Harrison Chiropractic

FEEL BETTER. MOVE BETTER. LIVE BETTER.

Patient Intake Information

Date:_____

First Name_____ Last Name_____ DOB_____

Address_____ Apt. _____

City_____ State _____ Zip Code _____

Marital Status ( ) Single ( ) Married ( ) Widowed ( ) Divorced

Height _____ Weight _____ Blood Pressure _____

Occupation:_____

Contact Information *(Parent/Guardian's Information if patient is a minor)*

Cell Phone _____ Work Phone _____

Email Address _____

Contact Preference ( ) Cell Phone ( )Work ( ) Email

Emergency Contact _____ Phone _____

How did you hear about our office? _____

Insurance Information: *(A copy of your insurance card(s) will be made. In addition, please complete below)*

Are you the policy holder? ( ) Yes ( ) No

If no, who is policy holder? _____ Policy holder DOB _____

Policy holder Member's ID _____ Group number _____

Do You Have Secondary Insurance? ( ) Yes ( ) No

Member's ID _____ Group number _____

Is this a Motor Vehicle Accident? ( ) Yes ( ) No

Law Firm/ Insurance:

Case Number _____ Adjuster's Name_____ Adjuster Phone Number_____

Adjuster Email Address _____

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Patient History

Please give a brief description of the problem you are experiencing: _____

_____

_____

Is it getting better? ( ) Yes ( ) No Getting Worse? ( ) Yes ( ) No When did this start?_____

What appears to have caused the issue(s)? _____

Is there anything you have done/ used to help the pain? _____

_____

Is there anything you have done/ used that made the pain worse? _____

_____

How would you describe the pain? _____

Is the pain radiating or traveling to another area? _____

_____

What you rate your pain(s) from 1-10, 10 being the worst? _____

Are you seeing/ seen any other providers for this condition? ( ) Yes ( ) No

( ) Yes ( ) No Have you had any surgeries?

( ) Yes ( ) No Is there any previous aliment you were diagnosed with? (Scoliosis, Lymes, Von-Willebrand's)

( ) Yes ( ) No Have you been involved in any trauma or car accidents in the past?

( ) Yes ( ) No Any diseases that your immediate family has had a history of? (Cancers, Hypertension, Diabetes)

If yes, what have they had? _____

_____

Do you smoke? (cigarettes/vape) ( ) Yes ( ) No If yes, how often do you smoke? _____

Do you Drink alcohol? ( ) Yes ( ) No If yes, how much do you drink? _____

Do you Drink Caffeine ( ) Yes ( ) No If yes, how many cups/ mL per day? _____

Do you use recreational Drugs ( ) Yes ( ) No If yes, how often? _____

How much water do you consume per day? _____

How Often do you Exercise? _____

Medications:

What mediations are you taking: Please list all prescription drugs and dosage _____

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Do you have any allergies? ( ) Yes ( ) No If yes, please list all _____

_____

Are you taking any Supplements ( ) Yes ( ) No If yes, please list everything you are taking _____

_____

Harrison Chiropractic PC
550 Mamaroneck Ave, Suite 307, Harrison, NY 10528
Phone: (914)601-2225 Fax: (914)619-5832

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Please check all of the following that applies to you:

General Information:

___ Recent abnormal weight gain/ loss
___ Weakness
___ Fatigue
___ Fevers
___ Faint Spells
___ Nausea
___ Vomiting
___ Balance Problems
___ Jaw Pain (TMJ)
___ Neck Pain
___ Neck Stiffness
___ Shoulder Pain
___ Arm Pain
___ Wrist/ Hand Pain
___ Numbness in Arms/ Hands
___ Upper Back Pain
___ Low Back Pain
___ Hip Pain
___ Leg Pain
___ Ankle/ Foot Pain
___ Numbness in Legs/ Foot
___ Joint Swelling
___ Tension
___ Nervousness
___ Anxiety
___ Irritability
___ Sleeping Problems/ Insomnia
___ Depression
___ Liver Problems
___ Metal Implants

Head:

___ Headaches/ Migraines
___ Loss of Consciousness
___ Lightheadedness
___ Dizziness
___ Memory Problems
___ Seizure/ Convulsions

Eyes:

___ Blurred Vision
___ Loss of Vision
___ Eye Skipping
___ Floaters
___ Sensitivity to light
___ Discharge from Eyes
___ Double Vision

Ears:

___ Loss of Hearing
___ Ring/ Buzzing in Ears (Tinnitus)
___ Ear Infections
___ Vertigo/ Dizziness
___ Any Discharge from Ears

Nose:

___ Sinus Problems
___ Nose Bleeds (Epitaxis)
___ Loss of Smell
___ Any discharge from Nose

Mouth/ Throat:

___ Tooth Aches/ Pain
___ Lesion/ Sore in Mouth
___ Frequent Sore Throats
___ Difficulty Swallowing
___ Difficulty Speaking
___ Thyroid Problems

Respiratory (Lungs)

___ Asthma
___ Bronchitis
___ Emphysema
___ Difficulty Breathing
___ Chronic Cough
___ History of Tuberculosis or Pneumonia
___ Date of Last Chest X-ray_____

Cardiovascular (Heart)

___ Chest Pains
___ Difficulty Breathing
___ Palpitations
___ Night Sweats
___ Cold/ Discolored Extremity
___ High Blood Pressure
___ Low Blood Pressure
___ Heart Murmurs
___ Shortness of Breath

GI (Gastrointestinal)

___ Upset Stomach/ Indigestion
___ Loss of Appetite

Urinary/ Genital:

___ Trouble Urinating
___ Blood/ Discharge In Urine
___ Numbness in Groin
___ Trouble with Arousal

___ Constipation
___ Diarrhea
___ Bloody Stool
___ Abdominal Pain
___ Excess Gas
___ Loss of Bowl Function

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent. If there is anyone that you do not want to receive your medical records, please inform the office.

Credit Guarantee Insurance Assignment & Personal Balance

Insurance Assignment: Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment.

Filing Procedure: Claims for initial services are submitted within 48 hours after your visit. On day 90, if your insurance company had not paid the bill, we will change your designated credit card below for the amount of the claim. You will be sent a payment voucher. Any payments made on these claims thereafter will be immediately refunded to you. Please keep in mind this office will not bill your card without first trying to contact you.

Personal Balance: Estimated personal portions are paid at the time of service.

_____ _____

Signature **Date**