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

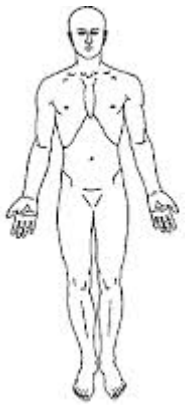
Date (MM/DD/YYYY)

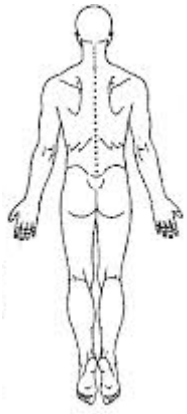
Patient Name _____ **Patient Number** (office use only) _____

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)**