders:	

Social Habits:

	Heavy	Moderate	Light
Alcohol			
Coffee			
Soda			
Tobacco			
Drugs			
Stress			
Electronics			
TV			
Artificial Sweeteners			

Exercise: □ 5-7x/wk □ 3-5x/wk □ 1-3x/wk

Type_____ Duration_____

Sleep:

□ 8+ hrs □ 7-8 hrs □ 6-7 hrs □ 5-6 hrs □ <5 hrs

Meals: □ 5+ □ 4 □ 3 □ 2 □ 1

Water: □ 64+oz □ 32-64oz □ 16-32oz □ <8oz

Work Activity:

□ Heavy duty □ Light labor □Mostly sitting

□ Mostly standing □ Walking/moving □ Driving

Privacy Policy:

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree how your records are used.

1. The patient understands and agrees to allow NFHC to use their PHI for treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office will not release any of your records without your written consent.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by NFHC to assure that your records are not readily available to those who do not need them.
6. If a patient has a complaint about the privacy of records, please contact Michaele, our office manager.
7. If the patient refuses to sign this consent, our office has the right to refuse care.

I have read and understand how my PHI will be used and I agree to these policies and procedures. Please let us know if you would like a full copy of the office "Notice of Patient Privacy Policy".

Signature: _____ Date: _____

Printed Name: _____

Permission to Communicate Protected Health Information:

I, _____ DOB: _____, grant permission for Natural Family Health Care, Inc. to disclose my health information as specified below:

I authorize the providers of NFHC to speak about my care with:

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

***I understand this may include detailed personal medical information including, but limited to: medical services to be provided, notification of supplements to be picked up, or appointments to be scheduled.**

_____ Date: _____
Signature of Patient or Authorized Representative

This consent form will expire when revoked in writing by the patient/representative or, in the case of a minor, on the date the minor becomes an adult under state law.

Consent for Professional Services:
I hereby authorize the employees of Natural Family Health Care, Inc. to leave a detailed voicemail/email regarding my services at any contact information given, knowing that it will identify me as a patient of the office. I also give permission to disclose my presence in the office to friends and family calling or coming in, for the purpose of scheduling or supplemental requirements.

_____
Signature of Patient or Authorized Representative

Financial Policy

I understand that Natural Family Health Care is not a provider for any insurance companies, other then Medicare.
I clearly understand that all services and products rendered to me are my personal responsibility. If this financial agreement is not paid when due, I agree to pay all reasonable costs of collections including but not limited to court costs, and attorney's fees.

****Any missed appointments without 24 hour prior cancellation notice will be charged the full amount of the visit.****

_____ Date: _____
Signature of Patient or Authorized Representative