# Patient Intake Form

# A blue logo with a bull  Description automatically generatedToday's Date:

Name: Birth date: Age: ( ) Male ( ) Female

Address:

City: State: Zip:

Home Phone: Cell Phone: Text? ( )Yes ( )N Best Hours:

Email Address:

( ) Married ( ) Single ( ) Divorced ( )Widowed # of Children

Referred to our office by: Relation:

Name of Emergency Contact: Phone:

Employer: Occupation:

Is this visit a result of an accident? ( ) Yes ( ) No Work: Auto: Other:

Health Insurance Information:

If you are in the office, you can present your card and skip section below

Primary Insurance Carrier: ID#:

Policy Holder's Name Group #:

# Medical Release/Assignment of Benefits/Cancellation Policy

I authorize Ageless Chiropractic & Wellness, LLC to release any information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Ageless Chiropractic & Wellness, LLC. I understand and that payments made directly to me from my insurance carrier for services rendered as an Out Of Network provider, are to be signed over to Ageless Chiropractic & Wellness, LLC. upon my receipt. I understand that I am fully responsible for any unpaid portion of charges incurred at this office. Regardless of insurance status, charges for services rendered are ultimately the patient's responsibility.

Patient's Signature Date:

(Parent or Guardian if Minor)

# General Health Information

Height Weight Left / Right Handed Do you have a pacemaker? ( )YES ( )NO

Have you ever received chiropractic care before? ( )YES ( )NO Dr's Name: Have you undergone previous chiropractic or physical therapy in the past year? ( )YES ( )NO

List any diseases or health conditions you now have or have been treated for in the past.

List any known allergies:

List any other trauma or injuries:

List any hospitalizations or surgeries:

Date of last physical: Date of last Blood Test

Dr with these results: XRAYS: MRI'S: Other tests:

Exercise: Type and Frequency:

Family History:

Check all that apply:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Stroke | Heart Disease | Arthritis | Cancer | Diabetes | Other |
| Mother's Side |   |   |   |   |   |   |
| Father's Side |   |   |   |   |   |   |

# Current Symptoms

Reason for consulting Dr today:

When did this pain or condition begin?: Is your Pain: Sharp Dull Constant Intermittent

Rate your pain on a scale from 0-10 (0=No Pain, 10=Severe Pain) Please circle: 0 1 2 3 4 5 6 7 8 9 10 Does your pain radiate or move? Please describe:

What aggravates your condition/pain?:

What relieves you condition/pain?: Is the condition/pain worse at certain times of day?

When?: Activities that are limited due to your condition/pain?: Is the condition/pain getting progressively worse?:

Previous Doctors or Treatments:

Any Home Remedies used:

Have you ever had the same or similar condition before? Please

explain:

Check any of the following symptoms which you have now or have had in the past.

 Headaches

 Pins & Needles in Arms/Legs

 Neck Pain

 Numbness in Fingers/Toes

 Back Pain

 Feeling of Anxiety

 Chest Pain

 Irregular Heart Rate

 Stiff Neck

 Tension/Irritability

 Sleeping Difficulties

 High Blood Pressure

 Clench/Grind Teeth

 Cold Sores/Fever

 Blisters

 Dizziness/Vertigo

 Depression/S.A.D.

 Alcoholism/Addictions

 Cold Hands/Feet

 Panic Attacks

 Stomach upset/Ulcers

 Irritable Bowel/Colitis

 Leg/Feet cramps at night

 Unexplained Fever

 Eczema/Skin Rashes

 Severe Menstural Cramps

 Chronic Fatigue

 Shortness of Breath/Asthma Eyes Sensitive to Light

 Roving Muscle/Joint Pain

 Ears Ringing/Buzzing

 Recent Unexplained Weight Loss

 Recent change in Bowel/ or bladder infection

Please list any medications you are prescribed and taking:

Please mark the diagrams with any of the following:

Numbness ----- Burning XXXX

Aching ++++

Pins & Needles 00000 Stabbing //////

Other \*\*\*\*\*\*

Please list any significant traumas or injuries you have had

Patients Signature: Today’s Date:

# Acknowledgement of Receipt of this Notice

Ageless Chiropractic & Wellness, LLC is concerned about the privacy of our patient’s health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

You may request a copy of Ageless Chiropractic & Wellness, LLC HIPPAA Notice of

Privacy Practices.

*I acknowledge that I have received the Notice of Privacy Practices for: Ageless Chiropractic & Wellness, LLC.*

Name of Patient (Print)

Signature of Patient or Authorized Representative Date

Consent To Contact

By supplying my phone number, email address and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system (ChiroTouch) to use personal limited information for the purpose of notifying me of pending appointment, a missed appointment, lab results or other communications.

D My signature indicates consent to be contacted by text message or email D I choose to decline digital contact.

Signature of Patient or Authorized Representative Date

# Financial Policy

If for any reason your account goes to our collection agency, all courtesy adjustments or discounts applied to your account will be removed. Attorney fees of 1/3 your total balance plus any processing fees that may be incurred will be added to your balance.

Patient Initials:

For subsequent visits, you may wish you keep your credit card on file for future payments. Please notify the front desk if you wish to keep your credit card on file.

Ageless Chiropractic & Wellness, LLC

Tyler Veretto, DC

158 Sullivan Avenue, Suite 5 South Windsor, CT 06074

Phone: (860)-555-5555

Email: agelesschiropractic.wellness@gmail.com

# INFORMED CONSENT TO TREAT

I hereby consent to the performance of chiropractic treatment, related modes of therapy, on me (or the patient named below, for whom I am legally responsible) by the doctors of chiropractic employed by Ageless Chiropractic & Wellness (Tyler Veretto, DC). I understand that those doctors are providing services within their scope of practice as defined by the State of Connecticut.

I have had an opportunity to discuss with clinic personnel the nature and purpose of chiropractic procedures, and understand that results are not guaranteed.

I understand that, as in the practice of medicine, in the practice of chiropractic and/or massage therapy there are some risks to treatments, including but not limited to: fractures, disc injuries, dislocations and sprains. I do not expect the doctor/massage therapist to be able to anticipate and explain all risks and complications. I wish to rely on the doctor’s judgment during the course of my treatment, based upon the facts then known, to provide therapies or procedures that he or she feels are in my best interests. As such, I understand that both my chiropractor must be made aware of any existing medical conditions, and that it is my responsibility to keep them updated on any changes to those conditions.

I have read the above noted consent and acknowledge that by signing this form, I confirm to consent to treatment and intend this consent to cover the treatment(s) discussed with me to deal with the physical condition for which I have sought treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

Patient Name: Date:

Patient Signature: Relationship:

(Or Patient Guardian/Representative)