CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
Address_____
_____
City _____ State _____ Zip_____
Home Phone_____
Cell Phone _____
Email _____
Sex M F Age _____ Birthday _____
Married Widowed Single Minor
_____

Today's date:

Employer/School _____
Occupation _____
Spouse's Name _____
Spouse's Employer _____
Spouse's Occupation _____
IN CASE OF EMERGENCY, CONTACT
Name _____
Relationship _____
Contact number

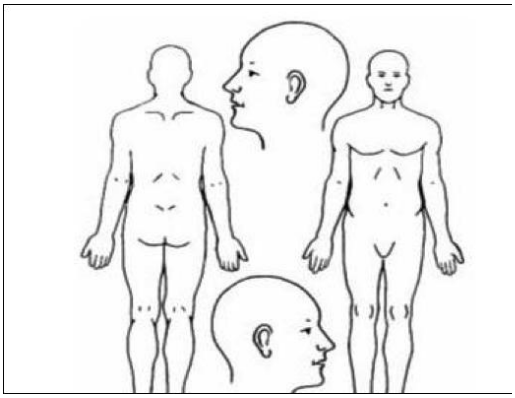
HOW CAN WE HELP YOU?

What brings you in today? _____
_____

If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle) NO SYMPTOMS 1 2 3 4 5 6 7 8 9 10 INTENSE

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



What does it feel like? (check where appropriate)

Numbness	Sharp
Tingling	Shooting
Stiffness	Burning
Dull	Throbbing
Aching	Stabbing
Cramping	Swelling
Nagging	Other_____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work					Energy				
Exercise					Attitude				
Recreation					Patience				
Relationships					Productivity				
Sleep					Creativity				
Self-Care					Other _____				

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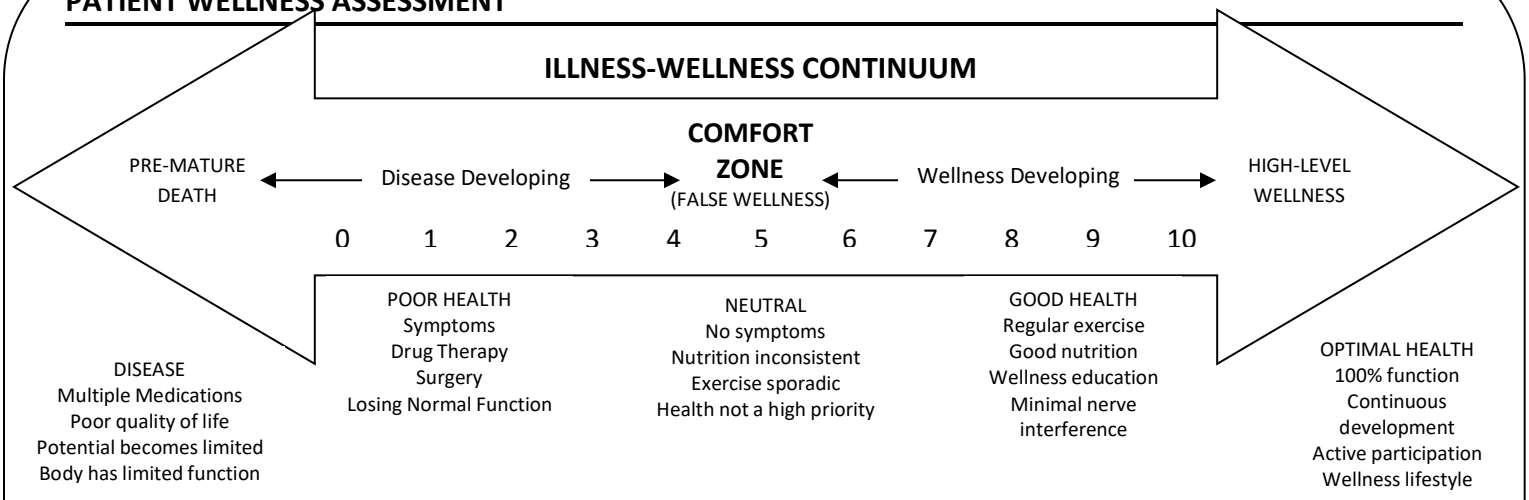
PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

CHILDREN AND PREGNANCY

How many children do you have? _____

Are you currently pregnant? No Yes, I am due _____

Childrens' ages? _____

Number of past pregnancies? _____

Childrens' health concerns?

Health concerns regarding this pregnancy?

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

AIDS/HIV	Circulation Issues	Headaches/Migraines	Ringing in the Ears
Alcoholism	Childhood Illness	Heart Disease	Scoliosis
Anxiety	Depression	Hepatitis	Shoulder Issues
Ateriosclerosis	Diabetes	Hip Issues	Stroke Issues
Arthritis	Digestive Issues	Immune Issues	TMJ Issues
Asthma/Allergies	Elbow/Wrist/Hand Issues	Lymphatic Issues	Urinary Issues
Back Pain	Endocrine Issues (Thyroid)	Multiple Sclerosis	Osteoporosis
Cardiovascular Issues	Foot/Ankle Issues	Neck Pain	Other _____
Cancer	Gout	Reproductive Issues	_____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

Please list.

ALLERGIES	MEDICATIONS	SUPPLEMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Office Policies: If I am accepted as a patient at Mahoney Family Chiropractic, I agree to pay for all services, including services not covered by my insurance company. I also acknowledge, that when I am given explanation of my benefits from the practice, it is not a guarantee of payment.

Signature:_____Date:_____

Parent/Guardian Signature:_____ Date: _____

CHIROPRACTIC INTAKE & HISTORY

MAHONEY FAMILY CHIROPRACTIC
COLCHESTER, VT / WAITSFIELD, VT
FINANCIAL AGREEMENT

Thank you for choosing us as your health care provider. We are committed to your care being successful. Please understand that payment of your bill is considered a part of your care. ***The following is a statement of our Financial Policy which we require you read and sign prior to any service.***

These policies apply only to the services actually performed, and in no way obligate you to continue the course of care recommended. If care is discontinued, any balances due for care received up to that date will become due immediately and payable in full, regardless of any claim submitted.

Payments are due at time of service.
We accept cash, checks, debit cards, Visa / Mastercard, Discover, and American Express

I have elected to use the following payment plan to finance my care at Mahoney Family Chiropractic:

Please circle the appropriate option below:

1. **CASH** - I will pay for services as they are rendered. **See us for pre-pay options to reduce fees .**

2. BC/BS of Vermont, CBA, Aetna, United Healthcare or CIGNA (please circle appropriate carrier) **-** I will be a cash patient until I can furnish the necessary forms and information for billing. I authorize my insurance carrier to pay Dr. Mahoney directly, based on my plan. **I will pay my initial deductible in full and the percentage agreed upon at the time of each visit**. If my insurance carrier fails to pay it's share, I will pay my due balance in full. I understand it is my responsibility to call my physician for any referrals necessary according to my plan.

3. OTHER INSURANCE - I have reimbursing insurance for which you are not a provider. **I will pay for services as they are rendered.** I will be given a receipt for each date of service and understand that I am responsible for my own billing.

4. MEDICARE - I will pay for services as they are rendered, and understand that I will be reimbursed by Medicare. Please see staff for special rates and procedures. I authorize Dr. Mahoney's office to bill my insurance carrier and provide any information needed to process my claim. I understand that any exam or x-ray fees are not covered by Medicare.

5. WORKER'S COMPENSATION - My employer has agreed to pay for services rendered by MFC. I will furnish the necessary information needed for billing. After verification is made, MFC will submit claims and await payment. I understand that I am responsible for any portion of this bill that my employer or its insurance carriers may refuse to pay.

6. PERSONAL INJURY - I have been injured due to an auto accident or personal injury. If all necessary documentation is provided and the case is approved, MFC will submit claims. See the Personal Injury Policy form for payment options, choose the option that applies to your situation and inform the front desk of your decision.

*** If my account balance should not be paid, and it is necessary for my account to be sent to a collections agency, I understand that I will be responsible for any recovery / collection fees.**

Print patient name: _____DOB: _____

Signature: _____ Date: _____