

# PATIENT INTAKE FORM

ALL INFORMATION IS CONFIDENTIAL



Patient Name: \_\_\_\_\_  
(Last) (First) (MI)

Date: \_\_\_\_\_ How were you referred to us? \_\_\_\_\_

Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

What type of case is responsible for today's problem?  Workman's Compensation  Auto Accident  Personal Insurance  Other

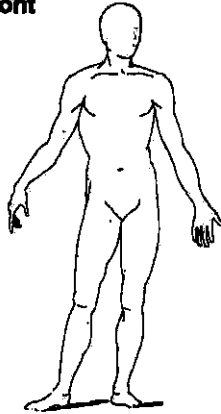
Are you personally insured?  Yes  No Are we going to be billing your personal insurance?  Yes  No

Insurance Company: \_\_\_\_\_

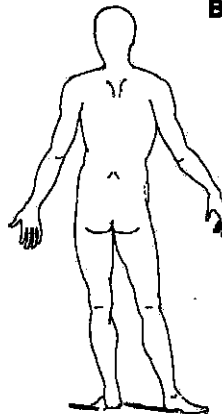
Policy ID: \_\_\_\_\_ Group No.: \_\_\_\_\_

Indicate on the drawings below where you have pain/symptoms:

Front



Back



You will have to answer questions about each of the different areas indicated on the above figures.

## NECK

How often do you experience your symptoms?

- Constantly (76-100% of the time)  Frequently (51-75% of the time)  Occasionally (26-50% of the time)  Intermittently (1-25% of the time)

How would you describe the type of pain?

- Sharp  Numb  Dull  Tingly  Diffuse  
 Sharp with motion  Achy  Shooting with motion  Burning  Stabbing with motion  
 Shooting  Electric like with motion  Stiff  Other: \_\_\_\_\_

How are your symptoms changing with time?

- Getting Worse  Staying the Same  Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

How much has the problem interfered with your work?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

How much has the problem interfered with your social activities?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

Who else have you seen for your problem?

- Chiropractor  Neurologist  Primary Care Physician  ER physician  Orthopedist  
 Massage Therapist  Physical Therapist  Other: \_\_\_\_\_  No one

How long have you had this problem? \_\_\_\_\_

How do you think your problem began? \_\_\_\_\_

Do you consider this problem to be severe?

- Yes  Yes, at times  No

What aggravates your problem?

- Bending  Sleeping  While at Work  Driving a Car  Climbing Stairs  
 Working at a computer  Flexing and extending  Standing Up  Golfing  Stress  
 Playing Tennis  Traveling  Running  Walking  Sitting  
 Other: \_\_\_\_\_

What alleviates your problem? \_\_\_\_\_

What concerns you the most about your problem; what does it prevent you from doing? \_\_\_\_\_

## Mid Back

### How often do you experience your symptoms?

- Constantly (76-100% of the time)       Frequently (51-75% of the time)       Occasionally (26-50% of the time)       Intermittently (1-25% of the time)

### How would you describe the type of pain?

- Sharp       Numb       Dull       Tingly       Diffuse  
 Sharp with motion       Achy       Shooting with motion       Burning       Stabbing with motion  
 Shooting       Electric like with motion       Stiff       Other: \_\_\_\_\_

### How are your symptoms changing with time?

- Getting Worse       Staying the Same       Getting Better

### Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

### How much has the problem interfered with your work?

- Not at all       A little bit       Moderately       Quite a bit       Extremely

### How much has the problem interfered with your social activities?

- Not at all       A little bit       Moderately       Quite a bit       Extremely

### Who else have you seen for your problem?

- Chiropractor       Neurologist       Primary Care Physician       ER physician       Orthopedist  
 Massage Therapist       Physical Therapist       Other: \_\_\_\_\_       No one

### How long have you had this problem?

### How do you think your problem began?

### Do you consider this problem to be severe?

- Yes       Yes, at times       No

### What aggravates your problem?

- Bending       Sleeping       While at Work       Driving a Car       Climbing Stairs  
 Working at a computer       Flexing and extending       Standing Up       Golfing       Stress  
 Playing Tennis       Traveling       Running       Walking       Sitting  
 Other: \_\_\_\_\_

### What alleviates your problem?

### What concerns you the most about your problem; what does it prevent you from doing?

## Low Back

### How often do you experience your symptoms?

- Constantly (76-100% of the time)       Frequently (51-75% of the time)       Occasionally (26-50% of the time)       Intermittently (1-25% of the time)

### How would you describe the type of pain?

- Sharp       Numb       Dull       Tingly       Diffuse  
 Sharp with motion       Achy       Shooting with motion       Burning       Stabbing with motion  
 Shooting       Electric like with motion       Stiff       Other: \_\_\_\_\_

### How are your symptoms changing with time?

- Getting Worse       Staying the Same       Getting Better

### Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

### How much has the problem interfered with your work?

- Not at all       A little bit       Moderately       Quite a bit       Extremely

### How much has the problem interfered with your social activities?

- Not at all       A little bit       Moderately       Quite a bit       Extremely

### Who else have you seen for your problem?

- Chiropractor       Neurologist       Primary Care Physician       ER physician       Orthopedist  
 Massage Therapist       Physical Therapist       Other: \_\_\_\_\_       No one

### How long have you had this problem?

### How do you think your problem began?

### Do you consider this problem to be severe?

- Yes       Yes, at times       No

### What aggravates your problem?

- Bending       Sleeping       While at Work       Driving a Car       Climbing Stairs  
 Working at a computer       Flexing and extending       Standing Up       Golfing       Stress  
 Playing Tennis       Traveling       Running       Walking       Sitting  
 Other: \_\_\_\_\_

### What alleviates your problem?

### What concerns you the most about your problem; what does it prevent you from doing?

What is your: **Age:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Gender:** M or F  
**Marital Status:**  S  M  W  D **How many children?** \_\_\_\_\_ **Name of  Spouse or  Parent:** \_\_\_\_\_  
**Email Address:** \_\_\_\_\_ **Emergency Contact:** \_\_\_\_\_  
**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**How would you rate your overall Health?**  Excellent  Very Good  Good  Fair  Poor

**What type of exercise do you do?**  Strenuous  Moderate  Light  None

**Indicate if you have any immediate family members with any of the following:**

- Rheumatoid Arthritis  Diabetes  Lupus
- Heart Problems  Cancer  ALS

**For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain
<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain
<input type="checkbox"/>	<input type="checkbox"/>	Upper Leg Pain
<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Tumor
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Dis.
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Depend.
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<b>For Females Only</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy

**List all prescription medications you are currently taking:** \_\_\_\_\_

**List all of the over-the-counter medications or supplements you are currently taking:** \_\_\_\_\_

**List all surgical procedures you have had:** \_\_\_\_\_

**What activities do you do at work?**

- Sit:  Most of the day  Half the day  A little of the day
- Stand:  Most of the day  Half the day  A little of the day
- Computer work:  Most of the day  Half the day  A little of the day
- On the phone:  Most of the day  Half the day  A little of the day
- Performs Manual Labor  Travels frequently

**What activities do you do outside of work?** \_\_\_\_\_

**Have you ever been hospitalized?**  No  Yes **If yes, why:** \_\_\_\_\_

**Have you seen a Chiropractor before?**  No  Yes **How long ago?** \_\_\_\_\_

**If yes, what was the result of treatment?**  Great  Good  Fair  Mixed  Poor

**Have you had significant past trauma?**  No  Yes **Are you current with pap smears/prostate exam?**  No  Yes

**Anything else pertinent to your visit today?** \_\_\_\_\_

In exchange for Bilan Chiropractic P.C.'s (clinic) forbearance from collecting all amounts owed by me for services rendered at the time of the provision of service, I hereby assign my rights to the clinic as follows: I understand and agree that health and accident insurance policies are an arrangement between an insurance company or carrier and my self. Furthermore, I understand that the clinic will prepare any necessary reports and forms provided by me to assist me, or my legal representative, in making collection from the insurance company or carrier. I hereby specifically authorize the release of any information concerning me to my insurance carriers, insurance carriers of persons or entities responsible for my injuries, my employer, claims adjusters responsible for claims filed by me, administrative agencies, the Alaska Workers' Compensation Board and my attorneys. To the extent of my unpaid bill to the clinic, I hereby irrevocably assign to said clinic on behalf of myself, my heirs and beneficiaries any interest that I might have now or in the future to any cause of action or claim, whether legal or administrative, and direct my legal representative that at the time of final judgment, and final disposition or settlement this assignment shall have priority over all others not entitled by law to superior priority.

I specifically request that any amount authorized to be paid to me by an insurance company, employer or legal representative shall be paid directly to the clinic, and will be credited to my account upon receipt. If the payment is insufficient to pay for all of my indebtedness, I will remain liable to Bilan Chiropractic P.C. for the balance, including finance charges and collection expenses.

I clearly understand and agree that all services rendered to me, whether I have health or accident insurance coverage or not, charged directly to me, and that I am personally responsible for payment and, unless arrangements are otherwise made, said payments are immediately due and payable at time of visit. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In such event, I agree that this assignment will remain effective until all sums I owe Bilan Chiropractic P.C. are fully paid.

**Patient Signature or Legal guardian's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient's Social Security No.:** \_\_\_\_\_ (Needed if we are billing an insurance)



## CANCELLATION POLICY

To ensure all patients have equal opportunity to schedule an appointment with our Licensed Massage Therapist, all massage appointments require a 24 hour cancellation notice. If an appointment is not cancelled 24 hours prior or if you fail to arrive for your appointment, you will be charged a \$50.00 cancellation fee. If you have booked your massage within 24 hours of the massage, but fail to arrive or cancel within 1 hour, you will be charged a \$25.00 cancellation fee. Please understand that every "no show" appointment occupies a block of time that could have been dedicated to another patient seeking care. Unfortunately, this fee will not be billed to, nor reimbursed by your insurance company, workers' compensation claim, or personal injury case.

This cancellation fee applies to anyone who has an appointment with a massage therapist for any reason. After three cancellations, payment in full will be required for all future massage therapy appointments.

Thank you for your understanding. Bilan Chiropractic strives to provide the finest care possible.

Patient's Name: \_\_\_\_\_

Patients Signature: \_\_\_\_\_

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

Staff: \_\_\_\_\_