INNER GATE
HEALTH & WELLNESS

Chiropractic Intake

Name: _____ Preferred Name: _____ Date: _____

Preferred Pronouns: _____ Date of Birth: _____ Age: _____

Gender (for insurance purposes): _____ Marital Status (for insurance purposes):: _____

Phone: _____ Email Address: _____

Home Address: _____ City: _____ State: _____ Zip code: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about our office? _____

When/how did your complaints first begin? _____

Have you had these complaints before? Yes / No Date of prior condition: _____

List chief symptoms in order of severity:
1) _____ 2) _____ 3) _____

What activities are most bothersome? _____

What relieves your symptoms? _____

How would you describe your pain? _____ Is your pain getting: worse / better / same

Have you seen anyone else for this condition? Yes / No If yes, who? _____

Have you had chiropractic care before? Yes / No If so, when was your last visit? _____

Current Medications: _____

_____

Allergies (medicine, food, environment): _____

Previous surgeries/hospitalizations: _____

Previous imagining (X-rays/MRI/CT, list date): _____

Last physical examination: _____ Primary care doctor: _____

OBGYN: Are you pregnant? Yes / No

Workers Compensation:

Is your condition due to an Employment Related Injury? Yes / No

Have you reported it? Yes / No Date of incident: _____

Supervisor: _____ Supervisor contact #: _____

Automobile Accident:

Is your condition due to an automobile accident? Yes / No If yes, please fill out separate form

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Dr. Jerrod Puckett, DC and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative nonsurgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer. I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Inner Gate Acupuncture for any reason, I will be responsible for payment of my entire outstanding balance. We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature _____Date_____

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being _____, age_____, do hereby authorize, request & direct Inner Gate Health & Wellness, it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required. It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained. As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____ Date Signed _____

Witness: _____

Health History & Assessment

Exercise: 0 1 2 3 4 5 6 7 days/wk _____minutes. Type_____

Alcohol use: drinks/week. Tobacco use: packs/day, other tobacco use: _____

Do you have any **family** history of: arthritis, stroke, cancer, heart disease, diabetes, thyroid problems, heart attack.

Please indicate if you have experienced any of the following conditions or symptoms:

General

- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ AIDS or HIV
- ❑ Fatigue
- ❑ Recent unexplained weight loss
- ❑ Decreased energy
- ❑ Loss of appetite
- ❑ Night sweats
- ❑ Fever or chills
- ❑ Recurrent infections
- ❑ Skin ulcers or rashes
- ❑ Excessive thirst

Neuromusculoskeletal

- ❑ Stroke
- ❑ Paralysis
- ❑ Seizures
- ❑ Mental disorders
- ❑ Fractures
- ❑ Dislocations
- ❑ Orthopedic problems
- ❑ Rheumatoid arthritis
- ❑ Gout
- ❑ Lupus
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Change in vision, smell, hearing or taste
- ❑ Light headedness
- ❑ Dizziness/vertigo
- ❑ Arthritis
- ❑ Loss of consciousness
- ❑ Difficulty speaking or swallowing
- ❑ Headaches
- ❑ Numbness or tingling
- ❑ Difficulty walking
- ❑ Change in mood or behavior

Cardiovascular

- ❑ Pacemaker
- ❑ Defibrillator
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Irregular heartbeat
- ❑ Heart attack
- ❑ Congestive heart failure
- ❑ TIA
- ❑ Peripheral vascular disease
- ❑ Blood clotting or bleeding disorder
- ❑ Anemia
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Nose bleeds
- ❑ Swollen ankles
- ❑ Redness or swelling of a limb
- ❑ Unusual bruising
- ❑ Bleeding gums
- ❑ Swollen lymph nodes

Respiratory

- ❑ Asthma
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ COPD
- ❑ Cough or change in cough
- ❑ Blood in sputum
- ❑ Wheezing
- ❑ Difficulty breathing

Digestive

- ❑ Liver disease
- ❑ Hepatitis
- ❑ Ulcers
- ❑ Gall stones
- ❑ Appendicitis
- ❑ Pancreatitis
- ❑ Reflux disease
- ❑ Stomach pain
- ❑ Pain or difficulty swallowing
- ❑ Indigestion
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bloating
- ❑ Excessive gas or belching
- ❑ Blood in stool
- ❑ Black stools

Genitourinary

- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Prostate enlargement
- ❑ Burning with urination
- ❑ Blood in urine
- ❑ Increased frequency of urination
- ❑ Difficulty with urination
- ❑ Loss of bladder or bowel control
- ❑ Change in menstrual bleeding

_____ Initial here if none of the listed symptoms or conditions apply to you.

I have personally read and completed this form. Signature_____