CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your photo ID and insurance card(s). All information you supply is confidential.

INITIAL INTAKE FORM

Today's Date (MM/DD/YYYY)

Patient Number (office use only)

Whom may we thank for referring you?

Birth Date (MM/DD/YYYY)

Age

Gender
◯ Male ◯ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (of Initial)

Address

City

State

Zip Code

Home Phone

Cell Phone

Email Address

Cell Carrier

Emergency Contact Name & Phone Number

Your Occupation

Your Employer

Primary Care Provider's Name and Phone Number

Insured's First and Last Name

Insured's DOB

Insurance Carrier

Policy Number

Address & Phone Number

Smoking Status (age 13 and over)
◯ Never ◯ Former
◯ Current Daily ◯ Occasional
◯ Heavy ◯ Light

Marital Status ◯ Married
◯ Single ◯ Divorced
◯ Widowed ◯ Separated

Preferred Language

Spouse's Name

Child's Name and Age

Child's Name and Age

Child's Name and Age

Work Phone

May we contact you at work?
◯ Yes ◯ No

Preferred method of Contact?
◯ Home Phone ◯ Cell Phone
◯ Work Phone ◯ Email
◯ Text Messages

Patient (or Guardian's) signature

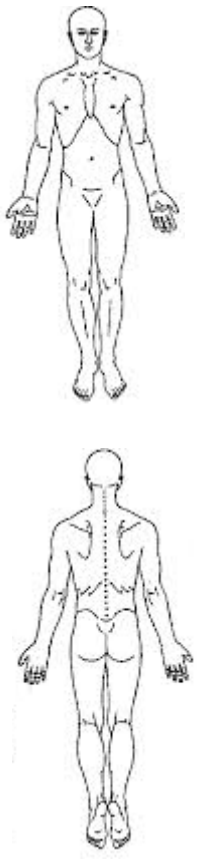
Date (MM/DD/YYYY)

Patient Name _____ **Patient Number** (office use only) _____

Please describe your Primary Complain in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint	**Secondary Complaint**	**Additional Complaint**
The primary symptom that prompted me to seek care today is: _____	The secondary symptom that prompted me to seek care today is: _____	The additional symptom that prompted me to seek care today is: _____
And are the result of:	**And are the result of:**	**And are the result of:**
◯ An accident or injury ◯ Work ◯ Auto ◯ Other_____	◯ An accident or injury ◯ Work ◯ Auto ◯ Other_____	◯ An accident or injury ◯ Work ◯ Auto ◯ Other_____
◯ A worsening long-term problem	◯ A worsening long-term problem	◯ A worsening long-term problem
◯ An interest in: ◯Wellness ◯ Other _____	◯ An interest in: ◯Wellness ◯ Other _____	◯ An interest in: ◯Wellness ◯ Other _____
Onset (When did you first notice your current symptoms?) _____	**Onset** (When did you first notice your current symptoms?) _____	**Onset** (When did you first notice your current symptoms?) _____
Prior interventions (What have you done to relieve the symptoms?)	**Prior interventions** (What have you done to relieve the symptoms?)	**Prior interventions** (What have you done to relieve the symptoms?)
◯ Prescription medication ◯Acupuncture	◯ Prescription medication ◯Acupuncture	◯ Prescription medication ◯Acupuncture
◯ Over the counter drugs ◯ Chiropractic	◯ Over the counter drugs ◯ Chiropractic	◯ Over the counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage	◯ Homeopathic remedies ◯ Massage	◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice	◯ Physical therapy ◯ Ice	◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat	◯ Surgery ◯ Heat	◯ Surgery ◯ Heat
◯ Other _____	◯ Other _____	◯ Other _____
Check any activities which aggravate this:	**Check any activities which aggravate this:**	**Check any activities which aggravate this:**
◯ Standing ◯ Lying down	◯ Standing ◯ Lying down	◯ Standing ◯ Lying down
◯ Bending ◯ Coughing	◯ Bending ◯ Coughing	◯ Bending ◯ Coughing
◯ Twisting ◯ Walking	◯ Twisting ◯ Walking	◯ Twisting ◯ Walking
◯ Sitting ◯ Lifting	◯ Sitting ◯ Lifting	◯ Sitting ◯ Lifting

Location
(Where does that hurt?) Circle the area(s) on the illustration.



1. What else should Dr. Enos know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____
Recreational activities: _____
Household responsibilities: _____
Personal relationships: _____

Check here if you have a family history of:

◯ Arthritis
◯ Diabetes
◯ Cancer
◯ Cardiovascular Disease

3. List all prescription drugs you now take: _____

4. List all prescription non-drugs you now take: _____

5. List all previous accidents: _____

6. Have you had any X-Rays/MRIs/CTs/etc? Where and When? _____

7. Have you ever been adjusted by a Chiropractor before? ◯ YES ◯ NO
Reason for those visits: _____
Doctor's Name: _____
Approximate Date of Last Visit: _____

Please check the type of care desired so that we may be guided by your wishes when possible:

◯ Temporary Relief ◯ Control of immediate pain ◯ Total healthcare ◯ I prefer the Dr. to select the type of care he feels is best for me

_____ **Patient (or Guardian's) signature**

_____ **Date (MM/DD/YYYY)**

Enos Chiropractic Center *12 Calef Street, Warwick, RI 02886* *p: 401-921-6550 f: 401-921-6552*

Patient Name _____ Patient Number _____
(office use only)

Acknowledgements

To set clear expectations, improve communication and help you get the best results in the shortest about of time, please read each statement and initial your agreement.

Initials _____ **I instruct Dr. Enos to deliver the care that, in his professional judgment, can best help in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials _____ **I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending doctor and it is the responsibility of the staff to carry out the instructions of such doctor.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials _____ **I grant permission to be texted to confirm or reschedule an appointment.**

Initials _____ **I grant permission to be emailed to confirm or reschedule an appointment.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **I understand that I am ultimately responsible for payment in full and agree to pay a $10 per month billing charge and a 1.25% monthly interest charge for all unpaid balances, which become 30 days past due. If necessary, I also agree to take full responsibility for all third party costs, including collection agencies, reasonable attorney fees and/or court costs incurred in attempting to collect this debt.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.**

_____ _____

Patient (or Guardian's) signature **Date (MM/DD/YYYY)**

_____ _____

Witness – Staff of Enos Chiropractic Center **Date (MM/DD/YYYY)**

12 Calef Street
Warwick, RI
02886

AUTO ACCIDENT QUESTIONAIRE

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occurred? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the incident? If yes, please describe. _____
11. Where were you sitting in the vehicle during the accident? _____
12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast as the other vehicle moving? _____
17. During and after the crash, what happened to your vehicle? (check all that apply)
    ◯ kept going straight ◯ spun around ◯ spun around and hit a stationary object
    ◯ hit a car in front of yours ◯ hit by another vehicle ◯ hit stationary object
18. Did you lose consciousness during the accident? ◯ yes ◯ no
19. How was your head positioned during the accident? _____
20. How as your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? ◯ no ◯ yes, please describe _____
23. Did your face hit anything during the accident? ◯ no ◯ yes, please describe _____
24. Did your shoulders hit anything during the accident? ◯ no ◯ yes, please describe _____
25. Did your neck hit anything during the accident? ◯ no ◯ yes, please describe _____
26. Did your chest hit anything during the accident? ◯ no ◯ yes, please describe _____
27. Did your hips hit anything during the accident? ◯ no ◯ yes, please describe _____
28. Did your knees hit anything during the accident? ◯ no ◯ yes, please describe _____
29. Did your feet hit anything during the accident? ◯ no ◯ yes, please describe _____

12 Calef Street
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30. What kind of headrest was in your vehicle?
◯ movable fixed ◯ non-movable fixed ◯ no headrest

31. Where was the headrest positioned at your head? _____

32. Did you have your seatbelt on during the accident? ◯ yes ◯ no

33. Did you slide out of your seatbelt during the accident? ◯ yes ◯ no

34. What was damaged in your vehicle? (check all that apply)
◯ windshield ◯ rear bumper ◯ mirror ◯ steering wheel ◯ front bumper ◯ knee bolster
◯ dashboard ◯ trunk ◯ back right door ◯ back left door ◯ front left door ◯ front right door
◯ side window ◯ rear window ◯ seat frame ◯ completely totaled

35. Choose the items that dented inward:
◯ floorboards ◯ side door ◯ dashboard

36. Choose the doors that would not open as a result of the accident:
◯ front left ◯ front right ◯ rear left ◯ rear right

37. Did you go to the hospital? If no, why and do not answer #s 38-43 _____

38. How did you get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized overnight? _____

41. Where you prescribed anything at the hospital? (check all that apply)
◯ pain medication ◯ muscle relaxers ◯ neck brace ◯ other: _____

42. Did you receive any stitches for any cuts at the hospital? ◯ no ◯ yes, please describe _____

43. Were any X-Rays/CT scans/MRIs taken at the hospital? ◯ no ◯ yes, please describe _____

44. Since the accident, how have you been feeling? (check only one)
◯ getting worst since the accident ◯ getting better since the accident
◯ not getting worst or better since the accident

_____ _____

Patient (or Guardian's) signature **Date (MM/DD/YYYY)**

NOTES: (office use only)