Charles River Chiropractic
Intake Form

Name_____Date_____File #_____

Address_____

City_____State_____ZIP_____

Home Phone_____Work Phone_____

Cell Phone_____E-Mail Address_____

Which number do you prefer to be reminded of appointments on?_____

SSN_____-____-_____ Date of Birth_____

____Single ____Married ____Widowed ____Divorced ____ Female ____ Male

Height:_____ Weight_____

Employer_____ Occupation_____

Work Address_____City_____Zip_____

How did you hear about Charles River Chiropractic?_____

Health History

Have you had previous chiropractic care? □No, if yes when?_____

Main Complaint_____

_____

How long have you had this condition? _____Have you seen another doctor for this problem? (whom?, how long? ,diagnosis?, treatment?)_____

_____

If this is a recurring problem how often do you notice it? (# of days per month or year)

_____

Do you feel that this condition is: _____getting better, _____same, _____getting worse.

Other Complaints_____

How long have you had this condition? _____Have you seen another doctor or health care provider for this problem?_____

If this is a recurring problem how often do you notice it? (# of days per month or year)

_____

List any allergies that you may have_____

List any prescription medication that you are taking and describe what they are for.

_____

List any non-prescription/over the counter medication that you are taking_____

List previous surgeries with dates_____

List any serious accidents/injuries with dates_____

Have you been diagnosed with any health condition in the past?

_____

Have you had any imaging performed in the past (X-rays, MRI's CT scans etc.) Yes___ No____, if yes, when and where_____

Have you had any recent, unexplained weight loss? Yes_____ No_____

Have you had a recent fever? Yes____ No____

Have you had any difficulty with urination or defecation? Yes____ No____

Have you had cancer in the past? Yes____ No____

Do you have any numbness and/or pins and needles? Yes____ No____, if yes how often?_____, where?_____

Do you have any immediate family members that have been diagnosed with a health condition in the past? _____

For Women Only Are you pregnant? Yes__No__, If yes expected due date_____

Review of Systems

General

□ night sweats □ night pain □ weakness □ fatigue □ weight change

Eyes

□ visual changes □ pain □ discharge

Ears

□ hearing difficulty □ ringing □ pain

Nose

□ bleeding

Mouth / Throat

□ sore □ bleeding

Skin

□ rash □ itching □ hair changes □ nail changes

Nervous System

□ headaches □ dizziness □ fainting □ paralysis □ forgetfulness □ convulsions □ cold / tingling extremities

Gastrointestinal

□ poor excessive appetite □ abdominal pain □ vomiting □ diarrhea □ constipation □ gas/bloating after meals

□ heartburn □ black bloody stools □ frequent nausea □ hemorrhoids

Genitourinary

□ frequent urination □ painful urination □ incontinence □ impotence □ sterility

Cardiovascular

□ chest pain □ palpitations □ difficulty breathing □ cough □ wheezing □ blue extremities □ swollen extremities

Psychological

□ anxiety □ depression □ moods □ memory

Musculoskeletal

□ low back pain □ neck pain □ upper back pain □ mid back pain □ arm/leg pain □ joint pain/stiffness

OFFICE POLICIES OF CHARLES RIVER CHIROPRACTIC

PERMISSION TO COMMUNICATE

I authorize and give permission to Dr. Benjamin Grace and his staff and/or associates to communicate with me in writing by regular mail, email, phone calls to my home, work, wireless phone, or answering machine(s). I understand that communication will be in regards to appointments as well as clerical and clinical issues. I understand that due diligence will be employed in being discrete about any clinical issues that is to be conveyed via the above modes of communication. I understand that I have the right to refuse certain types of communication by notifying Dr. Benjamin Grace or his staff.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I hereby authorize Dr. Benjamin Grace, or his assigned staff members, to release information contained in my medical record to any and all insurance carriers from whom I may be due benefits, to my primary care physician or other healthcare providers associated with my treatment, to the state chiropractic society in the event their assistance is needed on my behalf, and to my attorney of record (if an attorney is involved).

ASSIGNMENT OF BENEFITS

I authorize and direct my insurance company to pay directly to Charles River Chiropractic any charges, fees, payments or costs incurred by me for services rendered at their office.

COLLECTION POLICY AGREEMENT

- I hereby acknowledge that I, personally am ultimately and fully responsible for the payment of all charges or fees for services provided me, regardless of any contract of insurance. I also understand that I may be charged a 1.5% monthly interest for any patient balances unpaid after 30 days.
- I agree to deliver to Charles River Chiropractic any check, or other funds that I receive from any source intended as payment for services rendered me by Dr. Grace within 10 calendar days of receipt by me and to be responsible for 1.5% month interest accrued for failure to deliver funds after 30 days.
- I agree to reimburse Charles River Chiropractic for all reasonable collection costs that arise from collection actions that may be taken against me in the process of settling my account.

INSURANCE POLICY

- All deductible payments **MUST** be made prior to insurance submittal.
- You are considered to be a non-insurance patient until our office “qualifies” your coverage to determine the extent of benefits under your policy.
- **All co-payments are payable at the time of each visit.**

APPOINTMENT POLICY

We reserve the right to charge a $30 fee for appointments that are blatantly missed or appointments that are cancelled without notice of at least 24 hours. The $30 fee is your bill, not your insurance company’s bill.

I acknowledge that 1) I have read the HIPAA Policies of This Office And 2) I Have Read, Understood And Agreed To The Above Office Policies Per My Signature: _____Date: _____