INTAKE FORM

Patient Information

Patient Name _____
(last)

_____
(first) *(middle initial)*

Address _____

City _____ State _____ ZIP _____

Home Phone (___)_____ Cell Phone (___)_____

Email Address _____

SS# _____ Sex □ M □ F

Birth date _____ Age _____

Occupation _____

Employer _____

Work Phone (___)_____ Extension _____

□Married □Widowed □Single □ Minor
□Separated □Divorced □Partnered for _____ years

IN CASE OF EMERGENCY

Name _____ Relationship _____

Home Phone (___)_____ Cell Phone (___)_____

Which of the following of our marketing have you seen?

□ Direct mail □ Friend: _____
□ Internet □ Magazine(Which One _____)
□ Radio □ Talk:_____
□ Sign □ Other:_____

What specifically prompted you to choose us for your healthcare needs? _____

_____

Name of Primary Care Provider:
_____

City, State: _____

Last check up: _____

Are you under a doctor's care at the present time? □ Yes □ No

If yes, for what? _____

Name of Doctor: _____

City, State: _____

Insurance Information

Primary Subscriber _____

Relationship to Patient_____

Insurance Co. _____

ID # _____

Is there a Secondary Insurance? ☐ Yes ☐ No

Insurance Co. _____

ID # _____

ASSIGNMENT AND RELEASE

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay _____ the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of any health insurance or medical plan benefits directly to _____ for medical services rendered and for any supplies, tests, or medications provided. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other legal remedies necessary in connection with same. I hereby assign directly to _____ all current and prior rights, if any, to payment and benefits and all legal and other health plan rights that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). This assignment includes, but is not limited to, a designation that _____ personnel can act on my / our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to _____as a result of services rendered by _____ and authority to pursue any and all remedies to which I / we may be entitled, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

FINANCIAL POLICY

We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, Mastercard and Care Credit. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Rep.

_____ _____
Date Relationship to Patient

Medical History

Gynecologic History

Are you currently pregnant? ☐ Yes ☐ No
Pregnancies #:_____ Dates: _____
Deliveries #_____ Natural delivery or C-section? _____
Menstrual: Onset:_____ Duration: _____
Are they regular? □ Yes □ No
Pain associated? □ Yes □ No
Last menstrual period: _____

General History (Check all that apply to you)

__AIDS/HIV
__Alcoholism
__Allergy Shots
__Anemia
__Anorexia
__Appendicitis
__Arthritis
__Asthma
__Bleeding Disorders
__Blood Transfusion
__Breast Lump
__Bronchitis
__Bulimia
__Cancer
__Cataracts
__Chemical Dependency
__Chest pain
__Chicken Pox
__Cholera
__Constipation
__Diabetes
__Eating Disorder
__Emphysema
__Epilepsy
__Fractures
__Gallbladder Disorder
__Glaucoma
__Goiter
__Gonorrhea
__Gout
__Heart Attack
__Heart Disease
__Hepatitis
__Hernia
__Herniated Disk
__Herpes
__High Blood Pressure
__High Cholesterol
__Hormone Replacement Therapy
__Hypertension
__Jaundice
__Kidney Disease
__Liver Disease
__Malaria
__Measles
__Migraine Headaches
__Miscarriage
__Mononucleosis
__Multiple Sclerosis
__Mumps
__Nervous Breakdown
__Osteoporosis
__Pacemaker
__Parkinson's Disease
__Pinched Nerve
__Pleurisy
__Pneumonia
__Polio
__Prostate Problem
__Prosthesis
__Psychiatric Care
__Rheumatoid Arthritis
__Rheumatic Fever
__Scarlet Fever
__STD
__Stroke
__Suicide Attempt
__Swelling feet
__Thyroid Problems
__Tonsillitis
__Tuberculosis
__Tumors, Growths
__Typhoid Fever
__Ulcers
__Vaginal Infections
__Whooping Cough
__Other:
_____
_____

Medications

Medications: ***Dosages:***

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
(Use back of sheet if additional space is needed.)

Birth Control: _____

Medication Allergies: ***General Allergies:***

_____ _____
_____ _____
_____ _____

Do you have any surgical devices in your body? *(i.e. screws, pins, plates, etc?*
If yes, where are they located?_____

ACTIVITY LEVEL

Select one of the following:

☐ Inactive: no regular physical activity with a sit-down job

☐ Light Activity: no organized physical activity during leisure time

☐ Moderate Activity: Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.

☐ Heavy Activity: consistent lifting, stair climbing, heavy construction, etc. or regular participation in jogging, swimming, cycling or active sports at least three times per week.

☐ Vigorous Activity: participation in extensive physical exercise for at least 60 minutes per session, 4 or more times per week.

Family History

Possible Hereditary Diseases:_____

_____

_____

_____

Social Habits

***Habits*:** (please select all that apply)

□ Smoking	Packs/day: _____
□ Alcohol	Drinks/week: _____
□ Coffee/Caffeine drinks	Cups/day: _____
□ High Stress level	Reason: _____

Surgical History

Past Surgical History_____

_____

_____

_____

_____

_____

_____

_____

_____

Nutrition

Present Height: _____ feet _____ inches

Present Weight: _____ lbs.

Ideal Weight: _____lbs.

Weight at age 20: _____lbs.

Do you eat/snack after your evening meal? YES / NO

If yes, what and how much do you eat? _____

_____

What beverages do you drink throughout a day? _____

_____

PHYSICAL MEDICINE CURRENT CONDITIONS

Reason for Visit?_____

When did your symptoms appear?_____

Is this condition getting progressively worse? □Yes □No □ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: □Sharp □Dull □Throbbing □Numbness □Aching □Shooting

□Burning □Tingling □Cramps □Stiffness □Swelling □Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your □Work □Sleep □Daily Routine □Recreation

Indicate activities which are painful to perform: □ Sitting □ Standing □ Walking □ Bending □Lying Down

What treatment have you already received for your condition? □ Medication □ Surgery □ Physical Therapy

□ Chiropractic Services □ None □ Other_____

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Date of Last: Physical Exam_____ Spinal Exam/X-Ray_____ Lab work_____

Chest X-Ray_____ MRI, CT-Scan, Bone Scan_____

Is your condition due to an accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other: _____

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Work Comp. ☐ Other

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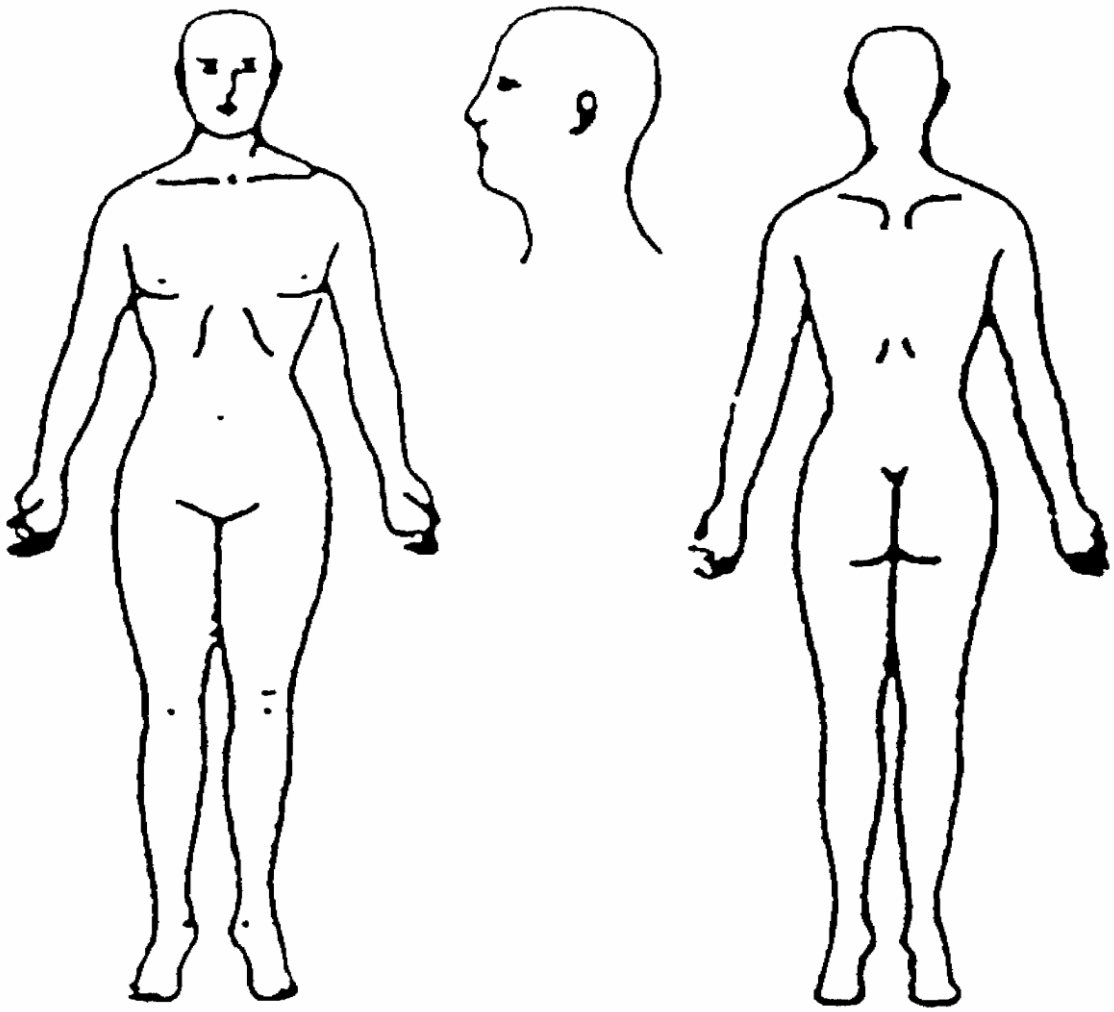
Name _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain and include all affected areas. You may draw on the face as well.

Aches ΛΛΛΛ Numbness oooo Pins/Needles ⌘⌘⌘⌘ Burning xxxx Stabbing ////



Indicate the severity of your symptoms by marking an "X" on the lines below:

How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe

healthfirst
WELLNESS CENTERS

X-ray Consent:

I authorize the use of diagnostic x-rays if the doctor deems it necessary or advised in my treatment. Every effort will be taken by the doctor to conform with the Illinois Department of Radiation Bureau's Regulations when it comes to radiation exposure.

Signature_____ Date_____

Minor:

I am the Parent/Legal Guardian of _____ and authorize the use of diagnostic x-rays if the doctor deems it necessary or advised in my treatment. Every effort will be taken by the doctor to conform with the Illinois Department of Radiation Bureau's Regulations when it comes to radiation exposure.

Parent/Legal Guardian Signature_____ Date_____

Females Only:

Pregnancy Release:

I certify that, to the best of my knowledge, I am not pregnant. I authorize the use of diagnostic x-rays if the doctor deems it necessary or advised in my treatment. Every effort will be taken by the doctor to conform with the Illinois Department of Radiation Bureau's Regulations when it comes to radiation exposure. I have been advised that certain x-ray examinations, especially of the pelvis, can be harmful to an unborn child.

Signature_____ Date_____

HIPPA and Cancellation Policy

NAME: _____ **ADDRESS: _____**

DATE OF BIRTH _____ **_____**

HIPPA Release of Medical Records:

I authorize any, legal representative, attorney, medical, psychological, psychiatric, osteopathic or chiropractic physician, any other medical practitioner of healthcare provider, hospital, clinic, rehabilitation facility to disclose information from the medical and health care records/bills of the injured person. I understand that the specific type of information to be disclosed includes but not limited to, breakdown of any settlement, medical records/bills, including history, treatment, diagnosis, and billing records. This authorization also permits discussion in person, by telephone, electronically, or by mail.

Consent to Treatment & Release of Information:

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment. I authorize the release of any medical information necessary to process this claim. Risks and benefits to therapy have been explained to me.

Cancellation Policy

In order to provide equal opportunity to all our patients and provide the best care possible, we really need your cooperation with keeping up with your appointments. Maintaining your schedule will help us give you the best clinical outcome possible. So please:

Please kindly give 24-hour notice if you are unable to keep your appointment, otherwise you will be charged a cancel fee:

Physical Therapy/Chiropractic Cancel Fee-$60
Dietician Cancel Fee-$60
Massage Cancel Fee - $60
Nurse Practitioner Cancel Fee- $30
Naprapathic Cancel Fee- $75
Court Representation Hourly-$300

I certify that I have read this form and understand its contents. I agree to the terms and agree to abide

Name: _____ *Date: _____*

Signature: _____

Financial Disclosure and Responsibility

In some instance your insurance carrier may deem the services as not payable. In the event that my health insurance plan determines a service to be "not payable", I agree to pay the costs of all services provided.

If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

_____ _____

Customer Signature Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

I,_____, hereby authorize Health First Wellness Center to charge my credit card below for agreed upon services as stated in the Financial Disclosure and Responsibility clause above. I understand that my information will be saved to file for future transactions on my account.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

Click or tap to enter a date.

_____ _____

Customer Signature Date