Patient Intake Form

1 About You

Today's Date:		File #:	
Patient's Name:			
What do you prefer to be called:			
D.O.B.:	Age:	SS #:	❑ Male ❑ Female
Complete Mailing Address:			
Home Phone:		Work Phone:	
Other Phone:		E-Mail Address:	
Referred By:			
Employer:		How Long?	
Employer's Complete Address:			
Occupation:		❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	
Spouse's Name:		Do you have children? ❑ No ❑ Yes How Many?	

2 Insurance Information

Company Name:	
Complete Mailing Address:	
Phone #:	Group #:
Insured's Name:	Insured's SS #:
Relation to Patient:	Insured's D.O.B.:
Insured's Employer:	

Please inform the front desk if you have a second source of insurance.

3 Reason For Visit

The reason for this visit is a result of: ❑ Auto Accident ❑ Chronic Illness or Pain ❑ Sports ❑ Trauma ❑ Work

Explain what happened:

Please describe the pain and its location:

When did condition begin? | Is this condition getting worse? ❑ No ❑ Yes; If yes, is it: ❑ Constant ❑ Comes and goes

Is this condition interfering with any of the following? ❑ Work ❑ Daily Routine ❑ Sleep

Have you had this or similar conditions in the past? ❑ No ❑ Yes If yes, explain:

Have you seen a Medical Doctor for this condition? ❑ No ❑ Yes If yes, by whom or where?

Have you been treated by a Chiropractor before? ❑ No ❑ Yes If yes, by whom? Phone:

4 In Event of Emergency

In an emergency, whom should we contact?	
Relation:	
Home Phone:	Work Phone:
Who is your Medical Doctor?	
Phone #:	

5 Health History

Do you have or have you had any of the following diseases or conditions?

❑ Arthritis	❑ Lower Back Problems	❑ Artificial Bones/Joints
❑ Chemotherapy	❑ Diabetes/Tuberculosis	❑ Difficulty Breathing
❑ Asthma	❑ Fainting/Seizures/Epilepsy	❑ Sinus Problems
❑ Ulcers/Colitis	❑ Severe/Frequent Headaches	❑ Kidney Problems
❑ Rheumatic Fever	❑ High/Low Blood Sugar	❑ Psychiatric Problems
❑ Anemia	❑ Frequent Neck Pain	❑ Emphysema/Glaucoma
❑ Cancer	❑ HIV/AIDS	❑ Shingles
❑ Hepatitis	❑ Alcohol/Drug Abuse	❑ Venereal Disease
❑ Artificial Valves	❑ Congenital Heart Defect	❑ Mitral Valve Prolapse
❑ Heart Murmur	❑ Heart Attack/Stroke	❑ Heart Surgery/Pacemaker

List any other serious medical condition(s) you have or have ever had:

List anything that you are or may be allergic to:

List previous surgeries/treatments, with dates:

List any past serious accidents, with dates:

List any family history you think we should know about:

Are you taking any of the following medications?

❑ Blood Thinners	❑ Muscle Relaxers	❑ Stimulants
❑ Dietary Pills	❑ Nerve Pills	❑ Tranquilizers
❑ Insulin	❑ Pain Killers (including aspirin)	❑ Other

Supplements/Vitamins? ❑ Yes ❑ No | Do you exercise? ❑ No ❑ Yes; If yes, how many hours ___ Day ___ Week | Special diet? ❑ Yes ❑ No

Do you smoke? ❑ No ❑ Yes If yes, how much do you smoke? How long have you smoked?

What is the age of your mattress? Is it comfortable? ❑ Yes ❑ No

For women patients only –

Birth Control Pills? ❑ Yes ❑ No | Pregnant? ❑ No ❑ Yes /wks | Nursing a baby? ❑ Yes ❑ No

6 Account Information

Person ultimately responsible for account:

Name: Relation:

Complete Billing Address: Work Phone #:

SS #: Driver's License #:

Payment Method ❑ Cash ❑ Check ❑ Credit Card: ❑ Visa ❑ M/C ❑ Amer. Exp. ❑ Other________ Card #:____________________ Exp. Date:________

By my initials________, I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company.

7 Additional Information

1. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or managed care organization to release any information required to process insurance claims.
2. I understand that payment in full, for all services rendered, is requested at the time of visit, unless other arrangements have been made beforehand with the business office. If my account is not paid within 90 days of the date of services and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, and other expenses incurred in collecting my account.
3. I understand the above information and guarantee, to the best of my knowledge, that this form was completed correctly. I understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature____ Date ____________________

Dr Kelly's Health & Healing Grotto

Patient Health Questionnaire

Patient Name________________________ Date______

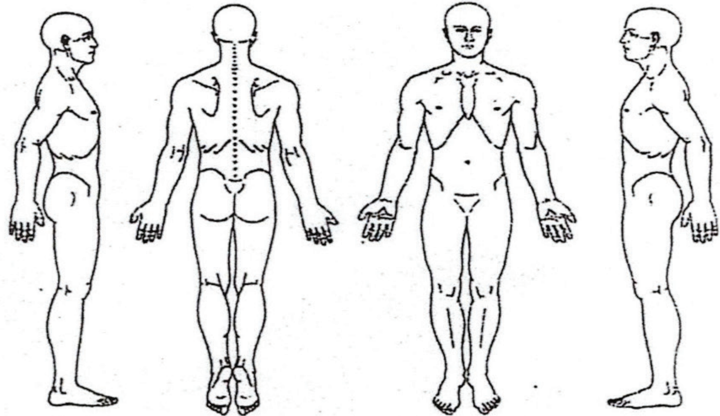
1. When did your symptoms start:________________ Describe your

____

____

2. How often do you experience your symptoms?
① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?
① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

7. What activities make your symptoms worse: ________________

8. What activities make your symptoms better: ________________

9. Who have you seen for your symptoms?
① No One ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. When and what treatment? ________________

b. What tests have you had for your symptoms and when were they performed?
① Xrays date:__________ ③ CT Scan date:__________
② MRI date:__________ ④ Other date:__________

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?
① This Office ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

11. What is your occupation?
① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student ⑦ Retired ⑧ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?
① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

12. What do you hope to get from your visit/treatment (select all that apply):
① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature________________________ Date ____________

Medication List

Date:___________

Patient:_____________________________________ DOB:__________________

ALLERGIES: ◊ KNA or List:____

List all prescribes and over the counter medications, supplements, herbs, salves and ointments. Remember to update with start and stop date. If exact date is not known, enter approximate date or "UNKOWN". If no medications, please write NONE on top line. Doctor should document that list was reviewed.

Medication Name	Dose	Frequency	Method taken (oral,inject,etc)	Date started	Date stopped

Medical Information Release Form

(HIPAA Release Form)

Name: ________________________________ **Date of Birth:** _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____________________________________

[ ] Child(ren)_________________________________

[ ] Other_____________________________________

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:__________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _______________________________________

The best time to reach me is (*day*)__________________ between (*time*)_________

Signed: ____________________________________ Date: ____/____/_____

Witness:____________________________________ Date: ___/____/______

2025 No Show / Cancellation Policy

I___________________________, understand and agree that I am personally responsible for payment of appointments missed without notice in advance and that it is NOT the responsibility of the insurance carrier or any third-party payor to make payments on my missed appointments.

I also understand that my card will be charged a fee of $25.00 dollars if I do not call to cancel or am a no-show for my appointment without sufficient/proper notice.

Massage appointments require a 24 hour or more cancellation and WILL BE CHARGED the full amount of the service if not cancelled in sufficient time.

OUTSTANDING ACCOUNT BALANCES:

If I have not made payment on my account over 60 days, I also agree that this card may be used for payment of any outstanding monies due BY ME. The office agrees to submit to me a receipt of payment upon charges for services rendered and unpaid after 60 days.

A copy of this form shall be as valid as the original

Name:____

Address:____

Credit Card #:____ Expiration:___________

CVC:__________

Email:____

Signature:____ Today's Date: _____________