

Welcome to Source Chiropractic and Wellness!

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| **Please fill in the following information with as much detail as possible. Thank you.** | | | | | | | | |
| Name | | | | | | | Date | |
| Referred by | | | Email | | | | | |
| Cell Phone | | | Home Phone | | | | | |
| Address | | | City | | | State | | Zip |
| Age | DOB | SS# | | Married / Single / Other | | | | |
| Names / Ages of Children | | | | | | | | |
| Emergency Contact Name | | | | | Phone | | | |
| Your Occupation | | | | | Work Phone | | | |
| Would you like a text reminder for your appointments? If so, please list your current carrier: | | | | | | | | |

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|  | **Primary Insurance** | | |
| Insurance Co. Name |  | | Phone |
| Insurance Co. Address |  | | |
| Insured Name |  | Insured Relationship to Patient | |
| Insured DOB | Insured ID/Claim # | | Group # |

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|  | **Secondary Insurance** | | |
| Insurance Co. Name |  | | Phone |
| Insurance Co. Address |  | | |
| Insured Name |  | Insured Relationship to Patient | |
| Insured DOB | Insured ID/Claim # | | Group # |

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| **Lifestyle questions. You may be brief; we’ll go into more detail if necessary.** |
| Main purpose for consulting for care? |
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| Is your symptom(s) related to an accident? Work Injury Motor Vehicle Accident Other Injury |
| Is there currently a claim or lawsuit open or pending regarding this injury? |
| If yes, please provide the name and phone number to your attorney: |
| Have you experienced chiropractic care before? Yes / No If yes, was it a positive / negative or neutral experience? |
| Are you taking any medications? Yes / No If yes, please list the name and purpose of each below. |
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| What percent of your diet consists of fruits and vegetables? % |
| How many ounces of water do you consume on average, daily? ounces |
| How much protein do you consume? None / Once in a while / Weekly / Daily / Multiple times per day |
| How much dairy do you consume? None / Once in a while / Weekly / Daily / Multiple times per day |
| How much alcohol do you consume? None / Once in a while / Weekly / Daily / Multiple times per day |
| Do you smoke? Never / Once in a while / Weekly / Daily / Multiple times per day |
| Do you exercise? Never / Once in a while / Weekly / Daily / Multiple times per day |
| Are you healthier now than you were 5 years ago? |
| What do you prefer for your symptom(s)? Ice / Heat |
| When do you generally feel your best? A.M / Noon / P.M. |
| When do you generally feel your worst? A.M / Noon / P.M. |
| Do you own a juicer? If so, how often do you juice? Monthly / Weekly / Daily / Multiple times per day |
| Do you take supplements? If so, please list. |
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| How committed to your health are you? Not 1 2 3 4 5 6 7 8 9 10 Extremely |

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| **Describe your main concern.** |  | **Describe your second concern.** |
| What? | What? |
| How did it start and when? | How did it start and when? |
|  |  |
| What does it feel like? Deep / Dull / Achy / Sharp | What does it feel like? Deep / Dull / Achy / Sharp |
| What makes it worse? | What makes it worse? |
| What makes it better? | What makes it better? |
| How often? Daily / Weekly / Monthly | How often? Daily / Weekly / Monthly |
| Is it constant? | Is it constant? |
| How severe? 1 (low) – 10 (high) | How severe? 1 (low) – 10 (high) |
| What all have you tried to do to resolve it? | What all have you tried to do to resolve it? |
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| **Circle P (previously) or C (currently) if applicable** | | | | | |
| P | C | Headaches / Migraines | P | C | Anxiety / Depression |
| P | C | Insomnia / Difficulty Sleeping | P | C | Chronic Fatigue / Chronic Tiredness |
| P | C | Dizziness / Vertigo | P | C | Lack of Mental Clarity |
| P | C | Sinus Trouble | P | C | Allergies If so, where? |
| P | C | Earaches / Infection | P | C | Vision Problems and or Ear Problems |
| P | C | Stiff Neck | P | C | Acne / Pimples / Eczema / Psoriasis |
| P | C | Thyroid Condition / Throat Condition | P | C | Adrenal Condition |
| P | C | Excessive Sweatiness | P | C | Excessive Dryness |
| P | C | ADD / ADHD / OCD | P | C | Asthma / Wheezing |
| P | C | Difficulty Breathing / Lung Condition | P | C | Heart Condition / Palpitations / Surgeries |
| P | C | Nausea / Vomiting | P | C | Frequent Flu / Cough / Colds |
| P | C | STD’s | P | C | Fibromyalgia |
| P | C | Immune System Challenges | P | C | Parkinson’s Disease |
| P | C | Gallbladder Condition / Removed / When? | P | C | Fevers |
| P | C | Liver Condition | P | C | Blood Pressure Challenges / High / Low |
| P | C | Poor Circulation / Arms / Hands / Legs / Feet | P | C | Diabetes / Type I / Type II / Insulin? |
| P | C | Slow to Heal from Cuts | P | C | Cancer |
| P | C | Arthritis | P | C | Indigestion |
| P | C | Heartburn | P | C | Ulcers |
| P | C | Kidney Challenges / Stones | P | C | Gas Challenges |
| P | C | Constipation / Diarrhea | P | C | Diarrhea |
| P | C | Bladder Challenges | P | C | PMS – Emotional / Mood Swings |
| P | C | Impotency | P | C | Stroke |
| P | C | Menstrual Cramps / Irregular Cycle | P | C | Sciatica |
| P | C | Knee Pain | P | C | Joint Pain |
| P | C | Leg Cramps / Nightly / Daily / Weekly / Monthly | P | C | Multiple Sclerosis |
| P | C | Hemorrhoids | P | C | TMJ / Jaw Problems |
| P | C | Grinding Teeth at Night | P | C | Shoulder Pain / Left / Right |
| P | C | Other: | P | C | Other: |

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| **Please list all surgeries, fractures, injuries and/or accidents you have experienced in your life (include dates).** |
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*Almost done! Lastly, we want to be absolute certain that agreements are in place in order to avoid any disagreements…*

# PHILOSOPHICAL AGREEMENT

I hereby agree and understand that health is a state of optimal physical, mental and social well-being, not merely the absence of disease. I understand that all doctors of Source Chiropractic and Wellness do not offer diagnosis or treatment for specific diseases. Our only practice objective is to eliminate interference to the expression of the body’s innate healing capacity and to create an alkaline environment that supports your body to integrate, update and hold the chiropractic adjustment.

# ASSIGNMENT, AUTHORIZATION AND FINANCIAL AGREEMENT

I hereby consent to a chiropractic evaluation and examination, NCM or Thermography scans, x-ray(s), chiropractic treatment(s)/adjustments, supplements, healthy lifestyle information (books, CD’s, DVD’s etc), activities of daily living information or laboratory procedures rendered to the client which Dr. John Cheney may consider or advise in the treatment of my case and guarantee payments of the charges incurred. I hereby assign and authorize payment of insurance benefits directly to Source Chiropractic and Wellness. I hereby authorize the above named doctor to release information requested on this form and I further authorize release of any and all medical records or other pertinent information necessary to obtain payment. I understand that payment is due at the time service is rendered, and the above named doctor/ Source Chiropractic and Wellness will not accept the responsibility for filing of collection my insurance claim of benefits or negotiation a settlement with my insurance company. I know I am responsible for payment of my account and I understand and agree that I am ultimately responsible to ensure that all services needing pre-authorization by my insurance company are pre-authorized and that any balances for denied services, deductibles, coinsurances and copays are my responsibility to pay.

# TERMS

Net 30 days from the date of the invoice unless otherwise indicated above. A finance charge of 1 ½ per month (annual percent rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.

*I have read the above statements and understand Source* *Chiropractic and Wellness’ objectives pertaining to my care in this office.*

Signature *\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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