Chiropractic Intake Form

Name: ______________________________________ Date of Birth: _______________ Age: ____

Please briefly describe your chief area of complaint, including the effect it has had on your life.

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If you are experiencing pain, is it... ☐ Sharp ☐ Dull ☐ Comes and Goes ☐ Travels ☐ Constant
Since the problem started, it is... ☐ About the Same ☐ Getting Better ☐ Getting Worse
What makes it worse? ____
What makes it better? ____
Yes, it interferes with... ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

What other doctors have you seen for this problem? ____

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headache	☐ Fatigue	☐ Dizziness	☐ Loss of Smell
☐ Depression	☐ Stiff Neck	☐ Neck Pain	☐ Loss of Taste
☐ Irritability	☐ Cold Hands	☐ Back Pain	☐ Loss of Balance
☐ Tension	☐ Constipation	☐ Diarrhea	☐ Cold Sweats
☐ Ringing in Ears	☐ Upset Stomach	☐ Ulcers	☐ Cold Feet
☐ Hot Flashes	☐ Problem Urinating	☐ Fever	☐ Numbness in Hands
☐ Heartburn	☐ Mood Swings	☐ Fainting	☐ Pins and Needles
☐ Sleeping Problems	☐ Sensitivity to Light	☐ Menstrual Pain	

Medication List - Please Indicate Dosage:

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

5. ______________________________ 6. ______________________________

Additional Questions:	Yes	No	Unsure	Comments:
Were you involved in any car accidents?	☐	☐	☐	______________________
Did you have any serious falls?	☐	☐	☐	______________________
Do/did you smoke?	☐	☐	☐	______________________
Do/did you drink alcohol?	☐	☐	☐	______________________
Have you had any surgeries?	☐	☐	☐	______________________
Do/did you play any adult sports?	☐	☐	☐	______________________
Did you suffer any other traumas?	☐	☐	☐	______________________
Did you have any childhood illness?	☐	☐	☐	______________________

	Yes	No	Unsure	Comments:
Did you have any serious falls as a child?	☐	☐	☐	___________________________
Did you play youth sports?	☐	☐	☐	___________________________
Do/did you take/use any drugs?	☐	☐	☐	___________________________
Any prolonged use of medicine such as antibiotics or inhaler?	☐	☐	☐	___________________________

On a scale of 1-10, please describe your stress level (1 = none, 10 = extreme: Work ______ Personal _____
On a scale of poor, good, excellent, describe your: Diet ______ Exercise _____ Sleep _____ Health ______

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: ____ Date: ________________________

Chiropractor Signature: ____ Date: ________________________

Appointment Policy

I, the patient, agree to be on time to receive the therapist's services for every appointment. I will make sure to see the front desk so that I can be checked in and my check in time will be recorded. I understand that reminder emails may be provided as a courtesy but I am still responsible for my appointments and any consequences associated with failing to keep or be on time to an appointment. I agree to *give at least 24 hours notice for any appointment I need to miss, cancel, or reschedule* or be subject to a **$50 missed appointment fee.**

I, _____________________ (name) have read and understand the above agreement and agree to comply fully with collections of any fee that I owe.

Patient's Signature: ___________________________________ Date: _____________________

Email Address (for email receipts): ____

Card on File Policy

Effective January 1, 2012, Balance Chicago has implemented a new card on file policy. Your information will be securely held to cover future charges with your notification before any transactions are processed. Signing this consent in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. I hereby authorize Balance Chicago to keep my card information on file for payment of any or all charges for medical services for which I am financially responsible and that remain unpaid after applying insurance payments and adjustments, if any. If my card information changes for any reason I will notify Balance Chicago. This consent shall remain in effect for one (1) year from the date set forth below or until I give written notification of its termination. *Please complete the credit card authorization form OR hand your card to the front desk person to swipe into the system*.

Credit Card Type: ☐ Visa ☐ Master Card ☐ Discover Card ☐ AMEX

Name on Card: ______________________________ Card Number: _________________________ Exp: ____/____

Billing Street Address: _______________________________ City, State, Zip: ________________________________