



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.

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

Medication List - Please Indicate Dosage:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

Additional Questions:

	Yes	No	Unsure	Comments:
Were you involved in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any serious falls?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any childhood illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Yes	No	Unsure	Comments:
Do/did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any prolonged use of medicine such as antibiotics or inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 LifeStyle. 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: _____