NEW PATIENT INTAKE INFORMATION

Name: _____ Today's Date: _____
Last First Middle

Mailing Address: _____
Complete Street &/or Box City State Zip Code

Street Address: _____ Gender: ___M ___F
if different then your mailing address

(___) _____ (___) _____ (___) _____
Home Phone Number Work Phone Number Cell Phone Number

Emergency Contact: _____ Phone Number:_____

Social Security #: _____ Height: _____ Weight: _____ Date of Birth: ___/___/____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed Spouse: _____

Children (Name and age): _____

Who is responsible for your bill? ( ) Self ( ) Spouse ( ) Parent ( ) Employer** ( ) Other: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone Number: _____

Spouse's Employer: _____ Employer Phone Number: _____

Spouse's Employer Address: _____

Who may we thank for referring you? _____

Insurance

***If you are requesting that we bill your insurance on your behalf, we MUST have a current photocopy of your insurance card on file. Your insurance WILL NOT BE BILLED WITHOUT IT!**

Type of Insurance ( ) Medicare ( ) Blue Cross/Blue Shield

Relationship to Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Primary Care Physician: _____

Insured's Social Security Number: _____ Insured's Date of Birth: _____

****Please Note: If "Employer" is selected we must have an authorization from your Employer to bill them**

Is your visit today due to an Auto Accident or a Work Injury? ( ) Yes ( ) No

If *yes,* please notify the staff before being treated!

NEW PATIENT INTAKE INFORMATION

AREA(s) OF PRESENT COMPLAINT ( ) NECK ( ) UPPER BACK ( ) MID-BACK ( ) LOW BACK ( ) HIP ( ) ARM/HAND ( ) LEG ( ) FEET ( ) OTHER _____

Intensity of Pain: _____ AMA Scale: Minimal 1-3, Slight 4-6, Moderate 7-9, Max 10

Quality of pain: ( )Sharp ( )Dull ( ) Achy ( )Burning ( )Throbbing ( )Other

Do symptoms radiate/extend into another area? ( ) Arms ( ) Legs ( )Other

Symptoms/Dysfunction Since Onset Have: ( ) Decreased ( ) Increased ( ) No Change ( ) Erratic

Symptoms are: ( ) Constant ( ) Off and on Have you had this before? Y / N

When are your symptoms most noticeable? ( ) Morning ( ) Night ( ) Other

Please explain your present condition in your own words: **"Why are you here today?"**_____

_____

When did you first begin to notice this problem? _____

Have you ever been treated by a Doctor of Chiropractic? ( ) Yes ( ) No

*By Dr. _____

How long since your last adjustment? _____

How did you respond? _____

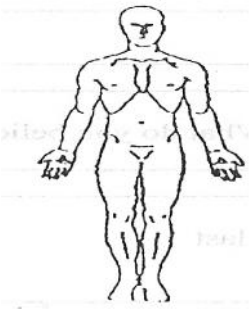
What if any additional remedies, treatments, or opinions have you sought regarding *this* condition: ☐ Prescription Medications ☐ Over the counter drugs ☐ Homeopathic Remedies ☐ Physical Therapy ☐ Acupuncture ☐ Surgery ☐ Massage ☐ Chiropractic ☐ Other _____

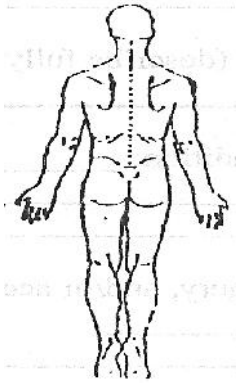
Describe: _____

List all hospitalizations & accidents in the past year:_____

_____

Please circle the location(s) of your pain:





Patient name: _____

Dr. Signature: _____

NEW PATIENT INTAKE INFORMATION

How is your current condition affecting your Activities of Daily Living (ADL's)?

Please mark all as they apply to you.

	No Effect	Mild	Moderate	Severe
Carrying				
Change position sit to stand				
Climb Stairs				
Driving				
Kneeling				
Lifting				
Reading (concentration)				
Bathing or Dressing				
Sleep				
Sitting				
Standing				
Walking				
Recreational Activities				

Notes

Please check all that apply to you:

OPERATIONS

Appendectomy		Hernia	
Heart		Female Organs	
Tonsillectomy		Spine (specify areas):	
Gall Bladder		Other:	

FRACTURES

Arm		Ankle		Wrist		Vertebrae:	
Leg		Rib		Finger		Other:	

If you have had any of the following diseases please place a check mark in the box.

Anemia		Heart Disease		Pneumonia	
Arthritis		Influenza		Polio	
Chicken Pox		Lumbago		Scarlet Fever	
Diabetes		Measles		Small Pox	
Eczema		Mental Disorders		Thyroid	
Epilepsy		Mumps		Tuberculosis	
Gout		Pleurisy		Cancer **	

**Please list type(s) of cancer: _____

NEW PATIENT INTAKE INFORMATION

Please review the following information and mark accordingly. If you have not had a problem with an area please leave it unmarked.

General Symptoms	*Have*	*Had*	**Muscle & Joint Symptoms**	*Have*	*Had*	**Eyes, Ears, Nose & Throat**	Have	Had
Headache			Neck Pain			Failing vision		
Fever			Stiff Neck			Near sightedness		
Chills			Pain Between Shoulders			Far sightedness		
Sweats			Backache			Eye pain		
Fainting			Spinal curvature			Deafness		
Loss of sleep			Poor posture			Earache		
Fatigue			Swollen joints			Nose bleeds		
Nervousness			Painful tail bone			Nasal obstruction		
Abnormal weight change			Foot trouble			Sore throat		
Numbness or pain			Disc Problems			Frequent colds		
Allergies (Please list):						Sinus infection (s)		
						Hay Fever		
						Nasal polyps		
Gastrointestinal Symptom	*Have*	*Had*	**Respiratory**	Have	Had	**Cardiovascular**	Have	Had
Poor appetite			Asthma			Rapid heart beat		
Difficult digestion			Chest pain			Slow heart beat		
Difficulty swallowing			Chronic cough			High blood pressure		
Excessive hunger			Difficult breathing			Low blood pressure		
Belching or gas			Spitting up blood			Pain over heart		
Nausea			Spitting up phlegm			Previous heart attack		
Vomiting						Hardening of arteries		
Vomiting of blood						Previous stroke		
Pain over stomach						Swelling of ankles		
Distention of abdomen						Poor circulation		
Constipation						Paralytic stroke		
Diarrhea			**Genitourinary Symptom**	Have	Had			
Colon trouble			Frequent urination			**Skin**	Have	Had
Hemorrhoids			Painful urination			Itching		
Intestinal worms			Blood in urine			Bruise easily		
Liver trouble			Kidney infections			Dryness		
Gall Bladder trouble			Kidney Stones			Boils or acne		
Jaundice			Bed wetting			Varicose veins		
Colitis			Inability to control urine			Sensitive skin		
Hernia			Prostate trouble			Hives		

For Women Only	Have	Had		Have	Had		Have	Had
Painful menstrual periods			Cramps or backache			Lumps in breast(s)		
Excessive flow			Previous miscarriage			Menopausal symptoms		
Irregular cycle			Vaginal discharge			Hot flashes/Chills		
Are you pregnant? ( )Yes ( ) No			Painful Intercourse					

Patient name: _____
Dr. Signature: _____

PERSONAL HABITS (Please note amounts of each)

Sleep (hours): ____ Coffee: ____ Tea: ____ Tobacco: ____ Alcohol: ____

Exercise: _____ Watch TV in bed: ____ Sleep on 2 or more pillows: ____

Sleeping Position: _____ "Pop" own back/neck: ____

Do you consider yourself to regularly consume a balanced and healthy diet? Yes ( ) No ( )

FAMILY HEALTH HISTORY:

Please list any developmental, hereditary, or chronic health conditions that occur in your family, taking into consideration both sides of your family tree.

Mother-_____

Father-_____

Grandmother-_____

Grandfather-_____

Siblings-_____

Children-_____

FINANCIAL POLICY

Financial responsibility is an important aspect of your health care. Just as Dr. Barnes respects your time as a patient you are expected to respect his time with your payments. In order to keep overhead costs to a minimum it is important that all services be paid for at the time of the office visit. Thank you.

Please initial

____ I understand that payment is due at the time of the office visit. The first office visit is payable in full at the time of service. If a payment schedule needs to be established, immediately notify the front desk staff.

Payment Plan Attached *Staff initial:* _____

FORMS OF ACCEPTED PAYMENT:

***Cash *Check *Money Order *Credit Card: Master card, Visa, or Discover**

PENALTY'S

_____ I understand that unpaid fees for services beyond 60 days are subject to a 2.0 % finance charge (24% annually). I understand a minimum interest of $2.00 per statement may apply.

____Returned checks are subject to a $25 fee.

It is the policy of Barnes Family Chiropractic to assess a **$45.00** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee. We reserve the right to charge for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

_____I understand the missed appointment policy.

NEW PATIENT INTAKE INFORMATION

Name and Address of Office:
Barnes Family Chiropractic
328 14th Street
Burlington, CO 80807

Name of Doctor Treating This Patient:

Jason Barnes, DC

Please initial below after reading:

_____ I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named herein and/ or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the doctor of chiropractic named herein, including those working at the clinic or office listed or any other office or clinic.

I understand I will have an opportunity to discuss with the doctor of chiropractic named and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

_____ 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. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

For Women:

_____I understand that x-ray can be hazardous to an unborn child. I certify that I am **not** pregnant.

Date of last menstrual period :____/___/___

_____ I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Signature: _____

***If** signing on behalf of patient/minor child please indicate relationship to patient* Date

Name of Patient: _____

Witness: _____

Patient name: _____
Dr. Signature: _____