LIGHTHOUSE CHIROPRACTIC ADULT INTAKE FORM
Ages 13 - Adult

PATIENT INFORMATION

Patient Name _____ (LAST NAME)
_____ (FIRST NAME) (MIDDLE INITIAL)
Address _____
City _____ State ____ Zip_____
Home Phone _____
Cell Phone _____
Email _____
Sex ❑ M ❑ F Age ____ Birthday _____
❑ Married ❑ Widowed ❑ Single ❑ Minor
❑ Separated ❑ Divorced ❑ Partnered

Employer / School _____
Occupation _____
Spouse's Name _____
Spouse's Employer _____
Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____
Contact Number _____
How did you hear about us? Friend Family Google Other
Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today?
Have you seen another doctor for this issue? Y N If yes, how long ago?

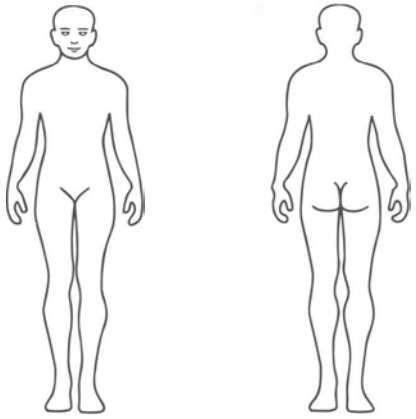
Is this your first time seeing a chiropractor? Y N

How intense are your symptoms? (circle)

NO SYMPTOMS — INTENSE SYMPTOMS

0 1 2 3 4 5 6 7 8 9 10

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

❑ Numbness
❑ Tingling
❑ Stiffness
❑ Dull
❑ Aching
❑ Cramping
❑ Nagging
❑ Sharp
❑ Shooting
❑ Burning
❑ Throbbing
❑ Stabbing
❑ Swelling
❑ Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other _____	❑	❑	❑	❑

How committed are you to correcting this issue?

0 (NOT COMMITTED) 1 2 3 4 5 6 7 8 9 10 (VERY COMMITTED)

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ❑ No ❑ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma/Allergies
- ❑ Back Pain
- ❑ Cardiovascular Issues
- ❑ Cancer
- ❑ Circulation Issues
- ❑ Childhood Illness
- ❑ Depression
- ❑ Diabetes
- ❑ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ❑ Elbow/Wrist/Hand Issues
- ❑ Endocrine Issues (Thyroid)
- ❑ Foot/Ankle Issues
- ❑ Gout
- ❑ Headaches / Migraines
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hip Issues
- ❑ Immune Issues
- ❑ Lymphatic Issues
- ❑ Multiple Sclerosis
- ❑ Neck Pain
- ❑ Reproductive Issues
- ❑ Ringing in Ears
- ❑ Scoliosis
- ❑ Shoulder Issues
- ❑ Stroke
- ❑ TMJ Issues
- ❑ Urinary Issues
- ❑ Osteoporosis
- ❑ Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

MEDICATIONS (list)

SUPPLEMENTS (list)

INSURANCE INFORMATION (IF APPLICABLE)

Name of insured _____

Date of Birth _____

Insurance Company _____

Phone # _____

ID # _____

Policy# _____

FINANCIAL INFORMATION

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. As a courtesy, Lighthouse Chiropractic will verify my insurance. I understand that "VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF COVERAGE OR PAYMENT. IT WILL BE BASED ON MEDICAL NECESSITY, CONTRACT EXCLUSION AND ELIGIBILITY AT THE TIME OF SERVICE." Furthermore, I understand that Lighthouse Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to Lighthouse Chiropractic will be credited to my account upon receipt. However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that if I suspend or terminate my case and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Name | Patient Signature | Date

Guardian's Name | Guardian's Signature | Date

CREDIT CARD POLICY

Please note that when you use a credit card in our office, it is **automatically saved** and will be used to pay for future appointments. **If you do not want to keep your card on file, please pay with cash or check.**

CONSENT TO INITIATE CARE

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. Our only practice objective is to eliminate subluxation which interferes with the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations

I, _____, have read and fully understand the above statements.

(Please Print Name)

I hereby authorize the Doctor to provide any and all forms of evaluation, x-rays and care that may be indicated in connection with the patient above, and further authorize the consent that the Doctor chooses and employs such assistance as he sees fit. I also understand that prior to care, a full explanation of the procedure(s) involved will be given.

Patient/Guardian Name | Patient/Guardian Signature | Date

Notice of Privacy Practices Acknowledgement
Lighthouse Chiropractic

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

OR

_____

Signature of Personal Represent: Date

Authority of Personal Representative to Sign for Patient (check one):

___ Parent ___ Guardian ___ Power of Attorney _____ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

_____

Lighthouse Chiropractic Office Use Only

I tried to obtain written Acknowledgement by individual note above of recipt of our **Notice of Privacy Practices**, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgment

___ A communication barrier prevented us from obtaining acknowledgement

___ The individual was unwilling to sign

___ Other: _____

_____ _____

Signature of Personal Representative Date

Medical Information Release Form

(HIPPA Release Form)

_____ _____

Patient's Name (Please Print) Patient's Date of Birth

Release of Information

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____ My Insurance Company (only minimum necessary information needed for billing purposes)

_____ Spouse _____
(Name – please print)

_____ Child(ren) _____
(Name(s) – please print)

_____ Other _____
(Name/relationship – please print)

_____ My information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

_____ _____

Signature of Personal Representative Date