

# Patient Intake



Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

This information is confidential. If, after gathering the necessary information, we do not believe your problem will respond favorably with chiropractic care, we will discuss our findings with you and make the necessary referrals or recommendations. In order for us to fully understand your health problems and be able to give you our best care and advice, please complete this form neatly, accurately, and thoroughly. Thank you.

Legal Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Preferred or nickname \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Local address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Other address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Gender: **M** **F** Height \_\_\_\_' \_\_\_\_" Weight \_\_\_\_ lbs

**Please check box** for preferred communication means  E-Mail \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_ - \_\_\_\_  Work Phone(\_\_\_\_) \_\_\_\_ - \_\_\_\_  Cell Phone(\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Ethnicity:**  Hispanic or Latino  NOT Hispanic or Latino **Race:**  American Indian or Alaska Native

African American or  Black  Asian  Hispanic or Latino  Hawaiian or Pacific Islander  White

Preferred language:  English  Spanish  \_\_\_\_\_ **If minor patient:** Parent/Guardian \_\_\_\_\_

Relationship \_\_\_\_\_ Address  Same as above \_\_\_\_\_

**Emergency contact** \_\_\_\_\_ Relationship \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_ - \_\_\_\_

Referred by \_\_\_\_\_ Your primary care physician: \_\_\_\_\_

Current Complaints	Date of Onset	Probable cause

**History of Current Complaints**  None If this is a recurrent problem please describe the **initial cause**, the frequency, how you have treated in the past, and if past treatment was successful:

**NONE** For the **PRESENTING CONDITION and OTHER CURRENT CONDITIONS** which you are treating, please list **ALL** providers, treatments and outcomes

Recommended by Self / Doctor / therapist	Treatment / Testing PT, exercises, medications, ice, heat, x-ray, MRI, CT, labs	Outcome partial or temp relief, no help, etc.

**NO** Have you received care from a Chiropractor in the past?

Who & Where	When & Reason	Outcome

<input type="checkbox"/> <b>NONE</b> Please list any other <u>serious</u> illnesses or conditions which you have been diagnosed and/or treated (cancer, heart, diabetes, mental, TB, high blood pressure, high cholesterol, HIV, asthma etc.)			
Condition	Date diagnosed	Treatment – if hospitalized please write <u>H</u>	Outcome

<input type="checkbox"/> <b>NONE</b> Prescription or over the counter medications AND supplements you are currently taking					
Name	Reason	Dosage	Frequency	How long	Side effects

<input type="checkbox"/> <b>NONE</b> Please list all significant trauma (auto, lifting, fracture, dislocation, sport)				
Type of trauma	Date	Body parts injured	Treatment please if hospitalized write <u>H</u>	Residual problems

<input type="checkbox"/> <b>NONE</b> Please list all surgeries or prostheses			
Surgery if hospitalized please write <u>H</u>	Date	Surgeon & location	Results

<input type="checkbox"/> <b>NONE</b> Please list any Allergies		
Food	Environmental	Medications

<input type="checkbox"/> <b>NONE</b>	Mother	Father	Sister	Brother	Grand mother	Grand father	Child
<b>Family History</b>							
Cancer							
Heart							
Diabetes							
Kidney							
Autoimmune							
Hereditary							
Psychiatric							
Other							

Do you wear  heel lifts or  sole lifts in shoes -  No  right  left  both  
Who prescribed \_\_\_\_\_ date \_\_\_\_\_

**WORK HISTORY**

Present occupation \_\_\_\_\_ Retired from \_\_\_\_\_  
Employer \_\_\_\_\_ Job description \_\_\_\_\_  
 Presently unemployed – Unemployment due to injury  Y  N Explain \_\_\_\_\_  
**Disability:**  N  Y Date \_\_\_\_\_ By whom \_\_\_\_\_ Due to \_\_\_\_\_  
**Work restrictions**  none  Y By whom \_\_\_\_\_ Starting date \_\_\_\_\_  
Total lost days \_\_\_\_\_ Define: \_\_\_\_\_  
With past and/or present job were/are you exposed to:  dust  coal  other airborne particles  toxic fumes  
 other \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

**SOCIAL HISTORY**

Marital Status S M W D Sep Name of Spouse \_\_\_\_\_  
No. of Children \_\_\_\_\_  No Children Ages \_\_\_\_\_ **Currently pregnant**  Y  N  possibly  
Tobacco use:  cigarettes  cigars  smokeless \_\_\_\_\_ Pk-can./day \_\_\_\_\_ Years  
 never  non-user since \_\_\_\_\_ but when used \_\_\_\_\_ Pk-can./day \_\_\_\_\_ Years  
Alcohol consumption:  never  rare  daily \_\_\_\_\_ days per week  recovering alcoholic  
Caffeine  coffee  tea  soda \_\_\_\_\_ cups/day Recreational drug use:  none \_\_\_\_\_

**Exercise:**  I do not exercise on a regular schedule.  
My exercise consists of \_\_\_\_\_ times per week \_\_\_\_\_ for \_\_\_\_\_ minutes

**Stress level:** currently rated (circle one) high - medium – low : major stress factors \_\_\_\_\_

**Highest level of Education** (circle one): Grade School Middle School HS GED  
Vocational School Undergraduate College Graduate College

**Sleeping posture** (circle all that apply): back sides stomach

**Diet:**  vegan  vegetarian  well balanced  could use some help  could use lots of help  
Average number of serving of fruits and vegetables per day \_\_\_\_\_

**Review of Systems:** Please check the box if you have experienced or others have observed in you:

<input type="checkbox"/> change in personality	<input type="checkbox"/> drop things / lose your grip	<input type="checkbox"/> bump into corners
<input type="checkbox"/> change in mood/mood swings	<input type="checkbox"/> trip easily	<input type="checkbox"/> neglecting one side
<input type="checkbox"/> change in motivation	<input type="checkbox"/> loss of strength	<input type="checkbox"/> confused with left and right
<input type="checkbox"/> change in outlook on life	<input type="checkbox"/> difficulty on fine motor skills	<input type="checkbox"/> difficulty with numbers
<input type="checkbox"/> change in empathy	<input type="checkbox"/> changes in penmanship	<input type="checkbox"/> blurring of vision
<input type="checkbox"/> change in concentration	<input type="checkbox"/> changes with speech	<input type="checkbox"/> double vision
<input type="checkbox"/> change in ability to organize	<input type="checkbox"/> changes with your voice	<input type="checkbox"/> blind spots
<input type="checkbox"/> feeling of depression	<input type="checkbox"/> difficulty smiling	<input type="checkbox"/> floaters
<input type="checkbox"/> irritability	<input type="checkbox"/> strange skin sensations	<input type="checkbox"/> flashes of lights
<input type="checkbox"/> extreme fears or phobias		<input type="checkbox"/> sensitivity to light
<input type="checkbox"/> eating disorder		<input type="checkbox"/> other visual changes
<input type="checkbox"/> suicidal thoughts		

- memory loss
- difficulty hearing
- difficulty localizing sounds
- poor auditory comprehension
- noise in the ears
- sensitivity to loud noises
- seizures
  
- tremors of any body part
- twitching/cramping muscles
- stiffness with movement
  
- changes in coordination
- clumsiness
- unsteadiness when walking in the dark
- chronic joints injury
- moments of unexplained confusion or disorientation
  
- jaw pain
- grind or clench your teeth
- jaw click / pop
- difficulty chewing
- difficulty opening your mouth
- fatigue easily
- hot flashes
- chills
- cold hands or feet
- sweat easily or excessively
- difficulty with smiling or other facial expression
- change in smell/taste / appetite
- wet or dry eyes
- do you have a drippy nose
- does your nose bleed easily
- difficulty swallowing

- soreness or tightness of throat
  
- heartburn
- choke easily
- shortness of breath
- coughing or wheezing
- dizziness / light-headedness with change of position
- dizziness / light-headedness with certain positions
- car sickness
- unexplained nausea
  
- swelling in the legs or feet
- chest pain
- irregular heart beats
- pain legs with walking
- chest pressure
- rapid heart beats
- heart valve problems
- pacemaker
  
- physical abuse
- sexual abuse
- emotional abuse
  - do not know
  
- Pain / Numbness / Weakness:
- head / neck
- shoulders /arms / elbows
- wrists / hands / fingers
- upper - mid - low back
- pelvis / tail bone
- hip / groin / thighs
- knees / legs / ankles / feet
- joints
- muscles

- stomach bloating
- digestion problems
- excessive gas
- stomach cramping
- irritable bowel symptoms
- changes in bowel movements
- blood in bowel movements
- persistent / recurrent constipation
- persistent / recurrent diarrhea
  
- frequent urination
- burning or pain when urinating
- difficulty starting to urinate
- difficulty emptying bladder
- leaking urine
- vaginal dryness
- erectile dysfunction
  
- weight gain of more than 10lbs in the last 6 months
- weight loss of more than 10lbs in the last 6 months

Skin / Nails / Hair:

- dry
- splitting / cracking
- ridges
- eczema
- acne
- bruise easily
- excess oil
- body odor
- discolored
- unexplained hair loss

**THE ABOVE INFORMATION IS ACCURATE AND COMPLETED TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
signature of patient

\_\_\_\_\_  
date

\_\_\_\_\_  
witness

\_\_\_\_\_  
date

\_\_\_\_\_  
patient's representative name printed

\_\_\_\_\_  
signature of patient's representative

\_\_\_\_\_  
date

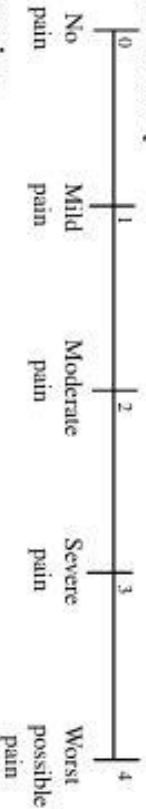
In-office review \_\_\_\_\_

# Functional Rating Index

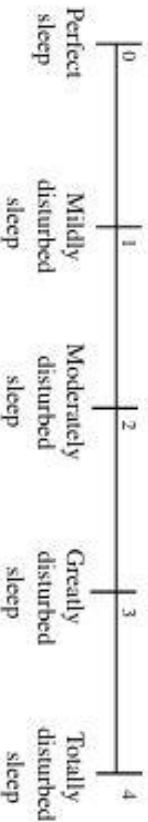
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

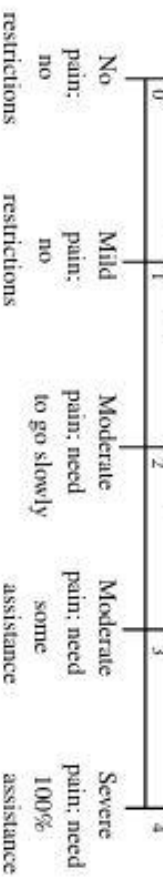
## 1. Pain Intensity



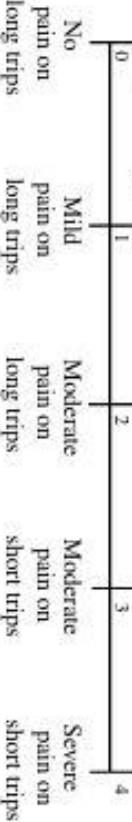
## 2. Sleeping



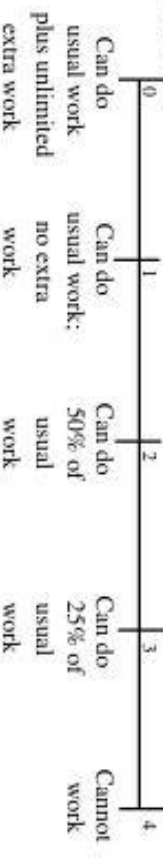
## 3. Personal Care (washing, dressing, etc.)



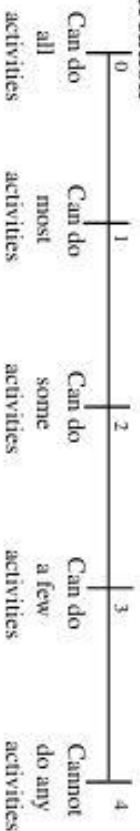
## 4. Travel (driving, etc.)



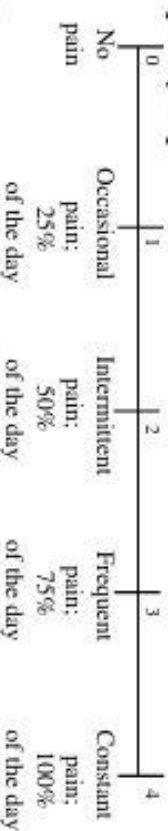
## 5. Work



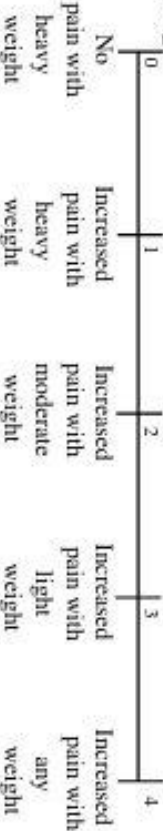
## 6. Recreation



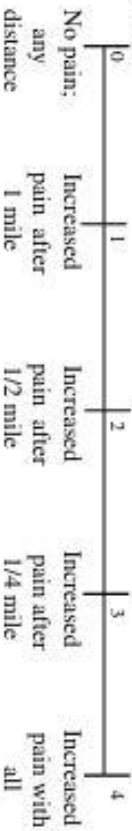
## 7. Frequency of pain



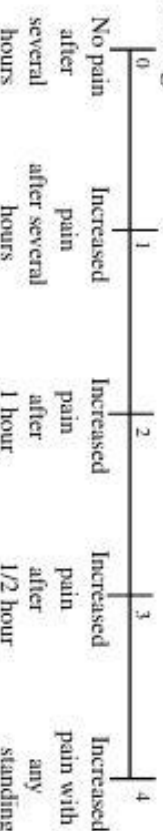
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_

PRINTED

Signature \_\_\_\_\_

Date \_\_\_\_\_

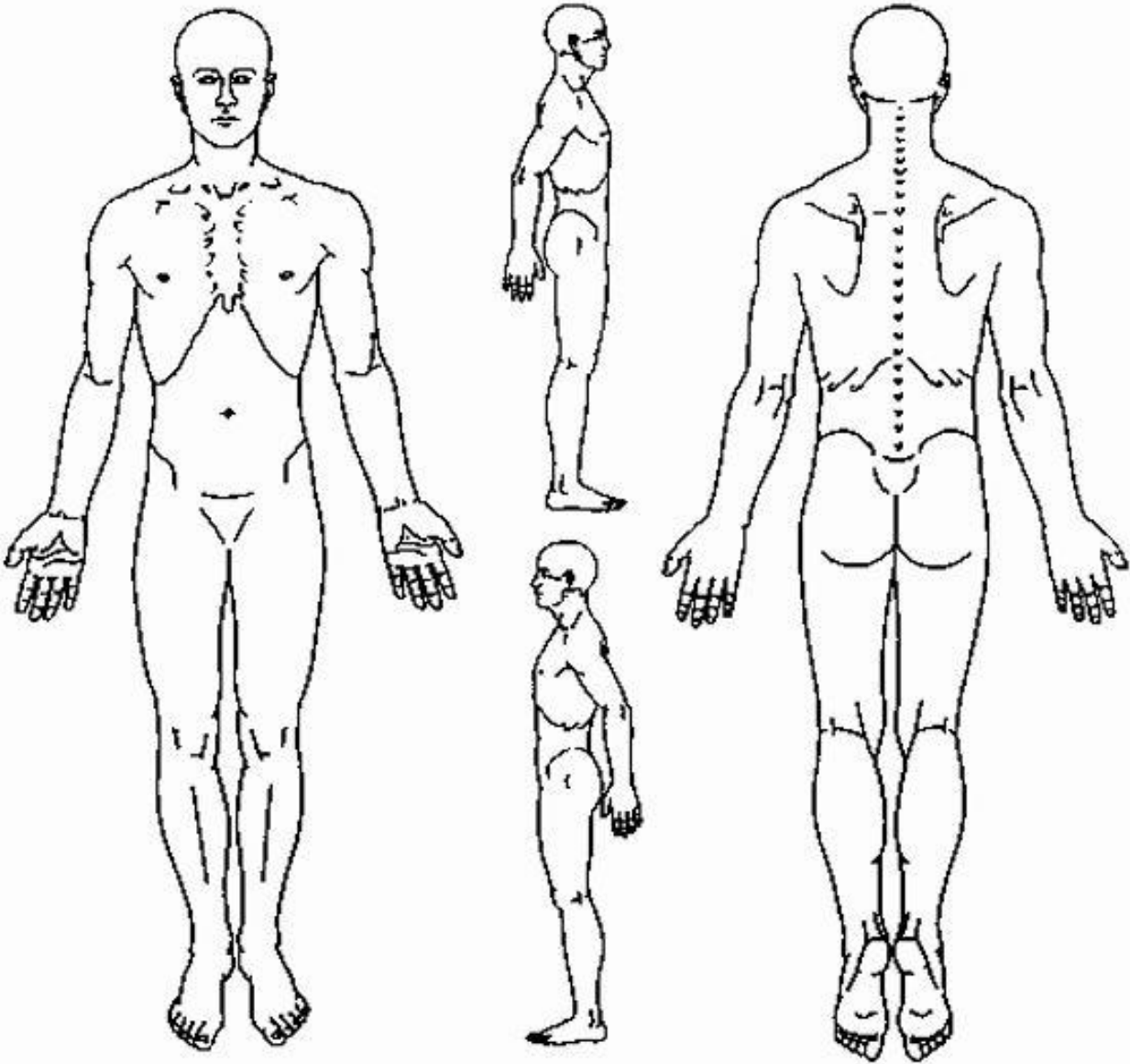
Total Score \_\_\_\_\_

# PAIN CHART

Name \_\_\_\_\_ DOB \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Please mark on the body diagrams all areas of pain, discomfort, or altered sensation, and use the key below to identify quality of each.

- |                    |             |                |                |
|--------------------|-------------|----------------|----------------|
| A = ache           | B = burning | E = electrical | S = stabbing   |
| P = pins & needles | N = numb    | O = other      | Th = throbbing |



# Elmhurst Chiropractic Clinic

## FINANCIAL CONSULTATION

**Primary Insurance** \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber \_\_\_\_\_

Subscriber ID \_\_\_\_\_ Subscriber DOB \_\_\_\_\_ Patient Relationship to Subscriber \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber \_\_\_\_\_

Subscriber ID \_\_\_\_\_ Subscriber DOB \_\_\_\_\_ Patient Relationship to Subscriber \_\_\_\_\_

- \_\_\_\_\_ (Pt. Initials) **OUR FEES:** All fees for services are based on the degree of complexity, the number of areas involved, and the time spent evaluating, treating, and instructing (do's & don'ts, exercises, etc.)  
Evaluation fees for new patients range from \$80.00 - \$287.00.  
Standard treatment fees range from \$45 - \$82.
- \_\_\_\_\_ (Pt. initials) **MISSED APPOINTMENT FEE:** The fee for a missed appointment is a minimum of \$40 for a basic chiropractic follow-up visit. It will be more for longer appointment times. Please provide 24 hours notice if you need to cancel or reschedule an appointment.
- \_\_\_\_\_ (Pt. initials) **DISCOUNT PLANS:** In order to participate in any discount plan offered, payment must be made at time of service.
- \_\_\_\_\_ (Pt. Initials) **BILLING STATEMENTS:** Statements are generated the first Tuesday of the month and mailed out within 1-2 days. Balances over 90 days are past due and a 9% (annual) interest charge will be assessed. If required for recovery of past due accounts, you will be charged the collection and/or legal fees. A \$20 fee will be charged for returned checks.
- \_\_\_\_\_ (Pt initials) **GENERAL INSURANCE PAYMENT POLICY:** Your portion of the services (full amount, co-pay, deductible, etc.) Is due on the day of service. Per your insurance plan, evaluation on this day may not be covered by insurance and will be your responsibility.
  - \_\_\_\_\_ (Pt initials) If your insurance covers chiropractic treatment, we will provide for your insurance company all necessary documentation, but we cannot accept responsibility for non-payment, late payment, or for negotiating a disputed claim. Your insurance policy is a contract between you and your carrier. **Even though we may have been given information by your insurance company regarding the benefits of your plan, this is not a guarantee of payment.**
  - \_\_\_\_\_ (Pt initials) **After 90 days, unpaid insurance claims will be converted to cash claims.**
  - \_\_\_\_\_ (Pt initials) We cannot reach the insurance company at this time (after hours, weekend, other). Until we can determine and discuss limitations on your plan, you will be responsible for payment on any excluded services.
- \_\_\_\_\_ (Patient initials) **3<sup>RD</sup> PARTY OR WORK INJURY:** Bills will be submitted to the **PI or L&I** insurance carrier. I understand that if the claim is denied by the insurance, I will be responsible for payment.
- \_\_\_\_\_ **Payment is expected at Time of Service unless prior arrangements are made. If you are unable to pay your portion at time of service, please alert the front desk.**

By signing this document, you are authorizing us to bill and receive insurance payments related to your treatment.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

# Elmhurst Chiropractic Clinic

## Acknowledgement of Receipt of Notice of Privacy Practices

*This form will be retained in your medical record.*

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### NOTICE TO PATIENT

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We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

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

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices, effective February 16<sup>th</sup>, 2026, which describes how my health information may be used and disclosed, my rights, and the practice's legal duties.

I understand that the Notice describes the uses and disclosures of my protected health information by **Elmhurst Chiropractic** and informs me of my rights with respect to my protected health information.

\_\_\_\_\_  
*Patient's Signature or that of Legal Representative*

\_\_\_\_\_  
*Printed Name of Patient or that of Legal Representative*

\_\_\_\_\_  
*Today's Date*

\_\_\_\_\_  
*If Legal Representative, Indicate Relationship*

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### FOR OFFICE USE ONLY

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We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement
- Communications barriers prohibited obtaining the acknowledgement
- Other (please specify): \_\_\_\_\_

\_\_\_\_\_  
*Employee Name*

\_\_\_\_\_  
*Today's Date*

## Informed Consent for Chiropractic Treatment

**TO THE PATIENT:** You have a right to be informed about your condition, the recommended treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss my diagnosis, the nature and purpose of my treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- |  |   |
|--|---|
| <input type="checkbox"/> Broken bones                          | <input type="checkbox"/> increased symptoms and pain                |
| <input type="checkbox"/> Dislocations                          | <input type="checkbox"/> No improvement of symptoms or pain         |
| <input type="checkbox"/> Sprains/strains                       | <input type="checkbox"/> Worsening/aggravation of spinal conditions |
| <input type="checkbox"/> Burns or frostbite (physical therapy) | <input type="checkbox"/> Other _____                                |

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment. I intend this consent form to cover the entire course of treatment for my current condition and for future conditions for which I may seek treatment.

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*To be completed by the patient:*

\_\_\_\_\_

print name

\_\_\_\_\_

signature of patient

\_\_\_\_\_

date signed

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*To be completed by the patient's representative:*

\_\_\_\_\_

print name of patient

\_\_\_\_\_

print name of patient's representative

\_\_\_\_\_

signature of patient's representative

as: \_\_\_\_\_  
relationship/authority of patient's representative

\_\_\_\_\_

date signed

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*To be completed by doctor or staff:*

\_\_\_\_\_

witness to patient's signature

\_\_\_\_\_

date

\_\_\_\_\_

Translated by

\_\_\_\_\_

date