Apex Chiropractic and Wellness Intake Form

120 Unionville Indian Trail Road C-102, Indian Trail, NC 28079
(704) 821-5000
apexchiropracticnc@gmail.com

PATIENT INFORMATION

Patient Name _____
Address_____
City_____ State _____ Zip Code _____
Home Phone _____
Cell Phone _____
Email _____
Sex M ☐ F ☐ Age _____ Birthday _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Employer/School _____
Occupation _____
Height _____ Weight _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

HOW CAN WE HELP YOU?

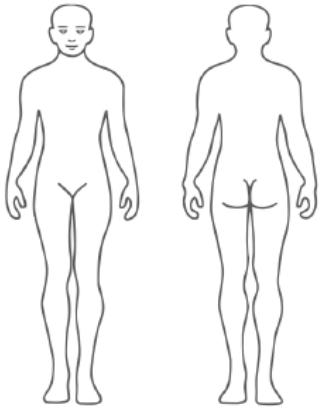
What brings you in today? _____
_____

Have you every experienced this before? _____

What makes it feel better? _____ What makes it feel worse? _____

How bad is it? How intense are your symptoms? (circle) 0 1 2 3 4 5 6 7 8 9 10

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness
☐ Tingling
☐ Stiffness
☐ Dull
☐ Aching
☐ Cramping
☐ Nagging
☐ Sharp
☐ Shooting
☐ Burning
☐ Throbbing
☐ Stabbing
☐ Swelling
☐ Other _____

IMPACT OF YOUR SYMPTOMS

How is the symptom/condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other_____	☐	☐	☐	☐

How committed are you at correcting this issue? 0 1 2 3 4 5 6 7 8 9 10

Not Committed Very Committed

HEALTH AND ILLNESS HISTORY

Please check the box besides any present or past history you've had.

☐ AIDS/HIV
☐ Alcoholism
☐ Anxiety
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma/Allergies
☐ Back Pain
☐ Cardiovascular Issues
☐ Cancer
☐ Circulation Issues
☐ Childhood Illness
☐ Depression
☐ Diabetes
☐ Digestive Issues
☐ Elbow/Wrist/Hand Issues
☐ Endocrine Issues (Thyroid)
☐ Foot/Ankle Issues
☐ Gout
☐Headache/migraines
☐Heart disease
☐Hepatitis
☐Hip Issues
☐Immune Issues
☐Lymphatic Issues
☐Multiple Sclerosis
☐Neck Pain
☐Reproductive Issues
☐ Ringing in ears
☐ Scoliosis
☐ Shoulder Issue
☐ Stroke
☐ TMJ Issues
☐ Urinary Issues
☐ Osteoporosis
☐ Other _____
_____

☐ Accidents/Broken Bones _____
☐ Hospitalizations _____
☐ Surgeries _____

FAMILY HISTORY

Check if you have any family history of:

High Blood Pressure ☐ If yes, who _____
Diabetes ☐ If yes, who _____
Cancer ☐ If yes, who _____
Stroke ☐ If yes, who _____
Heart Attack ☐ If yes, who _____
Other ☐ If yes, who _____

CHILDREN AND PREGNANCY

How many children do you have? _____
Childrens' ages? _____
Childrens' health concerns? _____

Are you currently pregnant? ☐ No ☐ Yes, I'm due _____
Number of past pregnancies _____
Health concerns with pregnancies? _____

ALLERGIES, MEDICATIONS, AND SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT WELLNESS

What are your health goals?
IMMEDIATE/LONG TERM _____
Have you ever been to a chiropractor before? ☐ Yes ☐ No
If Yes, how long ago? _____
How did you hear about us?
☐ Google/Yelp ☐ Social Media ☐ Website ☐ Street Advertisement
☐ Referral, if so who _____

How are you paying?
☐ Cash ☐ Medicare ☐ Insurance If yes, who _____

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and herby assign at clinic's request, and convey directly to Apex Chiropractic and Wellness all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I herby authorize any plan administrator o fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement, or any applicable remedies. I herby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I herby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage under any insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from the above names doctor and clinic to the extent permissible under the law to claim such medical benefits, insurance reimbursements and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurer and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understood this agreement.

_____ _____
Signature of Insured/Guardian Date