WELCOME TO AFFORDABLE CHIROPRACTIC

Dr. W.C. LaRock, D.C.
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Phone 915-875-0050 Fax 915-875-0068

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?
____

Will we be filing an insurance claim for you? ❑Yes ❑No (If YES, please fill out form below)

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. W.C. LaRock *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: ___________________

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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 ❑ supportive care to prevent recurrence of conditions/symptoms	❑ wellness care for optimal whole body health ❑ improved posture	❑ reduce/eliminate use of medications ❑ 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 ?

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New Patient Information

Patient Name ______________________ ***Date*** ______________________

1. When did your symptoms start: ______________________ ***Describe your symptoms and how they began:***

____

____

2. How often do you experience your symptoms?
- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms

3. What describes the nature of your symptoms?
- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?
- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: ______________________

8. What activities make your symptoms better: ______________________

9. Who have you seen for your symptoms?
- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. When and what treatment? ______________________

b. What tests have you had for your symptoms and when were they performed?
- ① Xrays *date:* ____________
- ② MRI *date:* ____________
- ③ CT Scan *date:* ____________
- ④ Other *date:* ____________

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?
- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

11. What is your occupation?

____
- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?
- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*
- ① Reduce symptoms
- ② Resume/increase activity
- ③ Explanation of condition/treatment
- ④ Learn how to take care of this on my own
- ⑤ How to prevent this from occurring again
- ⑥

Patient Signature ______________________ ***Date*** ______________________

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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, etc is denied.

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 Affordable Chiropractic, 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: ___________

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