1747 Smizer Station Rd, Ste 4, Fenton, MO 63026
Phone: 636-825-6555 Fax: 636-825-6546
Dr. Emily Odom – Dr. Katie Etnier

Patient Intake Forms (14 yrs old & Up)

Full Name:_________________________________ Date of Birth:__________ Date of Exam:__________

Address:____

City:_______________________________________ State:__________ Zip Code:__________________

Social Security Number:____________________ Email Address:__________________________________

Home Phone:_________________ Cell Phone: _____________________ Work Phone:_______________

Employer:_____________________________ Occupation: ______________________________________

Spouse's Name: ________________________________ Spouse's Date of Birth: ____________________

Emergency Contact: __________________________ Emergency Contact's Phone: __________________

Who may we thank for you referral:____

Payment Information

Person Responsible for Payment: ____

Social Security Number: __________________ Phone: __________________ Date of Birth: ___________

Insurance Information

Do you have health insurance? _____ Yes _____ No	
Primary Insurance	**Secondary Insurance**
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's DOB:	Policy Holder's DOB:
Group Number:	Group Number:
Member ID Number:	Member ID Number:
Please have your insurance card & driver's license ready so they can be copied for the clinic's records.	

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Patient Health Questionnaire

Height: _____________ Weight: ______________

Do you exercise? ☐ Yes ☐ No Hours per week:_____ What activities? __________________________

Are you dieting? ☐ Yes ☐ No Since: _____ Do you smoke? ☐ Yes ☐ No ______ packs per day

How many years have you been smoking? ____

Do you drink alcoholic beverages? ☐Yes ☐ No ____ drinks per day

Do you wear? ☐ Heel lifts ☐ Arch supports ☐ Prescription Orthotics

For women: Are you pregnant or nursing? ☐ Yes ☐ No If pregnant, How many weeks? _____________

Date of last menstrual period? ______________________

List all prescription, non-prescription medications & other supplements you take as well as the associated condition:

____
____
____

List all surgeries or hospitalizations you have had complete with month and year for each:

____
____
____

List anything you are allergic to: ____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

____
____

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History of Treatment

Primary care physician: ______________________________________ Phone: ______________________

Date last seen: _________________ May we updated them on your condition? ☐Yes ☐No

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, name of Chiropractor: ___________________

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider:

____

Medical History

Describe the reason(s) for your doctor visit today:

____
____
____
____

Are here because of an accident? ______________________ What type? _________________________

When did your symptoms start? ____

How did your symptoms begin? ____

How often do you experience symptoms? **(Circle one)** Constantly Frequently Occasionally Intermittently

Describe your symptoms? **(Circle all that apply)** Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? **(Circle one)** Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?

____
____

Have you experienced these symptoms in the past? ____

Chiropractic Family

Wellness Center

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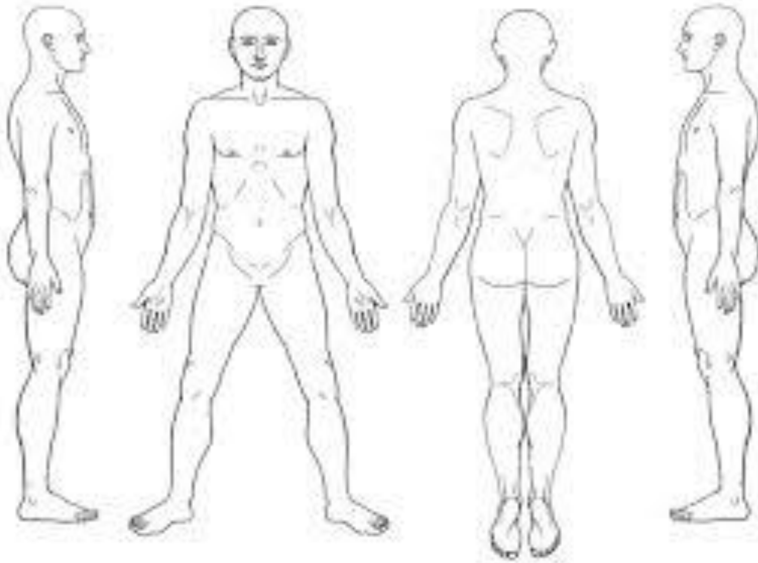
Description of Condition

Mark any area(s) of discomfort with the following key:

A= Ache N= Numbness B= Burning T= Tingling S= Stiffness O =Other



Right   **Front**   **Back**   **Left**

On a scale of one to ten how intense are your symptoms? Not intense 1 2 3 4 5 6 7 8 9 10 Unbearable

Additional comments you would like the doctor to know:

____

____

____

____

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For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition
		Abdominal Pain			High Blood Pressure
		Abnormal Weight gain/loss			Hip/upper leg pain
		Allergy Headaches			HIV/AIDS
		Angina			Hormone Therapy
		Ankle/foot pain			Jaw pain
		Arthritis			Joint swelling/stiffness
		Asthma			Kidney stones
		Bladder Infection			Knee/lower leg pain
		Birth Control Pills			Liver/ Gall Bladder Disorder
		Cancer			Loss of Bladder Control
		Chest Pains			Low back pain
		Chronic Sinusitis			Mid back pain
		Depression			Neck pain
		Dermatitis/Eczema			Painful urination
		Dizziness			Prostate problems
		Drug/Alcohol Use			Shoulder pain
		Elbow/upper arm pain			Smoking/tobacco use
		Epilepsy			Stroke
		Excessive thirst			Systematic Lupus
		Frequent Urination			Thoracic Outlet Syndrome
		General Fatigue			Tumor
		Hand Pain			Ulcer
		Heart attack			Upper back pain
		Hepatitis			Wrist pain

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Consent for Treatment/HIPAA

Assignment & Release

By signing below, I authorize Chiropractic Family Wellness Center to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Chiropractic Family Wellness Center, and I agree that a reproduced copy for this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am a guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

Cancellation Policy

I understand and agree to inform the office if I am unable to make my scheduled appointment. I agree to call at 2 hours ahead of my scheduled appointment time. If I do not call within this time frame, I understand that there may be a $25 cancellation/no call fee that is added to my account. I understand that this fee will my responsibility and is unable to be billed to my insurance. For any massage appointment that is missed or canceled less than six hours prior to scheduled appointment, I understand that I may be charged up to full price of the massage.

HIPAA & Authorization to Release

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. I understand that should I need a more detailed account of my policy and procedures concerning the privacy of the my Patient Health Information, I am welcome to read the HIPAA Notice that is available at the front desk before signing this consent. Copayments, coinsurance, and/or deductible are due at time of service.

In order for our office to provide **ANY** information to your spouse, parent, relative, or other designates, we must have you permission. (This would include appointments schedules, X-Rays, receipts, insurance information, health records and any other information that pertains to your treatment.) You may indicate your permission by listing names here:

My information may be shared with: (List Names & Relationship to patient)

Patient Name: ____

Patient/Parent/Guardians Signature: ______________________________________ Date:___/___/___

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Payment Policy

Due to the increasing high deductible health plans, we are now asking all patients to store a credit card on file with us. Your card will not be charged until after we submit your claims to your health plans. You will only be responsible for any amount that your health plan indicates that you owe. We will not charge your card if you do not owe anything.

Note:
When your credit card information is entered, it is encrypted and cannot be viewed or accessed by our organization. Your system is registered with Visa and MasterCard and independently certified as a PCI-DSS Level One Service Provider.

Authorization:
Until further notice, I authorize CHIROPRACTIC FAMILY WELLNESS CENTER to charge the patient responsible balance on my account to the following credit card.
Choose One: **□ Visa** **□ Mastercard** **□ Discover** **□Use Card on File**

Last Four Digits of Credit Card Number: _________
Expiration Date (mm/yy): __________

I understand that once the health plan has paid their portion of my care that I will receive an explanation of benefits (EOB). The health plan EOB will state any balance remaining to be paid by me. I agree that CHIROPRACTIC FAMILY WELLNESS CENTER may charge my credit card the balance due when they receive a copy of the EOB. I also understand that CHIROPRACTIC FAMILY WELLNESS CENTER may charge my credit card at time of visit for any copays and/or open balance due as well, if they determine that a prior balance exists.

I understand that if, after payments by credit card, I later dispute the charges, unless prohibited by law, I agree not to cancel, revoke, chargeback or dispute any previously entered charge on my credit card. If I do so, and it is later determined that the charge was properly authorized, I agree to pay all out of pocket fees and costs incurred by the CHIROPRACTIC FAMILY WELLNESS CENTER as a result of improper cancellation, revocation, chargeback or dispute.

I understand that I may cancel this authorization at any time by contacting CHIROPRACTIC FAMILY WELLNESS CENTER. This authorization will remain in effect until canceled.

Please notify me 7 days in advance of charging my card on file by:

□ Email at the following email address ____

□ Phone call at the following phone number ____________________________________

____ Date Signed _____________
Patient Signature
____
Printed Name
____
Patient Name (if different than above)

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Authorization for Care of a Minor

I hereby grant permission to Chiropractic Family Wellness Center to perform chiropractic examinations and therapeutic procedures including but not limited to spinal adjustments, ultrasound, heat/ice application, electrotherapy, and manual muscle therapy that are considered safe and effective methods of care.

I understand that any procedure intended to help may have complications. While the chances of experiencing complications are small it is the practice of this clinic to inform out patients about them. These complications include, but not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for specific cure or result.

Minor's Printed Name: ____

Minor's Date of Birth: _____/_____/_____

Printed name of Parent/Guardian: ____

Signature of Parent/Guardian: ____

Today's Date: _____/_____/_____