Pure Chiropractic And Wellness

2717 N. Grandview Blvd. Suite 101, Waukesha, WI 53188
(262) 349-9370 ● purechiropracticandwellness.com

Intake Form

DATE _____

PERSONAL INFORMATION

First Name: _____ M.I: ____ Last Name: _____

Preferred Name: _____

Address: _____

City / State / Zip: _____

Birth Date: ____-____-____ Age: _____ Sex: M F

Marital Status: Single Married Divorced Widowed Other Spouse's Name: _____

# of Children: _____ Children's Names & Ages: _____

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ Email: _____

Who can we thank for referring you or how did you hear about our office? :

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Pure Chiropractic and Wellness? _____

_____

When did this begin? (if applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your life? (list all that apply)

_____

Have you seen a chiropractor before? Yes ◯ No ◯

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (if applicable) _____

What is your level of commitment to yourself and your health? 1◯2◯3◯4◯5◯6◯7◯8◯9◯10◯

Explain: _____

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

_____

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Digestive Troubles
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Hypertension
- ☐ Arthritis
- ☐ Loss of Balance
- ☐ Neck/Back Pain
- ☐ Pain in Arms/Legs
- ☐ Irritability
- ☐ Fatigue/Sleep Issues
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Sensitivity to Light
- ☐ Loss of Concentration
- ☐ Memory Problems
- ☐ Headaches
- ☐ Stiffness/Flexibility
- ☐ Sinus Troubles/Allergies
- ☐ Cold Hands/Feet
- ☐ Other _____

Explain any boxes checked above or add additional concerns:_____

_____

_____

_____

_____

Is there anything else regarding your current condition you feel the doctor should know? _____

_____

_____

_____

MEDICATIONS

- ☐ Anxiety/Depression
- ☐ Blood Pressure
- ☐ Pain Narcotics
- ☐ Muscle Relaxers
- ☐ Migraine/Headache
- ☐ Cholesterol
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Explain any boxes checked above: _____

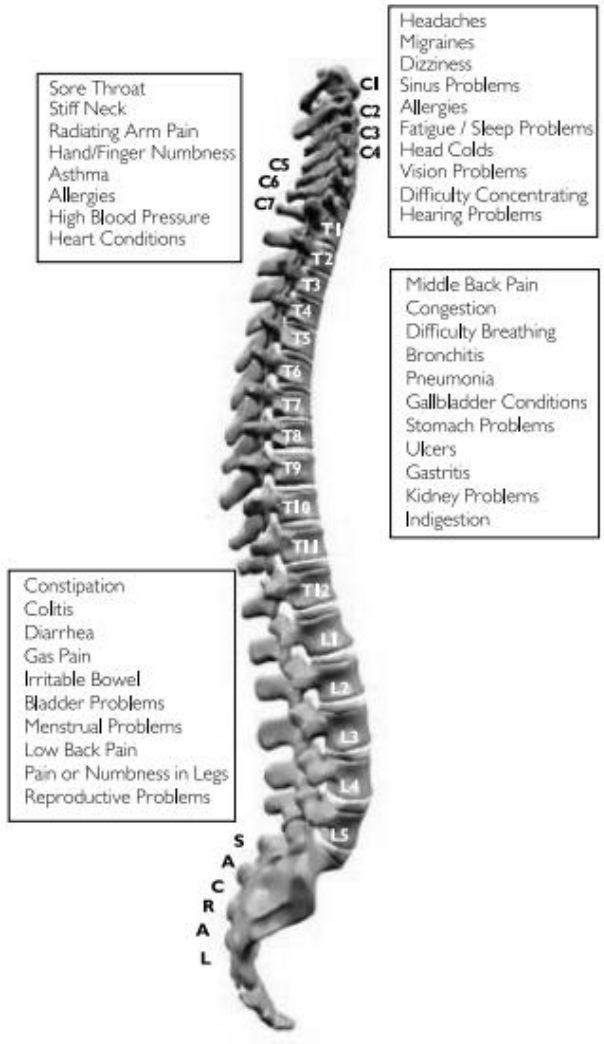
_____

_____

_____

DID YOU KNOW…

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



VITAMINS / SUPPLEMENTS

- ☐ Multi-Vitamin
- ☐ Vitamin D3
- ☐ _____
- ☐ _____
- ☐ Fish Oil/Omega-3
- ☐ Probiotics
- ☐ _____
- ☐ _____

Explain any boxes checked above:

_____

_____

_____

EMERGENCY CONTACT

First Name: _____ M.I.: ____

Last Name: _____

Preferred Name: _____

Address: _____

City / State / Zip: _____

Phone: ( ) _____ Relation: _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, your care plan must be followed.
- I authorize Pure Chiropractic and Wellness to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- In order to file your claims in a timely manner (if applicable), we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.
- This office will prepare any necessary reports and forms to assist me in making collection from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
- If you have any questions about our financial policies, please speak with our staff. If you need to make special payment arrangements, we will do everything possible to meet your financial needs.
- **FOR MINORS:** If the patient's parents are divorced, divisions of your child's treatment costs are the parent's responsibility. We do not split contracts. In signing, you are taking financial responsibility for your child's account payments.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature (for minors only): _____ **Date:** _____

CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic adjustments and other procedures by Dr. Heather Rogers King and her staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with Pure Chiropractic and Wellness personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I understand that Pure Chiropractic and Wellness will not be held responsible for any pre-existing medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of Pure Chiropractic and Wellness responsible for any errors or omissions that I may have made in the completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____