SUNSET CHIROPRACTIC INTAKE FORM

Name:____Date:_____/_____/_____ Age:_________ Male/Female

Address:____City:__________________ State:______Zip:________

Phone:Home_________________________Cell:_______________________ Date of Birth:_____/_____/_____

Email Address:____

Occupation:_________________________________ Employer's Name:________________________________

Single / Married / Divorced / Widowed Spouse's Name:____

Number of Children_________

Who may we thank for referring you? _____________________________________

***CIRCLE* ALL CURRENT PROBLEMS YOU HAVE**

DIZZINESS	*THROAT ISSUES*	*KIDNEY PROBLEMS*	*LIVER DISEASE*	*NERVOUSNESS*
HEADACHES	*THYROID PROBLEMS*	*MID BACK PAIN*	*SHOULDER PAIN*	*EPILEPSY*
VERTIGO	*ASTHMA*	*IRRITABLE BOWEL*	*CHRONIC FATIGUE*	*DISC PROBLEM*
EAR INFECTIONS	*ULCERS*	*SCIATICA*	*LUPUS*	*INFERTILITY*
NAUSEA	*NUMBNESS IN ARMS*	*NUMBNESS IN LEGS*	*FIBROMYALGIA*	*GASTRIC REFULX*
TMJ	*NUMBNESS IN HANDS*	*NUMBNESS IN FEET*	*CHEST PAIN*	*ALLERGIES*
NECK PAIN	*MENSTRUAL DISORDER*	*LOW BACK PAIN*	*ARM PAIN*	*OTHER*____________
MIGRAINES	*HEART DISORDERS*	*HIP PAIN*	*ADD/ADHD*	__________________
ANXIETY	*STOMACH DISORDERS*	*LEG PAINS*		__________________
CHRONIC SINUS	*BLADDER PROBLEMS*	*KNEE PAIN*		__________________

LIST YOUR TOP 3 HEALTH PROBLEMS

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. ________________________	________________	_____________	________________	_______________	_____________
2. ________________________	________________	_____________	________________	_______________	_____________
3. ________________________	________________	_____________	________________	_______________	_____________

***CIRCLE* ANY CONDITION YOU HAVE NOW/ HAVE HAD:**

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

Have you ever seen any other doctors for this condition? YES / NO

CHIROPRACTOR? YES / NO MEDICAL DOCTOR? YES / NO OTHER? YES / NO

Who and When?____

List and surgical operations and year ____

____

List ANY over the counter & PRESCRIPTION MEDICATIONS you are on:

____

____

Any auto accidents: Year Speed (MPH) Rear-ended? T-Boned?

____

____

Have you ever been knocked unconscious? YES / NO **Fractured a bone? YES / NO**

If yes, please describe____

Other trauma:____

Health Insurance Information (Must be Completed Before Services Can Be Rendered)

NAME: ____

FIRST MIDDLE LAST

SOCIAL SECURITY NUMBER:______________________

CONTACT IN CASE OF EMERGENCY:______________________________Phone #: __________________

NAME OF PRIMARY INSURANCE CARRIER: ____

Name of Insured__________________________ Insured Date of Birth ___________________

Insured Social Security Number ___________________

NAME OF SECONDARY INSURANCE CARRIER: ____

Name of Insured__________________________ Insured Date of Birth ___________________

Insured Social Security Number: ___________________

Insurance Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is complimentary.
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, orthopedic/neurological evaluation, range of motion, motion and/or static palpation, leg check $60-$150.
- **Chiropractic Adjustment-** The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $35-$60.
- **X-rays-** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $60-$110 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Jeffrey Moody, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signature____ **Date**_______________

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH, AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

PRINT PRACTICE MEMBER'S NAME HERE **PRACTICE MEMBER'S SIGNATURE**

XRAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

PLEASE NOTE: IF CLINICALLY NECESSARY X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.**
THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF SUNSET CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

PRINT YOUR NAME HERE **DATE**

SIGNATURE **YOUR AGE**

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT SUNSET CHIROPRACTIC.

SIGNATURE **DATE**