Apex Chiropractic and Wellness Intake Form

120 Unionville Indian Trail Road C-102, Indian Trail, NC 28079
(704) 821-5000
apexchiropracticnc@gmail.com

PATIENT INFORMATION

Patient Name _____
Address_____
City_____ State _____ Zip Code _____
Phone _____
Email _____

Sex M ☐ F ☐ Birthday _____ Age _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Employer/School _____
Occupation _____
Height _____ Weight _____

IN CASE OF EMERGENCY, CONTACT
Name _____
Relationship _____
Contact Number _____

Have you ever been to a chiropractor before? ☐ No ☐ Yes; how long ago_____
How did you hear about us?
☐ Google/Yelp ☐ Social Media ☐ Website ☐ Street Advertisement ☐ Referral, if so who_____

HOW CAN WE HELP YOU?

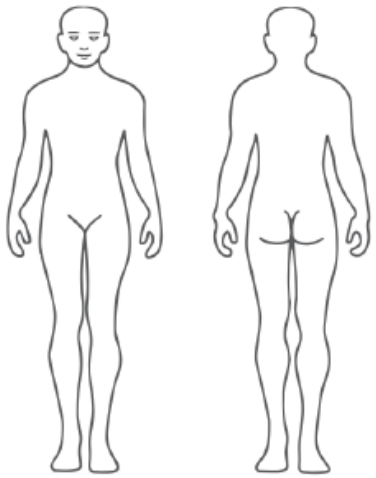
What brings you in today? _____
_____

Have you every experienced this before? _____

What makes it feel better? _____ What makes it feel worse? _____

How bad is it? How intense are your symptoms? (Circle) 0 1 2 3 4 5 6 7 8 9 10

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (Check where appropriate)

☐ Numbness
☐ Tingling
☐ Stiffness
☐ Dull
☐ Aching
☐ Cramping
☐ Nagging
☐ Sharp
☐ Shooting
☐ Burning
☐ Throbbing
☐ Stabbing
☐ Swelling
☐ Other _____

Anything else bothering you today? _____

IMPACT OF YOUR SYMPTOMS

How is the symptom/condition interfering with your life? (Check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severely Effected
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐

HEALTH AND ILLNESS HISTORY

Please check the box besides any present or past history you've had.

☐ AIDS/HIV
☐ Alcoholism
☐ Anxiety
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma/Allergies
☐ Back Pain
☐ Cardiovascular Issues
☐ Cancer
☐ Circulation Issues
☐ Childhood Illness
☐ Depression
☐ Diabetes
☐ Digestive Issues
☐ Elbow/Wrist/Hand Issues
☐ Endocrine Issues (Thyroid)
☐ Foot/Ankle Issues
☐ Gout
☐Headache/migraines
☐Heart disease
☐Hepatitis
☐Hip Issues
☐Immune Issues
☐Lymphatic Issues
☐Multiple Sclerosis
☐Neck Pain
☐Reproductive Issues
☐ Ringing in ears
☐ Scoliosis
☐ Shoulder Issue
☐ Stroke
☐ TMJ Issues
☐ Urinary Issues
☐ Osteoporosis
☐ Other _____
_____

☐ Accidents/Broken Bones _____
☐ Hospitalizations _____
☐ Surgeries _____

FAMILY HISTORY

Check if you have any family history of:
Father side: ☐ High Blood Pressure ☐ Diabetes ☐Cancer ☐ Stroke ☐ Heart Attack ☐ Other_____
Mother side: ☐ High Blood Pressure ☐ Diabetes ☐Cancer ☐ Stroke ☐ Heart Attack ☐ Other_____

CHILDREN AND PREGNANCY

Are you currently pregnant? ☐ No ☐ Yes, I'm due _____
How many children do you have? _____ Age of children? _____

ALLERGIES, MEDICATIONS, AND SUPPLEMENTS

ALLERGIES (list)
_____
_____
_____

MEDICATIONS (list)
_____
_____
_____

SUPPLEMENTS (list)
_____
_____
_____

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HEALTH CARE AUTHORIZATION FORM

THE PATIENT IDENTIFIED BELOW AUTHORIZES APEX CHIROPRACTIC AND WELLNESS TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

- Apex Chiropractic and Wellness may use your health information to provide or coordinate your medical treatment and services. We may also prove that information to other healthcare providers who may assist in your treatment.
- Apex Chiropractic and Wellness may use and disclose your health information so that the services you receive in this office may be billed and/or collected from you, an insurance company or a third party. We may need to share information with your insurer so as to receive proper reimbursement and/or obtain prior approval for treatment and services. We may also use and disclose health information to third parties that may be responsible for costs and expenses such as family members.

SPECIFIC AUTHORIZATIONS

- I give permission for Apex Chiropractic and Wellness to use my phone number or address to contact you to confirm upcoming appointments.
- I give permission to Apex Chiropractic and Wellness to use my address and/or phone number to contact you with birth cards, holiday related cards, sympathy cards, thank you cards, and information about health alternatives or other health related information.
- I give Apex Chiropractic and Wellness permission that any pictures that are sent to the office for non-medical purposes can be posted in the office. (Holiday cards, birth announcements)
- I give permission to Apex Chiropractic and Wellness to disclose health information to a family member or friend who assists in caregiving and/or accompanies a child to the office such as stepparent, nanny, grandparent, etc. *PLEASE NOTE ANY UNAUTHORIZED PERSONS.*
- Other uses and disclose of protected health information for any purpose other than those identified in this notice can be made with your written authorization or that of a legal guardian. At any time, you or your legal guardian may revoke the authorization in writing. We will no longer release information upon receipt of the notice but cannot take back disclosures already made with your permission.

By signing this form you are giving Apex Chiropractic and Wellness permission to use and disclose your protected health information in accordance with treatment, payment or healthcare operations.

Print Name of Patient: _____

Signature of Patient/Legal Guardian: _____ Date: _____

Please list on the following lines, persons that have your permission to have access to your health records.

1. _____ 2. _____