INITIAL PATIENT INTAKE QUESTIONAIRRE

DATE: _____

PATIENT INFORMATION:

NAME: _____ HOME PHONE #: _____

CELL PHONE #: _____

SEX: M F DATE OF BIRTH: _____ SS#: _____

ADDRESS: _____

_____

EMAIL: _____ MARITAL STATUS: _____

OCCUPATION: _____ EMPLOYER: _____

PHONE # : _____ EMPLOYER ADDRESS: _____

_____

REFERRED BY: _____ REASON FOR REFERRAL: _____

_____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

_____ PHONE NUMBER: _____

INSURANCE INFORMATION:

WHO IS RESPONSIBLE FOR THIS ACCOUNT?: _____

RELATIONSHIP TO PATIENT: _____ SUBSCRIBER NAME: _____

INSURANCE COMPANY: _____ GROUP #: _____

ID #: _____ CARDHOLDERS DATE OF BIRTH: _____

PATIENT CONDITION QUESTIONAIRRE

NAME: _____ DATE OF BIRTH: _____

REASON FOR VISIT: _____

_____

WHEN DID YOUR SYMPTOMS APPEAR? _____

WHAT WERE YOU DOING WHEN YOUR SYMPTOMS APPEARED? _____

_____

IS YOUR CONDITION GETTING PROGRESSIVELY WORSE? Y N

ARE YOU CURRENTLY PREGNANT? Y N

WHAT TREATMENT HAVE YOU RECEIVED FOR YOUR CONDITION?

Medications: _____ Surgery: _____ Physical Therapy: _____

Chiropractic: _____ Other: _____

NAME OF OTHER PHYSICIANS WHO HAVE TREATED YOU FOR THIS CONDITION: _____

_____

RATE YOUR PAIN:

Least Pain 1 2 3 4 5 6 7 8 9 10 Severe pain

TYPE OF PAIN: Persistent Intermittent

Sharp	Dull	Throbbing	Numbness	Aching
Shooting	Burning	Tingling	Cramps	Stiffness
Swelling	Other _____			

HOW OFTEN DO YOU HAVE THIS PAIN? _____

ACTIVITIES THAT ARE PAINFUL TO PERFORM:

Sitting Standing Walking Bending Lying Down

IS YOUR CONDITION DUE TO AN ACCIDENT? Y N

DATE OF ACCIDENT: _____ ATTORNEY NAME (OPTIONAL): _____
TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT? : _____

PATIENT MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____

HAVE YOU HAD ANY OF THE FOLLOWING?

AIDS/HIV	Diabetes	Liver Disease	Rheumatoid
Alcoholism	Emphysema	Measles	
Allergies	Epilepsy	Migraines	Rheumatic Fever
Anemia	Fractures	Miscarriage	Scarlet Fever
Anorexia	Glaucoma	Mononucleosis	Sexually Transmitted
Disease			
Appendicitis	Goiter	Multiple Sclerosis	Stroke
Arthritis	Gonorrhea	Mumps	Thyroid Problems
Asthma	Gout	Osteoporosis	Tonsilitis
Bleeding Disorder	Heart Disease	Pacemaker	Tuberculosis
Breast Lump	Hepatitis	Parkinson's Disease	Tumors/Growths
Bronchitis	Hernia	Pinched Nerve	Typhoid Fever
Bulimia	Herniated Disk	Pneumonia	Ulcers
Cancer	Herpes	Polio	Vaginal Infections
Cataracts	High Blood Pressure	Prostate Problems	Whooping Cough
Chemical Dependency	High Cholesterol	Prosthesis	Other: _____
Chicken Pox	Kidney Disease	Psychiatric Care	_____

PLEASE EXPLAIN: _____

_____

EXERCISE: None Moderate Daily Heavy

HABITS: Smoking (Quantity): _____ Alcohol (Quantity): _____

Coffee/Caffeine (Quantity): _____

PREVIOUS INJURIES/SURGERIES: _____

_____

_____

MEDICATIONS: _____

ALLERGIES: _____

OTHER: _____

_____

ACKNOWLEDGEMENT FORM

Name _____ **Birthday** _____

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature _____

I have received a copy of the Cancellation Policy and I have been provided an opportunity to review it.

Signature _____

Date _____

Owen Family Chiropractic
Andrew J. Owen, DC

Records Release:

I do hereby authorize Owen Family Chiropractic, Andrew J. Owen, DC to release my medical and billing records to any of its billing companies, attorneys, adjusters, etc for the purpose of getting my bill paid.

_____ _____

Signature Date

Consent to Treat:

I hereby authorize Owen Family Chiropractic, Andrew J. Owen, DC and their assistants to perform medical examination, physical therapy, spinal manipulation, and/or diagnostic testing on me.

_____ _____ Signature

Date

Financial Agreement:

I have been advised by Owen Family Chiropractic, Andrew J. Owen, DC that my co-payment or co-insurance will be collected on each visit. I also understand that if I am not able to afford my entire co-pay or co-insurance, special arrangements may be made for me. However, it is my responsibility to notify Owen Family Chiropractic, Andrew J. Owen, DC of my situation.

_____ _____ Signature

Date

Assignment of Benefits:

I understand that my insurance company may not accept assignment. I understand that my insurance company will pay me directly for the services rendered to me from Owen Family Chiropractic, Andrew J. Owen DC immediately upon receipt. I understand that it is illegal for me to cash or deposit the insurance check that I receive for services provided to me. I know that I will be given five business days to settle my account before legal proceedings begin. If my account is not settled I will also be responsible for any additional costs, such as court costs and legal fees. I understand that services provided to me today may be issued on more than one check, and I agree to forward ALL checks regarding today's treatment to Owen Family Chiropractic, Andrew J. Owen, DC. I willingly sign this agreement.

_____ _____ Signature Date

Limited Power of Attorney:

I expressly authorize and give power of attorney to Owen Family Chiropractic, Andrew J. Owen, DC and their billing agents for the signing and completing of any form in the completion of my claims and endorsing and check made payable to me, in support of processing or making payment of a claim for any charges incurred by me at this office. Further, these offices acknowledge that it is only entitles to receive payment for those charges , which were incurred through this office and any over payment will be refunded appropriately and timely.

_____ _____

Signature Date