



1. PATIENT INFORMATION

Full Name: Preferred Name: Date of Birth: Address: City: State: ZIP: Phone (Cell): Home: Email: Occupation: Employer: How did you hear about us? Emergency Contact: Relationship: Phone:

2. INSURANCE INFORMATION

Primary Insurance Company: Insurance ID #: Group #: Policy Holder Name: DOB: Relationship to Patient: Secondary Insurance Company (if applicable): Insurance ID #: Group #: Policy Holder Name: DOB: Relationship to Patient:

3. REASON FOR TODAY'S VISIT

Primary reason for visit: When did this condition begin? Is this condition due to an accident or injury? Type of accident: Auto Work Sports Slip / Fall Other

4. HEALTH HISTORY

Please check any of the following conditions you have or have had in the past.

- Arthritis, Osteoporosis, Kidney Disease, Asthma, Seizures, Liver Disease, Cancer, Fibromyalgia, Ulcers, Diabetes, Migraines / Headaches, Herniated Disc, Heart Disease, Depression / Anxiety, Scoliosis, High Blood Pressure, Respiratory Disorder, Pacemaker, Stroke, Digestive Disorder, Pregnancy, Thyroid Disorder, Autoimmune Disorder, Other:

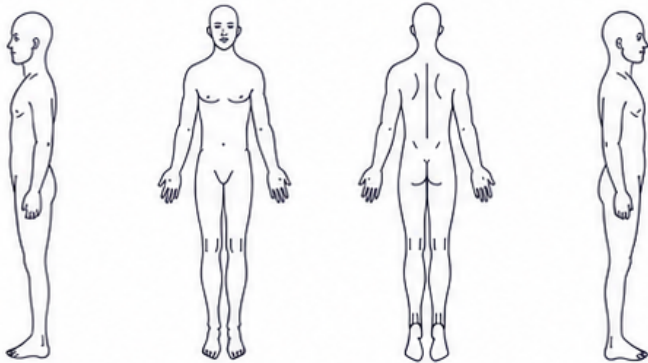
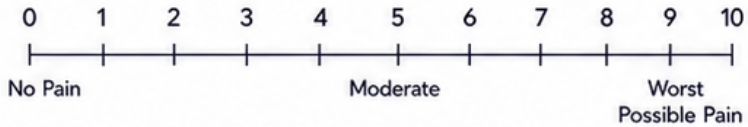
Do you smoke? Do you drink alcohol? Do you exercise regularly? How would you rate your overall health? Family Physician: Last Physical Exam:

5. MEDICATIONS, SUPPLEMENTS, ALLERGIES & PAST SURGERIES

Current Medications, Vitamins / Supplements, Allergies, Past Surgeries / Hospitalizations

**6. PAIN ASSESSMENT**

Rate your pain right now:



**PLEASE MARK ANY AREAS OF PAIN:**



At its best (0-10): \_\_\_\_\_ At its worst (0-10): \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

**7. CHIROPRACTIC INFORMED CONSENT**

I understand that chiropractic care may include spinal manipulation, mobilization, soft tissue therapy, therapeutic exercise, and other adjunctive therapies.

I understand the purpose, benefits, and known risks associated with chiropractic care, including but not limited to:

- Temporary soreness
- Aggravation of pre-existing conditions
- Rare risks, including disc injury, stroke, or fracture

I have had the opportunity to ask questions and have them answered to my satisfaction.

I consent to the examination and care deemed necessary by my provider.

I may refuse or stop care at any time.

Initials: \_\_\_\_\_

**8. MEDICARE PATIENTS – IMPORTANT INFORMATION**

Medicare coverage for chiropractic services is limited.

**✓ Medicare COVERS ONLY:**

- Spinal manipulation to correct a subluxation.

**✗ Medicare DOES NOT COVER:**

- Examinations (initial or re-examinations)
- X-rays (if taken in our office)
- Therapies (e.g., soft tissue, electrical stimulation, traction)
- Orthotics, supports, or braces
- Maintenance or wellness care

**Active Care vs. Maintenance Care**

Active Care: Treatment expected to improve a condition or function.

Maintenance Care: Ongoing care to maintain current function or prevent decline. Medicare does not cover maintenance care.

I understand that I am financially responsible for any services not covered by Medicare.

Initials: \_\_\_\_\_

**9. FINANCIAL POLICY & ACKNOWLEDGMENTS**

- Payment is due at the time of service unless other arrangements have been made.
- I authorize release of information necessary to process insurance claims.
- I assign all insurance benefits to Chiropractic Resonance and Integrative Nutrition, LLC.
- I am financially responsible for any balance not covered by insurance.
- Some services offered may not be covered by insurance and may be provided on a cash basis. These services will be discussed prior to treatment.

By initialing below, I acknowledge that I have read, understand, and agree to the above policies and information.

Initials: \_\_\_\_\_

**10. REQUIRED ACKNOWLEDGMENTS – PLEASE CHECK ALL THAT APPLY**

I acknowledge that I have received the Notice of Privacy Practices.

I acknowledge that I may receive an Advance Beneficiary Notice (ABN) when required.

I have read and understand the Cancellation / No-Show Policy.

I understand that late cancellations (less than 24 hours) or no-shows may be subject to a fee.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



*Where structure meets flow, movement begins.*



Thank you for choosing Chiropractic Resonance and Integrative Nutrition, LLC.