Gator Family Chiropractic Intake Form

Date: _________________

Title: (circle one) Mr. Mrs. Miss Dr. Other________________

First Name_______________ Middle Initial____ Last Name__________________

I prefer to be called by ____

Date of Birth______/__________/___________ Sex/Gender__________________

Address____

City______________________ State________________ Zip Code_____________

Cell Phone ( )__________________ Work Phone ( )___________________

Email____

Marital Status: (circle one) Single Married Other

Employment Status: (circle one) Employed FT Student PT Student Other

Occupation if employed: ____

Emergency Contact: ____

Relationship to Patient: __________________ Cell Phone ( )_______________

How did you hear about our office? _____________________________________

Have you ever had chiropractic care before? (circle one) Yes No

For what problem? ____

Were the results satisfactory? (circle one) Yes No N/A

Have you seen anyone else for this problem? ______________________________

Are you pregnant? Yes No N/A

What brings you in today? Please be specific in describing your major complaints:

____

____

When did you FIRST notice this problem/pain? ____________________________

____

How do you believe this problem/pain began? ______________________________

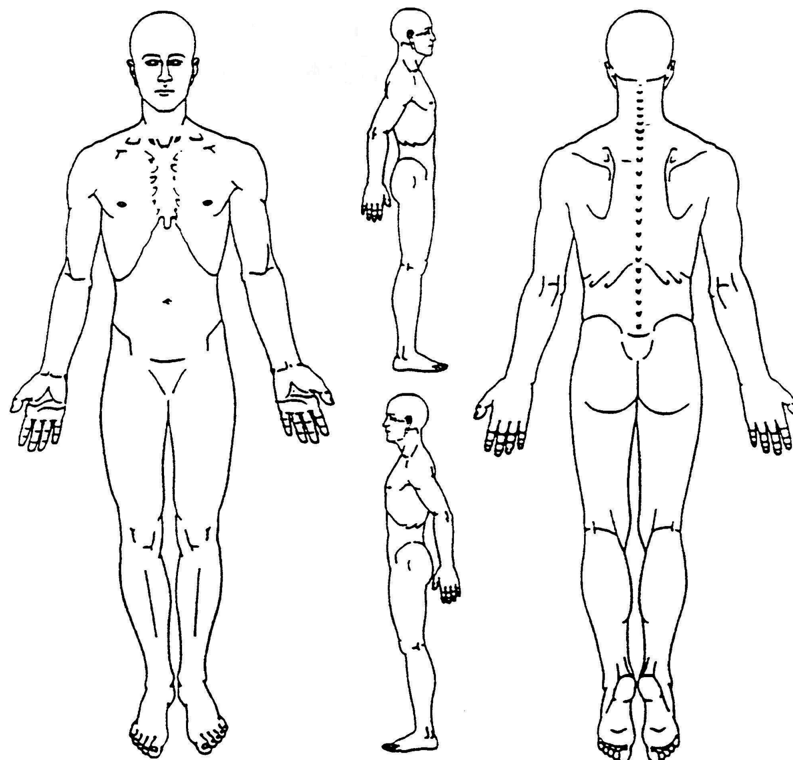
____

On a scale of 1 to 10 (ten being worst) how is your pain today? _______________

During the course of the day how often do you experience your symptoms?

- o Intermittently 0 – 25%
- o Occasionally 26 – 50%
- o Frequently 51 – 75%
- o Constantly 76 – 100%

<u>Please indicate on the body diagram where you are experiencing pain:</u>



Medical History

Medical Conditions: check all that apply to you

Arthritis
Diabetes
Heart Disease
Hypertension
Stroke
Other:___________________________________

Surgeries: check all that apply to you

Appendectomy
Joint Replacement
Brain
Carpal Tunnel
Shoulder
Cardio-vascular procedure
Prostate
Gastro-intestinal
Cervical spine
Lumbar Spine
Thoracic Spine
Hysterectomy
Knee
Hernia
Other: ______________________

Allergies: (please list any and all) ____
____

Please list ALL current medications, vitamins, and/or supplements being taken:
____
____

Social History: (please circle all that apply to you)

Caffeine use: Occasional Often Never
Drink Alcohol: Occasional Often Never
Tobacco use: Occasional Often Never
Exercise: Occasional Often Never

Sleep: Hours per night= ____________________

Stress level: (circle one) High Moderate Low None

Family History: Circle all that apply

Arthritis: Parent Sibling
Cancer: Parent Sibling
Diabetes: Parent Sibling
Heart Disease: Parent Sibling
Hypertension: Parent Sibling
Thyroid: Parent Sibling
Kidney disease: Parent Sibling
Ulcer: Parent Sibling
Asthma: Parent Sibling
Stroke: Parent Sibling
Other: ______________________

For the following questions please use a scale of 1-10:

1= no pain: 10 = worst pain imaginable

If you are experiencing **neck pain**, please circle the pain level over the last week: 1 2 3 4 5 6 7 8 9 10

If you are suffering from **back pain**, please circle the pain level over the last week: 1 2 3 4 5 6 7 8 9 10

If you are enduring **shoulder pain**, please circle the pain level over the last week: 1 2 3 4 5 6 7 8 9 10

Does this pain cause you **difficulty when standing** over the last week?

1 2 3 4 5 6 7 8 9 10

Does this pain cause you **difficulty when sitting**? 1 2 3 4 5 6 7 8 9 10

Do you feel that your **pain limits or hampers** your **personal life**?

1 2 3 4 5 6 7 8 9 10

Do you feel **pain** that **prevents** you from **walking**? 1 2 3 4 5 6 7 8 9 10

Does this pain cause you **difficulty trying** to **fall asleep** or **stay asleep**? 1 2 3 4 5 6 7 8 9 10

Does your pain make it more **difficult** for you to **concentrate**? 1 2 3 4 5 6 7 8 9 10

For the following questions please use a scale of 1-10:

1= very easy: 10= difficult or painful

How **difficult** is it for you to **touch your toes**? 1 2 3 4 5 6 7 8 9 10

How **easily** can you **reach your hand behind your head** to touch your shoulder blades? 1 2 3 4 5 6 7 8 9 10

How **difficult** is it for you to **bend your neck downward**? 1 2 3 4 5 6 7 8 9 10

How **challenging** is it to rotationally **twist your torso**? 1 2 3 4 5 6 7 8 9 10

Do you feel that a **lack of flexibility or mobility** is impacting your personal life? 1 2 3 4 5 6 7 8 9 10

Do you find that your **physical performance is hindered** by limited flexibility or mobility? 1 2 3 4 5 6 7 8 9 10

Please total your score from each question: = ___________Total Points

Score over: 0-45	Recommendation: Red light deep tissue laser
Score over: 46	Recommendation: red light deep tissue laser and assisted stretching

Patient Signature: ____

Date: ____

Please list all imaging studies (XRAY/MRI/etc.) taken in last 6 months: __________

____

My pain/symptoms have previously been made better by: (check all that apply)

- Chiropractic
- Physical Therapy
- Stretching
- Corrective Exercise
- Massage
- NSAIDS
- Heat
- Ice
- Other: ____

My pain is: (check all that apply)

- Worse in the morning
- Worse during the day
- Worse at night
- Worse while sleeping
- Does NOT change during course of day
- Other: ____

What type of treatment are you looking for? Check which apply

____ I am looking for the most minimal amount of care to “patch up the symptoms” of my problem

____ I am looking to resolve my symptoms and then go on to “fix the cause: of my problem

____ I am looking to take care of my problem and then go on to “achieve optimal health and wellness”

Signature: _____________________________________

Date: ____

Assignment on Benefits/Insurance Assignment

I hereby assign Gator Family Chiropractic insurance benefits and any causes of action on all insurance policies otherwise payable to me. I authorize Gator Family Chiropractic to submit insurance claims to insurance companies and apply insurance proceeds to my bill and to make refunds to insurance companies, as refunds are due, under the provision of the insurance policies. I authorize Gator Family Chiropractic or its billing agent or suppliers, to release information necessary to apply for payment of these benefits. I direct my insurance carrier to accept a photocopy of this assignment in lieu of the original.

Name (print): __________________________

Sign (responsible party): ____

Date: _________________________________

Witness: ____

Missed Appointment Policy

Dear valued patient,

Your care plan has been designed specifically to expedite your complete recovery. That is why it is imperative that you do not miss your scheduled appointments. When one misses an appointment, it disrupts the healing process and slows down your recovery.

If you are unable to make your scheduled appointment, we ask you give our office a 24-hour notification. We do reserve the right to charge a cancellation fee for missed appointments without a 24-hour notice.

Adjustment Cancellation Fee- $45

Stretch Cancellation Fee- $30/$60

Massage Cancellation Fee- $70

Patient Name (print): ___________________________

Patient Signature: ______________________________

Date: ____