



**Patient Intake Form**

**Patient Information**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Female: \_\_\_\_\_ Male: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell/Other: \_\_\_\_\_

I prefer to receive calls at (circle) Home/Work/Cell I am (circle) Under Age18/Single/Married/Divorced/Widowed/Separated

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Phone Number: \_\_\_\_\_

**Payment Information**

Person Responsible for Payment: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Insurance Information**

Do you have health insurance?  Yes  No

| Primary Insurance           | Secondary Insurance         |
|-----------------------------|-----------------------------|
| Insurance Company:          | Insurance Company:          |
| Policy Holder's Name:       | Policy Holder's Name:       |
| Relationship to Patient:    | Relationship to Patient:    |
| Policy Holder's Birth Date: | Policy Holder's Birth Date: |
| Group Number:               | Group Number:               |
| Policy ID Number:           | Policy ID Number:           |

**Please have your insurance card and driver's license ready so they can be copied for the clinic's records.**

**Consent for Treatment**

*Assignment & Release - By signing below, I authorize Indiana Chiropractic and Rehab, LLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Indiana Chiropractic and Rehab, LLC and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

*By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient*

Signed \_\_\_\_\_ Date \_\_\_\_\_

## Financial Policy

### Insurance Coverage

Welcome to **Indiana Chiropractic and Rehab, LLC**. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of \$100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your \$100 at the beginning of the year. Our clinic will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

### Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

#### Private Pay: (please initial)

**A** \_\_\_\_\_ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

**B** \_\_\_\_\_ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

#### Health Insurance: (please initial)

**C** \_\_\_\_\_ I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

### Missed Appointments

It is the policy of **Indiana Chiropractic and Rehab, LLC** to assess a **\$25.00** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

\_\_\_\_\_ My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you want us to file with your insurance carrier:

You are responsible for knowing if you have chiropractic benefits. As a courtesy we will call your insurance company to obtain these benefits. However, it is **NOT** a guarantee of coverage.

Patient initials: \_\_\_\_\_

To find out whether you have chiropractic benefits, please call the member customer service number located on your health insurance card.

Patient initials: \_\_\_\_\_

I understand I may or may not have chiropractic benefits. I also understand I am responsible for payment if my insurance company does not cover my services.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Health Questionnaire

### Patient Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

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List any surgeries or hospitalizations you have had complete with the month and year for each:

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List anything you are allergic to: \_\_\_\_\_

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

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Do you exercise?  Yes  No Hours per week \_\_\_\_\_ What activity(s)? \_\_\_\_\_

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Are you dieting?  Yes  No Since: \_\_\_\_\_ Do you smoke?  Yes  No \_\_\_\_\_ packs per day.

How many years have you been smoking? \_\_\_\_\_ Do you drink alcoholic beverages?  Yes  No \_\_\_\_\_ drinks per day.

Do you wear?  Heal lifts  Arch supports  Prescription Orthotics

For women: Are you pregnant or nursing?  Yes  No If pregnant, How many weeks? \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_



**Medical History**

Describe the reason(s) for your doctor visit today:

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Are you here because of an accident? \_\_\_\_\_ What type? \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_ How did your symptoms begin? \_\_\_\_\_

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How often do you experience symptoms? (Circle one) Constantly    Frequently    Occasionally    Intermittently

Describe your symptoms? (circle all that apply) Sharp    Dull ache    Numbing    Burning    Tingling    Shooting

Are your symptoms? (Circle one) Getting better                      Staying the same                      Getting worse

How do your symptoms interfere with your work or normal activities? \_\_\_\_\_

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Have you experienced these symptoms in the past? \_\_\_\_\_

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**History of Treatment**

Primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date last seen: \_\_\_\_\_ May we update them on your condition? \_\_\_Yes \_\_\_ No

Have you seen a chiropractor before? \_\_\_Yes \_\_\_ No Who referred you to us? \_\_\_\_\_

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: \_\_\_\_\_

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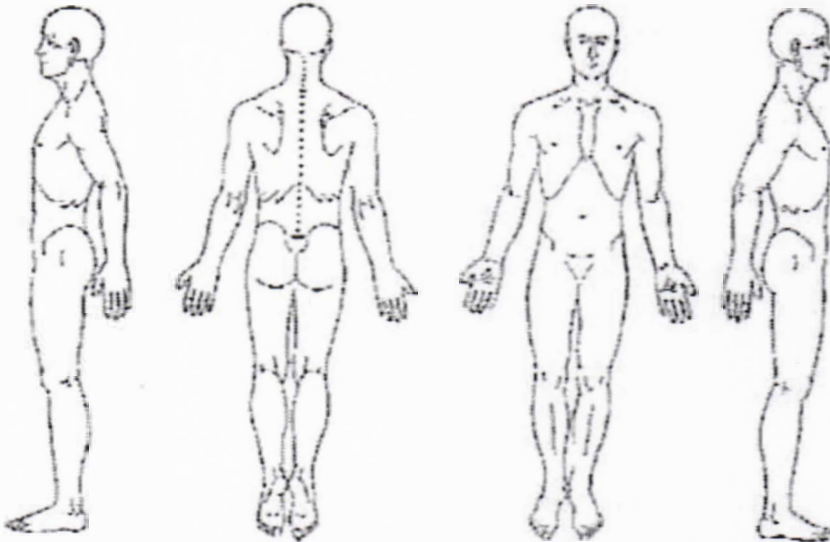




## Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left

Back

Front

Right

On a scale of one to ten how intense are your symptoms? Not intense ①②③④⑤⑥⑦⑧⑨⑩ Unbearable

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

| Past                  | Present               | Condition                 | Past                  | Present               | Condition                | Past                  | Present               | Condition                   |
|-----------------------|-----------------------|---------------------------|-----------------------|-----------------------|--------------------------|-----------------------|-----------------------|-----------------------------|
| <input type="radio"/> | <input type="radio"/> | Abdominal Pain            | <input type="radio"/> | <input type="radio"/> | Elbow/upper arm pain     | <input type="radio"/> | <input type="radio"/> | Liver/Gall Bladder Disorder |
| <input type="radio"/> | <input type="radio"/> | Abnormal Weight gain/loss | <input type="radio"/> | <input type="radio"/> | Epilepsy                 | <input type="radio"/> | <input type="radio"/> | Loss of Bladder Control     |
| <input type="radio"/> | <input type="radio"/> | Allergies Headache        | <input type="radio"/> | <input type="radio"/> | Excessive thirst         | <input type="radio"/> | <input type="radio"/> | Low back pain               |
| <input type="radio"/> | <input type="radio"/> | Angina                    | <input type="radio"/> | <input type="radio"/> | Frequent Urination       | <input type="radio"/> | <input type="radio"/> | Mid back pain               |
| <input type="radio"/> | <input type="radio"/> | Ankle/foot pain           | <input type="radio"/> | <input type="radio"/> | General Fatigue          | <input type="radio"/> | <input type="radio"/> | Neck pain                   |
| <input type="radio"/> | <input type="radio"/> | Arthritis                 | <input type="radio"/> | <input type="radio"/> | Hand pain                | <input type="radio"/> | <input type="radio"/> | Painful Urination           |
| <input type="radio"/> | <input type="radio"/> | Asthma                    | <input type="radio"/> | <input type="radio"/> | Heart attack             | <input type="radio"/> | <input type="radio"/> | Prostate Problems           |
| <input type="radio"/> | <input type="radio"/> | Bladder Infection         | <input type="radio"/> | <input type="radio"/> | Hepatitis                | <input type="radio"/> | <input type="radio"/> | Shoulder pain               |
| <input type="radio"/> | <input type="radio"/> | Birth Control Pills       | <input type="radio"/> | <input type="radio"/> | High blood pressure      | <input type="radio"/> | <input type="radio"/> | Smoking/tobacco Use         |
| <input type="radio"/> | <input type="radio"/> | Cancer                    | <input type="radio"/> | <input type="radio"/> | Hip/upper leg pain       | <input type="radio"/> | <input type="radio"/> | Stroke                      |
| <input type="radio"/> | <input type="radio"/> | Chest Pains               | <input type="radio"/> | <input type="radio"/> | HIV/AIDS                 | <input type="radio"/> | <input type="radio"/> | Systematic Lupus            |
| <input type="radio"/> | <input type="radio"/> | Chronic Sinusitis         | <input type="radio"/> | <input type="radio"/> | Hormone Therapy          | <input type="radio"/> | <input type="radio"/> | Thoracic Outlet Syndrome    |
| <input type="radio"/> | <input type="radio"/> | Depression                | <input type="radio"/> | <input type="radio"/> | Jaw pain                 | <input type="radio"/> | <input type="radio"/> | Tumor                       |
| <input type="radio"/> | <input type="radio"/> | Dermatitis/Eczema         | <input type="radio"/> | <input type="radio"/> | Joint swelling/stiffness | <input type="radio"/> | <input type="radio"/> | Ulcer                       |
| <input type="radio"/> | <input type="radio"/> | Dizziness                 | <input type="radio"/> | <input type="radio"/> | Kidney Stones            | <input type="radio"/> | <input type="radio"/> | Upper back pain             |
| <input type="radio"/> | <input type="radio"/> | Drug/Alcohol Use          | <input type="radio"/> | <input type="radio"/> | Knee/lower leg pain      | <input type="radio"/> | <input type="radio"/> | Wrist pain                  |

Additional comments you would like the doctor to know: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's signature: \_\_\_\_\_ Doctor's signature: \_\_\_\_\_

## Oswestry Disability Index

### Section 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### Section 2 – Personal Care (washing, dressing, etc.)

- I can look after myself normally but it is very painful.
- I can look after myself normally but it is very painful.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

### Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

### Section 4 – Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

### Section 5 – Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

### Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

### Section 7 – Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

### Section 8 – Sex life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

### Section 9 – Social Life

- My social life is normal and cause me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

### Section 10 – Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from travelling except to receive treatment.

### Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- No
- Yes (if yes, please state the type of treatment you have received)



## Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

### Section 1 – Pain Intensity

- I have no pain at the moment. (0)
- The pain is very mild at the moment. (1)
- The pain is moderate at the moment. (2)
- The pain is fairly severe at the moment. (3)
- The pain is very severe at the moment. (4)
- The pain is the worst imaginable at the moment. (5)

### Section 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain. (0)
- I can look after myself normally but it causes extra pain. (1)
- It is painful to look after myself and I am slow and careful. (2)
- I need some help but manage most of my personal care. (3)
- I need help every day in most aspects of self care. (4)
- I do not get dressed, I wash with difficulty and stay in bed. (5)

### Section 3 – Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

### Section 4 – Reading

- I can read as much as I want to with no pain in my neck. (0)
- I can read as much as I want to with slight pain in my neck. (1)
- I can read as much as I want with moderate pain in my neck. (2)
- I cannot read as much as I want because of moderate pain in my neck. (3)
- I can hardly read at all because of severe pain in my neck. (4)
- I cannot read at all. (5)

### Section 5 – Headaches

- I have no headaches at all. (0)
- I have slight headaches that come infrequently. (1)
- I have moderate headaches which come infrequently. (2)
- I have moderate headaches which come frequently. (3)
- I have severe headaches which come frequently. (4)
- I have headaches almost all the time. (5)

### Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty. (0)
- I can concentrate fully when I want to with slight difficulty. (1)
- I have a fair degree of difficulty in concentrating when I want to. (2)
- I have a lot of difficulty in concentrating when I want to. (3)
- I have a great deal of difficulty in concentrating when I want to. (4)
- I cannot concentrate at all. (5)

### Section 7 – Work

- I can do as much work as I want to. (0)
- I can do my usual work, but no more. (1)
- I can do most of my usual work, but no more. (2)
- I cannot do my usual work. (3)
- I can hardly do any work at all. (4)
- I cannot do any work at all. (5)

### Section 8 – Driving

- I can drive my car without any neck pain. (0)
- I can drive my car as long as I want with slight pain in my neck. (1)
- I can drive my car as long as I want with moderate pain in my neck. (2)
- I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- I can hardly drive at all because of severe pain in my neck. (4)
- I cannot drive my car at all. (5)

### Section 9 – Sleeping

- I have no trouble sleeping. (0)
- My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- My sleep is mildly disturbed (1-2 hours sleepless). (2)
- My sleep is moderately disturbed (2-3 hours sleepless). (3)
- My sleep is greatly disturbed (3-5 hours sleepless). (4)
- My sleep is completely disturbed (5-7 hours sleepless). (5)

### Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all. (0)
- I am able to engage in all my recreation activities, with some pain in my neck. (1)
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- I can hardly do any recreation activities because of pain in my neck. (4)
- I cannot do any recreation activities at all. (5)

0-4 No disability

5-14 Mild disability

15-24 Moderate disability

25-34 Severe disability

> 35 Complete disability

## The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name: \_\_\_\_\_ File # \_\_\_\_\_ Date: \_\_\_\_\_

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

### SECTION 1-PAIN INTENSITY

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is severe and does not vary much.

### SECTION 2-PERSONAL CARE

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

### SECTION 3-LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

### SECTION 4-WALKING

- I have no pain on walking.
- I have some pain on walking, but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

### SECTION 5-SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more 10 minutes.
- I avoid sitting because it increases pain right away.

### SECTION 6-STANDING

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain right away.

### SECTION 7-SLEEPING

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than 1/4.
- Because of pain, my normal night's sleep is reduced by less than 1/2.
- Because of pain, my normal night's sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

### SECTION 8-SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

### SECTION 9-TRAVELLING

- I get no pain while travelling.
- I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while travelling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

### SECTION 10-CHANGING DEGREE OF PAIN

- My pain is rapidly getting better.
- My pain fluctuates, but is definitively getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.