

## PATIENT INTAKE FORM AND CASE HISTORY

Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will work to refer you to the appropriate health care provider.

### PERSONAL INFORMATION

Name:  Dr.  Mr.  Mrs.  Ms  Miss \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_

(W) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(C) \_\_\_\_\_

Email: \_\_\_\_\_

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

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

Work Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status:  M  S  W  D

Spouse's Name \_\_\_\_\_

Children's Names and Ages: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Affiliated with Group? \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### RESPONSIBLE PARTY / INSURANCE INFORMATION

Name of Primary Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_

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

Group Number: \_\_\_\_\_ Employer Number: \_\_\_\_\_

Have you met this year's deductible?  Y  N

Do you have additional insurance (Secondary)?  Y  N If yes, please complete the following.

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

Group Number: \_\_\_\_\_ Employer # / ID # \_\_\_\_\_

Have you met this year's deductible?  Y  N

**HEALTH INFORMATION**

Please check all that apply with regard to your reasons for consulting our office:

- I have a specific problem and require help only with this problem
- After my specific problem has been relieved, I am interested in strategies to ensure this problem does not return. (Maintenance)
- After my specific problem has been relieved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health. (Wellness)
- Neck Pain     Mid-back Pain     Low Back Pain     Joint Pain
- Headache
- Respiratory Problems
- Abdominal Problems
- Other; please specify: \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

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

Have you had this or similar conditions in the past  N     Y, when? \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Is this condition getting progressively worse?  Y     N     Constant     Comes and goes

Is this condition interfering with your activities?  N     Y(check all that apply)     Work     Sleep     Daily Routine

Have you seen any other health professional for this condition?  N     Y; name, when and what was the outcome?

\_\_\_\_\_  
\_\_\_\_\_

Please list any surgeries (with year completed): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list any prescription drugs, OTC drugs, vitamins and supplements you are currently taking: \_\_\_\_\_

\_\_\_\_\_

Do you wear:  Heel lifts     Sole lifts     Insoles     Arch supports     Orthotics     None of these

Have you been in an auto accident?  Never     Past year     Past 5 years     Over 5 years ago

Description of Accident \_\_\_\_\_

Date of most recent physical exam: \_\_\_\_\_

Environment / Lifestyle:

	<input type="checkbox"/> Y <input type="checkbox"/> N	Amounts / Comments
Do you smoke?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Do you drink alcohol?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Do you have a healthy diet?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Do you exercise regularly?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Do you sleep well at night?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Is your job stressful?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Can you think of any other habit or activity that has a positive or negative effect on your health?	<input type="checkbox"/> Y <input type="checkbox"/> N	_____

Are you affected by any of the following? (Please check all that apply)

- | <b>Past</b>              | <b>Present</b>                                 | <b>Past</b>              | <b>Present</b>                                    | <b>Past</b>              | <b>Present</b>                                   |
|--------------------------|--|--------------------------|---|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches             | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> | <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> | <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> | <input type="checkbox"/> Excessive Thirst        |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Back Pain       | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains              | <input type="checkbox"/> | <input type="checkbox"/> Frequent Urination      |
| <input type="checkbox"/> | <input type="checkbox"/> Mid Back Pain         | <input type="checkbox"/> | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> | <input type="checkbox"/> Diarrhea/Constipation   |
| <input type="checkbox"/> | <input type="checkbox"/> Low Back Pain         | <input type="checkbox"/> | <input type="checkbox"/> Angina                   | <input type="checkbox"/> | <input type="checkbox"/> Nausea/Vomiting         |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder Pain         | <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones            | <input type="checkbox"/> | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> Elbow Pain            | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disorders         | <input type="checkbox"/> | <input type="checkbox"/> Allergies               |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist Pain            | <input type="checkbox"/> | <input type="checkbox"/> Bladder Infection        | <input type="checkbox"/> | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> | <input type="checkbox"/> Hand Pain             | <input type="checkbox"/> | <input type="checkbox"/> Painful Urination        | <input type="checkbox"/> | <input type="checkbox"/> Systemic Lupus (SLE)    |
| <input type="checkbox"/> | <input type="checkbox"/> Hip Pain              | <input type="checkbox"/> | <input type="checkbox"/> Loss of Bladder Control  | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy                |
| <input type="checkbox"/> | <input type="checkbox"/> Knee Pain             | <input type="checkbox"/> | <input type="checkbox"/> Prostate Problems        | <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rash  |
| <input type="checkbox"/> | <input type="checkbox"/> Lower Leg Pain        | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite         | <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain       | <input type="checkbox"/> | <input type="checkbox"/> Unusual Weight Gain/Loss |                          | <b><i>Females Only</i></b>                       |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain           | <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills     |
| <input type="checkbox"/> | <input type="checkbox"/> Joint Swelling        | <input type="checkbox"/> | <input type="checkbox"/> Ulcer                    | <input type="checkbox"/> | <input type="checkbox"/> Hormone Replacement     |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> | <input type="checkbox"/> Difficult Pregnancy     |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis  | <input type="checkbox"/> | <input type="checkbox"/> Liver Disorder           | <input type="checkbox"/> | <input type="checkbox"/> Currently Pregnant?     |
| <input type="checkbox"/> | <input type="checkbox"/> General Fatigue       | <input type="checkbox"/> | <input type="checkbox"/> Gall Stones/GB Disorder  |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Muscle Incoordination | <input type="checkbox"/> | <input type="checkbox"/> Asthma                   |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Visual Disturbances   | <input type="checkbox"/> | <input type="checkbox"/> Chronic Sinus Infections |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> | <input type="checkbox"/> Cancer, Type _____       |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Numbness/Tingling     | <input type="checkbox"/> | <input type="checkbox"/> Tumor, Type _____        |                          |  |

Please list here any other conditions not listed above:

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We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Doctor's Comments:

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**RADICE FAMILY CHIROPRACTIC**  
**Financial Arrangement and Assignment of Benefits**

I understand that I am financially responsible to Radice Family Chiropractic for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Radice Family Chiropractic and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services and products received.

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Radice Family Chiropractic, P.A. for any medical services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by Radice Family Chiropractic, P.A.

By signing this document, I also acknowledge that I have been provided a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

If you have any questions regarding our policies listed above please ask the front desk staff. We can assist you in filling out any forms as well as explain payment arrangements that are in line with Radice Family Chiropractic's financial arrangement.

I have read, fully understand and agree to abide by Radice Family Chiropractic financial arrangement policies that pertain to me. I furthermore acknowledge and agree that I am responsible for paying Radice Family Chiropractic their fee for treating me and at any time, Radice Family Chiropractic can demand payment for all or part of the balance of said fee. I also agree to pay all of Radice Family Chiropractic's expenses to collect that fee, including reasonable attorney costs.

_____	_____	____/____/____
Print Patient Name	Patient Signature	Date
_____	_____	____/____/____
Parent/Guardian Name	Parent/Guardian Signature	Date
	_____	____/____/____
	RFC Representative	Date

## PATIENT CONSENT TO X-RAY

I, \_\_\_\_\_ authorize the performance of diagnostic x-ray examination on myself which Dr. Radice or the appropriate staff consider necessary or advisable in the course of examination and treatment.

\_\_\_\_\_  
Signed

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

## VERIFICATION OF NON-PREGNANCY

This is to certify that to the best of my knowledge, I, \_\_\_\_\_ am not pregnant and that Dr. Radice or the appropriate staff has my permission to perform diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.

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

\_\_\_\_\_  
Signed

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

## CONSENT TO X-RAY A MINOR

I, \_\_\_\_\_, authorize the performance of diagnostic x-ray examination of my child or ward which Dr. Radice or the appropriate staff consider necessary or advisable in the course of examination and treatment. The patient, \_\_\_\_\_ is a minor, \_\_\_\_\_ years of age.

\_\_\_\_\_  
Signed

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

