Patient Intake Form

Personal Information Date: _____

First Name: _____ **Last Name:** _____

Preferred Name: _____ **Marital Status:** _____

DOB: _____ **Age:** _____ **Email:** _____

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

Cell #: ( )_____-_____ **Provider:**_____

Best Way To Reach You (circle): Call Text Email

Position: _____ **How long:** _____

What physical activity does your job entail? _____

Do you sit at a computer? Yes / No How long? _____ **How often do you get up?** _____

Who may we thank for sending you to us? _____

Reason For Seeking Chiropractic Care

Previous Chiropractic Care: Yes / No When: _____/_____/_____ **Reason:** _____

Current Complaint: _____

How did this develop: _____

Date of Onset: _____ **Is this condition getting worse: Yes / No Constant Occasional**

Has anyone else treated this condition: _____

What helps the condition: _____

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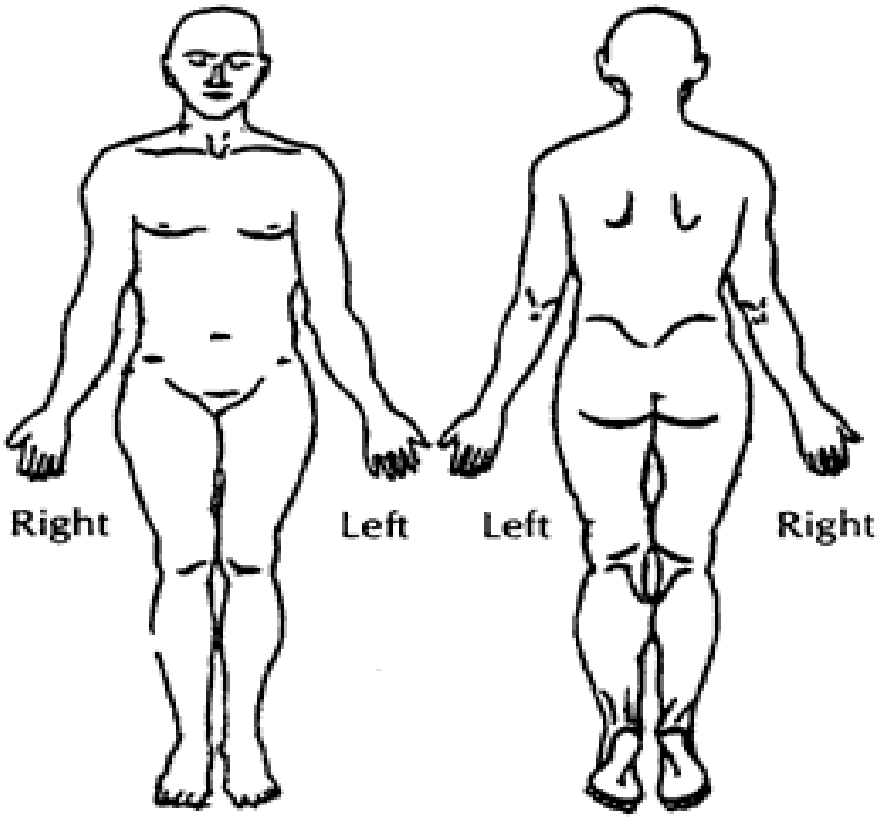
What aggravates the condition: _____

Pain Drawing

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc). Please indicate which sensations you feel by referring to the key below.

Key
///// Stabbing
XXXXX Burning
00000 Needles
===== Numbness
+++++ Aching



Circle your current pain level

0 1 2 3 4 5 6 7 8 9 10

None **Extreme**

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Medical History

Medical Physician: _____ **Phone #:** ( ) ___-_____

Date of last physical exam: ____/_____/_____ **Height** _____ **Weight**_____

Do you now, or have you ever had any of the following conditions?

Y N	Heart Attack/Stroke	Y N	Fainting/Seizures
Y N	Congenital Heart Defect	Y N	Diabetes: Type ____
Y N	Heart Surgery/Pacemaker	Y N	Kidney Problems
Y N	Heart Murmur	Y N	Artificial Bones/Joints
Y N	Mitral Valve Prolapse	Y N	Cancer/Chemotherapy
Y N	Artificial Valves	Y N	Anemia
Y N	High/Low Blood Pressure	Y N	Arthritis: Rheumatoid/Osteo
Y N	Difficulty Breathing/Asthma	Y N	Frequent Headaches/Migraines
Y N	Sinus/Allergy Issues	Y N	Anxiety/Depression
Y N	Frequent Neck/Back Pain	Y N	ADD/ADHD
Y N	Extremity Pain	Y N	Shoe Lifts/Arch Supports
Y N	Numbness/Tingling	Y N	Foot Surgery
Y N	Spinal Surgery	Y N	Carpal Tunnel Surgery

Other Medical Conditions:

_____

Have you had any surgeries or hospitalizations?

_____

Allergies? (seasonal, medicines, foods, etc): _____

Accidents/Traumatic Injuries?: _____

Do you exercise? Y N How often/long: _____
Do you smoke/drink? Y N How much? _____
Do you play sports? Y N How often: _____
Any injuries? Y N _____

For Women: Are you pregnant: Yes No How long? _____ **weeks**

Nursing? Yes No Are you taking birth control: Yes No

_____	_____	_____
Person Filling Out Medical Form	**Relationship to Patient**	**Date**
_____	_____	_____
Name of Patient	**Patient Signature**	**Date**

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HIPAA Consent

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view changes to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. I authorize the use of my full name for the purpose of greeting me, announcing me into a room, or around the office in the presence of others. This is effective as of January 2, 2003, and remains in effect until further notice.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third-party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understood the Notice of Privacy Practices. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date: ____/____/____ Patient Name: _____ Signature: _____

Relationship to Patient: _____

People Authorized to Obtain Medical Information: _____

Financial Policy

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal we need your commitment as well.

- **We urge you to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office as soon as possible to make any changes. In order to obtain the level of achievement we both desire, care must be followed.**
- **I authorize Midwest Family Wellness to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.**
- **We will bill your insurance for all procedures completed in our office. Your insurance may or may not cover all of these services. We do not cater our care to what your insurance covers, but by what the doctors feel is necessary to correct any vertebral subluxations we find. Although your benefits may show that a procedure is covered it is not a guarantee of payment. We will always submit any information which your insurance may request in order to have your claims paid. However, you will be responsible for any amount which your insurance does not cover, unless a prior agreement between you and Midwest Family Wellness exists. Payment will be expected within 30 days of notification of the amount due.**
- **Should insurance payments be remitted to you, the patient, in the form of PR 100's, those payments will need to be submitted to Midwest Family Wellness immediately.**
- **Midwest Family Wellness is a provider with Medicare. After you have met your deductible, Medicare Part B pays for a portion of the visits when you are adjusted only if you have first had an exam and x-rays.**
- **All charges are to be paid by cash, check or credit card before services are rendered. We do not bill for services rendered.**
- **You are expected to make us aware of any changes to your insurance.**
- **If you have any questions about our financial policies, please ask to speak to our financial officer. If you need to make special arrangements, please ask. We will do everything possible to make sure your chiropractic care fits into your budget.**

Patient Name: _____ Signature: _____ Date: _____

Radiology Consultants Midwest
201 Enchanted Parkway Ballwin, MO 63021
(636)256-7779 Phone / (636)227-0624 Fax
FED ID# 43-1912520

PATIENT NAME: _____

PHONE #: ( )_____ EMAIL: _____

DOB: _____ MALE/FEMALE

Your signature on this form gives permission for Radiology Consultants Midwest to read our x-rays.

Radiology Consultants Midwest will provide Midwest Family Wellness with a written radiology report which we will then go over with you.

*There is no fee associated with this service.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS SERVICE.

_____ _____
Patient Signature **Parent/Guardian**

_____
Date

***Doctor comments or questions:**

Dr. Joshua Fink
RCM OFFICE USE ONLY
C/S 2 3 5 7 B _____
T/S 1 2 _____
L/S 2 3 4 5 B _____
PELVIS _____
F/S 1 2 _____