**WELCOME TO ARISE CHIROPRACTIC WELLNESS CENTER**

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Phone 301-662-4220 ❋ Fax 301-662-8195

NEW PATIENT INTAKE FORM

**Patient Information**

Date: _____

Name: _____
(First) (Middle) (Last)

Nickname: _____

Age: _____ Date of Birth: _____

Sex: ❑ F ❑ M Marital Status: S M D W

Home Address: _____

_____

Email Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Spouse/Signif. Other: _____

No. Of Children: _____ Their Ages: _____

Your occupation: _____

Employer: _____

Is your condition related to an accident?
❑ Yes ❑ No Date: _____
*If yes, please inform our staff and obtain additional necessary paperwork.*

How did you hear about our office?

_____

**Insurance Information, Financial Agreement & Authorization for Release:**

If you are interested in utilizing an insurance policy for any part of your financial obligation please complete the following and allow us to make a copy of your insurance card and driver's license.

Name of Insured: _____ Insured's DOB: _____

Insured Social Security#: _____ Relation to Patient: _____

Insurance Company: _____ Policy ID#: _____

*I, the undersigned, certify that I (or my dependent) have insurance coverage with the above written company and assign directly to Dr. Lisa M. Hinkle all insurance benefits, if any, otherwise payable to me, as payment for services rendered.*
*I agree to be financially responsible for all charges incurred at this clinic, whether or not they are paid by insurance.*
*I authorize the doctor and her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of an consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.*
*I authorize the use of this signature on all insurance submissions.*

Signature: _____ Date: _____

Patient Name: _____ Date: _____

**Reason For Visit:** PLEASE ANSWER **ALL** QUESTIONS

For what primary reason are you seeking chiropractic care? _____

When did you first experience signs or symptoms? _____

Did your symptoms begin ❑ suddenly OR ❑ gradually?

Is this condition getting progressively ❑ worse ❑ better ❑ staying the same?

Rate severity of your symptoms from 0-10, where 0 indicates no pain and 10 is most severe:

Today: ___ Average: ___ Worst it has been: ___ Best it has been: ____

Which best describes the quality of your symptoms (choose all that apply):

❑Sharp ❑Dull Ache ❑Throbbing ❑Numb/Tingling ❑Shooting ❑Tightness ❑Other _____

Are symptoms ❑constant OR ❑ come & go ?

I experience these symptoms: ____ times per day ____ times per week ____times per month.

Do your symptoms interfere with your: ❑ work ❑ sleep ❑ daily routine ❑other_____

What activities increase/aggravate symptoms: _____

What treatment have you already received for this condition? ❑ Chiropractic ❑ Physical Therapy

❑ Medical ❑ Acupuncture ❑ Massage Therapy ❑ None ❑ Other _____

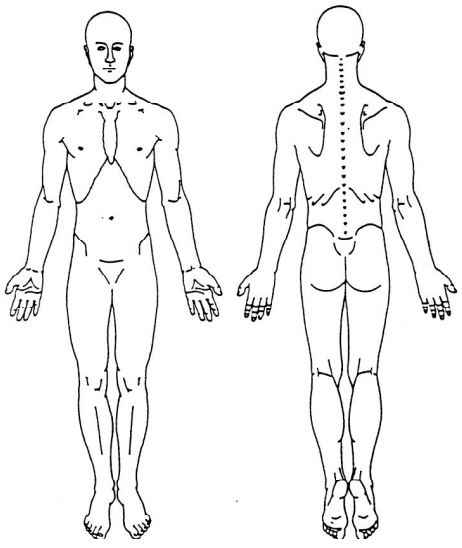
**OTHER CONCERNS:** List all other conditions you would like us to address below in order of importance:

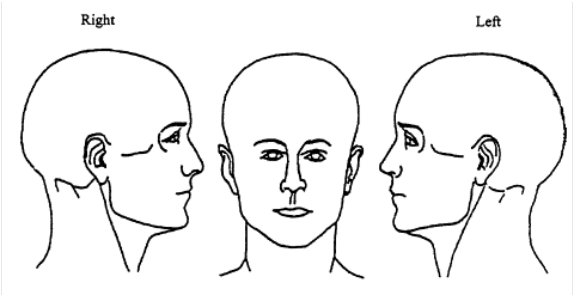
_____

_____

**Pain Diagram: Indicate the LOCATION and QUALITY of your symptoms using the symbols below**

| Ache | Burning | Numbness | Pins/Needles | Stabbing | Other _____ |
|---|---|---|---|---|---|
| ^^^^ | BBBBB | OOOOO | /////////// | VVVVV | XXXXX |






Patient Signature: _____ Date: _____

Patient Name: _____ Date: _____

| Personal Health History | | |
|---|---|---|
| **CIRCLE** the following conditions that **YOU** have ever had and **WRITE THE DATE(S)** they were diagnosed or experienced to the right of the condition | | |
| AIDS/HIV | Emphysema | Mononucleosis |
| Alcoholism | Epilepsy | Multiple Sclerosis |
| Anemia | Fractures | Osteoporosis |
| Anorexia | Gout | Pacemaker |
| Appendicitis | Headaches | Pneumonia |
| Arthritis | Heart Disease | Polio |
| Asthma | Hepatitis | Prostate Problems |
| Bleeding Disorders | Hernia | Psychiatric Disorder |
| Breast lump | Herniated Discs | Rheumatoid Arthritis |
| Bulimia | Herpes | Stroke |
| Cancer | High Blood Pressure | Thyroid Problem |
| Chemical Dependency | High Cholesterol | Tuberculosis |
| Chicken Pox | Kidney Disorders | Tumors/Growths |
| Diabetes | Liver Disease | Ulcers |
| Depression | Miscarriage | Other _____ |

**WOMEN:** Date of last menstrual period: _____ Spinal health is especially important during pregnancy.

Are you currently pregnant? ❑ Yes ❑ No Due Date: _____ OBGYN/Midwife/ Group: _____

Where will you be birthing your baby? Hospital Home Birthing Center Other_____

**Who is your Primary Care Physician:**

Please **LIST and DATE** all surgeries you have undergone:

Please **LIST** all current prescription and non-prescription drugs by NAME and **PURPOSE:**

Please **LIST and DATE** any injuries or accidents (falls, fractures, motor vehicle accidents, trauma):

In the last year: _____

Occurred > 1 year ago: _____

In childhood:_____

| **Family Health History:** Mark conditions **YOUR PARENTS, SIBLINGS, OR GRANDPARENTS** have had & indicate which family member they apply to: | |
|---|---|
| ❑ Back Problems _____ | ❑ Diabetes _____ |
| ❑ Hypertension _____ | ❑ Osteoporosis _____ |
| ❑ Thyroid Disorder _____ | ❑ Rheumatoid Arthritis _____ |
| ❑ Stroke _____ | ❑ Cancer _____ |
| ❑ Heart Disease _____ | ❑ Neurological Disease _____ |

Patient Name: _____ Date: _____

**Wellness Profile:**

Our goal is to provide a holistic evaluation of your health, considering mind, body and spirit. There may be seemingly insignificant events or aspects of your daily life that are contributing to today's picture of you. Please answer the following to the best of your ability.

**Current Health Rating**:

On a scale of 0-10, with 10 being the best, please rate your overall health today:_____

On a scale of 0-10, with 10 being the highest, rate your current stress level: _____

**WHAT ARE YOUR GOALS FOR CARE? Check all that apply**

| | | |
|---|---|---|
| ❑ relief of current symptoms | ❑ wellness care for optimal whole body health | ❑ reduce/eliminate use of medications |
| ❑ supportive care to prevent recurrence of conditions/symptoms | ❑ improved posture | ❑ better sleep |
| | | ❑ other _____ |

Have you ever been under chiropractic care? ❑ Yes ❑ No

If yes, when and for what reasons? _____

Have you been under the care of any other holistic health care professionals? ❑ Yes ❑ No If yes, please list:

_____

Do you follow a special diet? _____

List any vitamins or supplements you take: _____

Do you have any allergies (seasonal, foods, meds, etc)? _____

Do you smoke? ❑Yes ❑ No Quantity/day _____ Years you have smoked _____

Do you drink alcohol? ❑ Yes ❑ No Average quantity _____

Do you drink caffeine? ❑ Yes ❑ No Drinks/day _____

Do you exercise? ❑ Yes ❑ No If yes, How many days/week? _____

Describe your exercise routine/physical activity: _____

_____

What position do you sleep in? right side left side back stomach other_____

How many hours of sleep do you get per night? _____ What is the age of your mattress?_____

Indicate the **type** and **number** of pillows you use:

❑thick ____ ❑medium ____ ❑thin _____ ❑memory foam ____ ❑contoured ____ ❑other _____

Do you wear ❑heel lifts ❑arch supports ❑orthotics ?

Patient Name: _____ Date: _____

# INFORMED CONSENT & OFFICE POLICIES

## Informed Consent

Any procedure intended to help may also do harm. While chiropractic examination and therapeutic procedures are considered remarkably safe and effective, please understand that occasionally there may be adverse reactions. Although the chances of experiencing any of these complications are extremely small, it is the practice of this chiropractic office to fully inform and educate all of our patients.

By signing below, I understand that these complications include, but are not limited to, muscle strains and sprains, fractures, dislocations, disc injuries, and strokes. I do not expect the doctor to be able to anticipate or explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of my treatments that she feels are in my best interest based upon the facts known at the time of treatment.

I understand that there is no guarantee or warranty for a specific cure or result. I understand that at any time, I can request further explanation regarding risks and benefits of care in this office, alternative courses of care, and the consequences of not having the proposed treatment.

**Patient/Legal Guardian's Initials: _____**

## Office Payment Policies

I agree to take full responsibility for my care in the event that the assumed insurance coverage, including worker's compensation, no fault insurance, personal injury insurance, Medicare, etc is denied.

I further understand that I will be charged a $30 missed appointment fee for appointments that are missed or canceled without 24 hours notice prior to the scheduled appointment time.

**Patient/Legal Guardian's Initials: _____**

## Notice of Patient Privacy Practices: HIPAA

By signing below, I acknowledge that I have had the opportunity to review a copy of the Patient Privacy Practices of Arise Chiropractic Wellness Center, LLC, and a copy will be available for me at any time upon my request.

The Health Insurance Portability and Accountability Act ensures a patient's right to privacy regarding personal health information and it is this office's policy to maintain confidentiality to the highest degree.

**Patient/Legal Guardian's Initials: _____**

**I have read this form in its entirety and have been given the opportunity to ask questions about its contents.**

Patient/Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____