PATIENT DATA SHEET

General Information

First Name _____ M.I._____ Last Name _____
Called Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____

Sex Male Female
Marital Status Single Married Separated Divorced Widowed
Birthdate _____ / _____ / _____
Social Security _____
Referred By _____

Work Status Employed Full-time student Part-time student
Employer: _____
Job Title: _____

Payment Method:
Health Insurance Cash Worker's Comp Auto Insurance

Insurance Information – Office Use Only

Plan Carrier _____ Card Holder _____
Insurance ID _____
Group No _____
Customer Service _____
Benefits Primary Secondary Other
Effective Date ____ / ____ / _____

Is this provider in Network? Y / N

Benefit Information – Office Use Only

Contact Name: _____ Date: _____
CA Initials: _____ Time: _____

Co-Pay? Y / N Amount Per Visit $_____
Co-pay covers? Office Visit **Y / N** Manipulation **Y / N** Radiology **Y / N** Therapies **Y / N**
Deductible applied? **Y / N** IND $_____ Amt. Satisfied $_____
FAM $_____ Amt. Satisfied $_____
Is there **coinsurance**? **Y / N** _____% Insurance Covers _____ % Patient Covers
Out of Pocket Max? IND $_____ Amt Used $_____Including deductible? **Y / N**
FAM $_____ Amt. Used $_____
Max Visits per Year _____ How many exhausted? _____
Is there a dollar amount max for chiropractic? **Y / N** Amt. $_____ Amt. Used $_____
Other Information:
_____
_____
_____

Reference No: _____

Patient Intake Form

Date: ___________________________ Name: ____

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: ________________________________

If "NO" please skip to next section

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: ____

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: _________________

Briefly describe the accident, injury or illness:____

____

____

____

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom

______________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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List any tests, studies or medications received for this condition:

❑Tests/Studies: ______ ❑Medications: ______

Where you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ______________________Transported by? ❑Ambulance ❑Police ❑Other: ____________________

Date Admitted: _______________ Date Released: ____________ Length of Stay: ______________

List the hospital procedures received: ____

List symptoms you are experiencing today: Choose the severity level associated with each symptom

______________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Do you have any current work restrictions due to your current condition?

Off work: ❑Yes ❑No ❑Previously From: ____________________ To: ____________________

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) ___________________________________

What type of work do you do?____

____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No _____

_____

List any past conditions you may have had: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	❑

HABITS

❑Current Every Day Smoker ❑Current Some Day Smoker **EXERCISE**

❑Former Smoker ❑Never Smoker ❑None

❑Drinking Alcohol: (Cups/day): _____ ❑Coffee Cups/Day: _____ ❑Moderate

❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _____ ❑Daily

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No
If Yes, please indicate the following:

Medication: _____ Medication: _____
Route: Oral Route: Oral
Intravenous Intravenous
Other: _____ Other: _____
Frequency: _____ Frequency: _____
Began Use: _____ Began Use: _____
Discontinued Use: _____ Discontinued Use: _____

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Intravenous Intravenous
Other: _____ Other: _____
Frequency: _____ Frequency: _____
Began Use: _____ Began Use: _____
Discontinued Use: _____ Discontinued Use: _____

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Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
	Back Operation		Hernia	_____	Gall Bladder
	Female Organs		Thyroid	_____	Stomach

Other _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom?

For what ailments were these X-rays taken?

PAST OR CURRNET SYMPTOMS

GENERAL SYMPTOMS

- ❑ Allergy(What) ____ _____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

EYE/EAR NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?

_____ Last Pap Date

_____ Last Menstrual Cycle

Disclosure statement: All health care fields (chiropractic, medical, dental, etc…) have the potential to help there is also a risk for injury. Chiropractic care has been extensively studied and proven to be the safest and most inexpensive form of health care. We have and will continue to take the necessary steps to keep our services as natural, safe and effective as we are capable of for you, your family and our community.

Office Financial Policy

1. PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

Payment can be made with cash, check, debit or credit card.

2. HEALTH INSURANCE

It is important that you understand that health and accident insurance policies are an arrangement between you and your insurance carrier. **YOU ALONE ARE RESPONSIBLE FOR ALL CHARGES INCURRED IN OUR OFFICE**. We expect payment in full when services are rendered until your insurance coverage is verified

Insurance companies base your coverage ability on things other than your health (ie. Your policy, national averages etc.) Our recommendations are always based on your health, your goals and our experience. Ultimately it is your investment in your health that determines what we will and will not do.

It has been our experience that insurance companies never pay for wellness care. Any and all wellness care therefore is your responsibility.

Payment of your Co-pays, deductible, and coinsurance (the portions your insurance does not pay) is expected at each visit unless other payment arrangements have been made in writing. In cases where your coverage is 100%, payment may not be required.

3. WORK COMP/ AUTO-PERSONAL INJURY

Verification of coverage is needed **before** we can file your claim for you.

All necessary information to file your claim must be provided at your first visit. You are responsible for all charges incurred in our office.

-I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims; including, but not limited to, hospital or medical service companies, insurance companies, worker compensation carriers, welfare funds, or patients employer.

-I understand all incurred costs used to collect payment are the responsibility of the patient. All extra costs will be added to my account

-I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health status.

-I authorize Excel Chiropractic and the appropriate personal to retain my debit/credit card information on file to use to keep my account current. I realize that the information will only be used with prior notice from an Excel Chiropractic team member.
-I authorize Excel Chiropractic and the appropriate personal thereof to disclose the results of my DOT examination to include but not limited to current or perspective employers, state employees, law enforcement, federal employees, or as deemed necessary by Excel Chiropractic.

Card number: _____ Exp. Date: _____ CVC: _____ Type: Visa / MasterCard / Discover

Signature: _____ Date:_____

Permission to Treat a Minor (To be completed if patient is under age 18)

I, (Parent or Guardian) _____ (please print) give Excel Chiropractic permission to examine, x-ray and treat:

(Patient)_____ (Print Please)

Signature: _____ Date: _____