120 6th Avenue
Coon Rapids, IA 50058
Office Phone: (712) 999-2447
Natalie Lewis DC, CCSP, Cert Acupuncture

Patient Intake Form

Full Name: ______________________________ Date: __________

Date of Birth: ____________ Gender: ☐M ☐F Email: ______________________

Address: ______________________ City: ____________ State: ____ Zip: ______

Phone 1: ____________________ C H W Phone 2: ____________________ C H W

Job Status: ☐Not Employed ☐Employed ☐Retired ☐Student ☐Other: __________

Employer: ______________________ Occupation: ______________________

Marital Status: ☐Single ☐Married ☐Other: ____________________

Reason(s) for Visit: ☐New Patient ☐Adjustment ☐Physical
(check all that apply) ☐Therapy ☐Auto Accident ☐Workers Comp

Referred by: ☐Provider: ☐Family: ☐Friend:
____________ ____________ ____________

How did you hear about us? ☐Referral ☐Website ☐Facebook ☐Radio
(check all that apply) ☐Sign ☐Advertisement ☐Other: ______________

Emergency Contact: ______________ Relationship: __________ Ph: __________

Language Preferred: ______________ Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino
(If other than English)

Hand Dominance: ☐Right ☐Left ☐Ambidextrous

Relationship to Insured:
❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Name: ______________________ D.O.B: ________

Insured Address: ______________________________
____

Have you seen another provider for the same reason?
☐Yes ☐No

Have you received chiropractic care before?
☐Yes ☐No

Medical History

Medications/Vitamins/Supplements:

Allergies to Medications:

Illnesses (Past and/or Present): Please check all that apply

☐ AIDS/HIV	☐ Chronic Fatigue	☐ Heart Disease	☐ Miscarriage	☐ Seizures
☐ Anemia	☐ Depression	☐ Hepatitis	☐ Multiple Sclerosis	☐ Stroke
☐ Arthritis	☐ Diabetes	☐ Hernia	☐ Osteoporosis	☐ Suicide Attempt
☐ Asthma	☐ Emphysema	☐ Herniated Disc	☐ Pacemaker	☐ Thyroid Problems
☐ Bleeding Disorder	☐ Epilepsy	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Tuberculosis
☐ Breast Lump	☐ Fibromyalgia	☐ High Cholesterol	☐ Pinched Nerve	☐ Tumors/Growths
☐ Bronchitis	☐ Fractures	☐ Immune Deficiency	☐ Prostate Problems	☐ Ulcers
☐ Cancer	☐ Gallstones	☐ Kidney Disease	☐ Prosthesis	☐ Vaginal Infections
☐ Chemical Dependency	☐ Glaucoma	☐ Liver Disease	☐ Psychiatric Disorder	☐ Venereal Disease
☐ Chicken Pox	☐ Gout	☐ Migraine Headaches	☐ Rheumatoid Arthritis	☐ Whooping Cough

☐ Other:____

Surgeries:

1.______________________ Date: ________ 5.______________________ Date: ________

2.______________________ Date: ________ 6.______________________ Date: ________

3.______________________ Date: ________ 7.______________________ Date: ________

4.______________________ Date: ________ 8.______________________ Date: ________

Traumas/Broken Bones/Fractures:

1.______________________ Date: ________ 3.______________________ Date: ________

2.______________________ Date: ________ 4.______________________ Date: ________

Have you had any unexpected weight loss in the last 6 months? ☐ Yes ☐ No If so, how much?_______

Daily Habits: (check your typical habits)

Tobacco:	☐ Never	☐ Former Smoker	☐ Current Everyday		☐ Current Somedays
Caffeine:	☐ None	☐ 1-3/Day	☐ 4-6/Day	☐ 7-10/Day	☐ +10/Day
Alcohol:	☐ None	☐ 1-3/Wk	☐ 4-6/Wk	☐ 7-10/Wk	☐ +10/Wk
Exercise:	☐ None	☐ Light	☐ Moderate	☐ Heavy	
Stress:	☐ None	☐ Low	☐ Moderate	☐ Severe	
Overall Health:	☐ Very Good	☐ Good	☐ Average	☐ Poor	

Review of Systems

Check all that Apply

Musculoskeletal: ☐ None

☐ Arm/Hand Pain ☐ Back Pain ☐ Swelling of Joints ☐ Hip Pain ☐ Knee Pain ☐ Lower Back Pain ☐ Feet/Leg Pain
☐ Redness of Joints ☐ Neck Pain ☐ Shoulder(s) Pain ☐ Stiffness ☐ Foot/Leg Pain ☐ Muscle/Joint Pain ☐ Upper Back Pain

Head/Neck: ☐ None

☐ Dizziness ☐ Pain ☐ Facial Pain ☐ Headache ☐ Swollen Glands ☐ Hoarseness ☐ Jaw Clicks
☐ Migraines ☐ Lumps ☐ Grinding Teeth ☐ Stiffness ☐ Tooth Problems ☐ Sore Throat ☐ Trouble Swallowing
☐ Other: ______________________________

Cardiovascular/Respiratory: ☐ None

☐ Chest pain, pressure, or discomfort ☐ Difficulty breathing ☐ Coughing up phlegm ☐ Cold hands/feet ☐ Fainting
☐ Coughing up blood (hemoptysis) ☐ Shortness of breath ☐ Dizziness/lightheaded ☐ Wheezing ☐ Palpitations
☐ Tightness in chest ☐ Swelling (edema) ☐ Irregular heartbeat ☐ Persistent Cough
☐ Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea) ☐ Other: ______________

Eyes: ☐ None

☐ Blurred Vision ☐ Flashing Lights ☐ Burning ☐ Itching ☐ Redness
☐ Double Vision ☐ Glasses/Contacts ☐ Cataracts ☐ Pain ☐ Specks
☐ Vision Problems ☐ Glaucoma ☐ Dryness ☐ Other: ______________

Ears: ☐ None

☐ Buzzing in Ears ☐ Decreased Hearing ☐ Drainage ☐ Poor Balance
☐ Ringing in Ears (tinnitus) ☐ Ear Infections ☐ Earache ☐ Poor Hearing
☐ Other: ______________

Nose: ☐ None

☐ Allergies ☐ Blocked Sinuses ☐ Discharge ☐ Nose Bleeds
☐ Hay fever ☐ Sinus Pressure/Pain ☐ Itching ☐ Stuffiness/Blockage
☐ Excessive Mucus ☐ Other: ______________

Throat/Mouth: ☐ None

☐ Bleeding ☐ Dentures ☐ Braces ☐ Difficulty Swallowing ☐ Dry Mouth ☐ Swelling
☐ Hoarseness ☐ Sore Throat ☐ Redness ☐ Non Healing Sore ☐ Mouth Pain ☐ Thrush
☐ Sores on lips or tongue ☐ Tooth Pain ☐ Blue Lips ☐ Other: ______________

Urinary: ☐ None

☐ Frequent urinary tract infections ☐ Kidney Stones ☐ Kidney Infections ☐ Burning or Pain
☐ Unable to hold urine (Incontinence) ☐ Difficulty Urinating ☐ Frequent Urination ☐ Urgency
☐ Blood in Urine (hematuria) ☐ Up at night to urinate ☐ Water Retention ☐ Other: ______________

Gastrointestinal: ☐ None

☐ Yellow eyes or skin (jaundice) ☐ Change in appetite ☐ Heartburn ☐ Diarrhea
☐ Change in bowel habits ☐ Rectal bleeding ☐ Constipation ☐ Nausea
☐ Swallowing difficulties ☐ Other: ______________

Endocrine: ☐ None

☐ Change in appetite ☐ Cold intolerance ☐ Constipation ☐ Diarrhea
☐ Frequent urination ☐ Heat intolerance ☐ Sweating ☐ Dry skin
☐ Excessive Thirst ☐ Other: ______________

Vascular/Hematologic: ☐ None

☐ Calf pain with walking (claudication) ☐ Cold hands & feet ☐ Ease of bleeding ☐ Ease of bruising ☐ Leg cramping

Review of Systems *Continued*

Neurologic: ☐None

☐Dizziness ☐Easily angered/irritated ☐Fainting ☐Frequent Crying ☐Memory Confusion
☐Nervousness ☐Poor concentration ☐Tingling ☐Neuralgia ☐Numbness
☐Seizures ☐Suicidal thoughts ☐Tremors ☐Weakness ☐Worry/anxiety
☐Other:______________________________

Psychiatric: ☐None

☐Anxiety ☐Depression ☐Memory loss ☐Nervousness ☐Stress ☐Other:______________________________

Female:

Are you pregnant? ❍ Yes ❍ No Date of Last Period: ____________ Number of days between periods: ______

Age Started: _____ Age Stopped: _____

Number of Pregnancies: _____ Number of Deliveries: _____ Number of Miscarriages: _____

Number of Abortions: _____ Number of Cesareans: _____ Operations: ❍ Cervix ❍ Uterus ❍ Ovaries

Please check all that apply: ☐None

☐Clotting ☐Dark color ☐Discharge ☐Food cravings ☐Heavy bleeding
☐Hot flashes ☐Infections ☐Irregular periods ☐Itching or rash ☐Leg cramps
☐Light bleeding ☐Little/no sex drive ☐Menstrual pain/cramps ☐Missed periods ☐Mood swings
☐Painful breasts ☐Pain with sex ☐STD's ☐Vaginal discharge ☐Vaginal dryness
☐Vaginal Sores ☐Water retention ☐Other:______________________________

Male: ☐None

☐Painful urination ☐Prostate problems ☐Hernia ☐Other: ______________________________

My Certification:

I certify that the above information is correct and I request services. Furthermore, I hereby authorize Lewis Chiropractic PC to release any information pertinent to my case to any insurance company, adjuster, and/or attorney involved in this case; and hereby release Lewis Chiropractic PC of any consequences thereof. I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, copayments and any services reflected by my insurance company, and it is my responsibility to notify Lewis Chiropractic PC of any changes to this information.

Print Name: ______________________________

Signature: ______________________________ Date: ________________

Lewis Chiropractic PC

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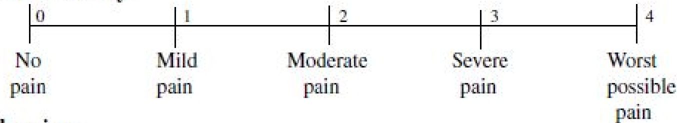
Functional Rating Index

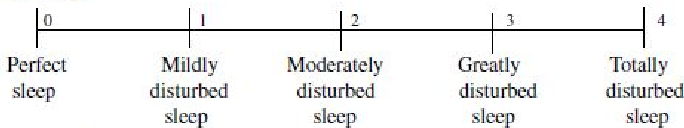
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

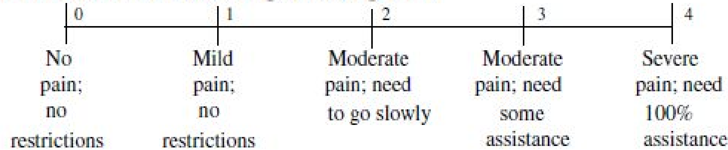
1. Pain Intensity



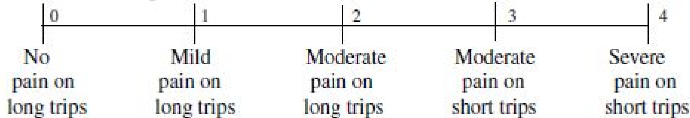
2. Sleeping



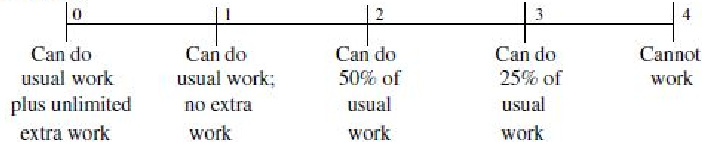
3. Personal Care (washing, dressing, etc.)



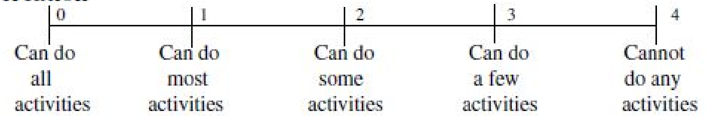
4. Travel (driving, etc.)



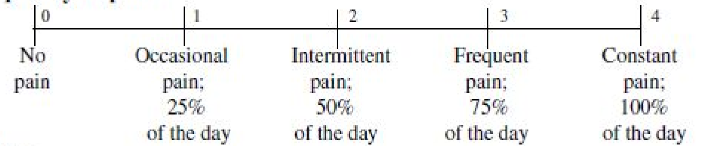
5. Work



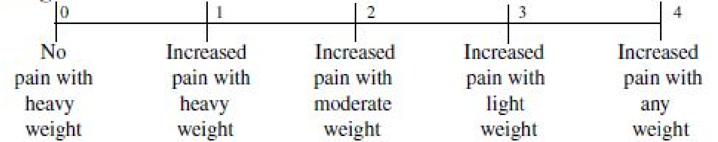
6. Recreation



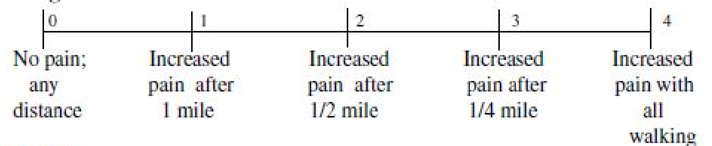
7. Frequency of pain



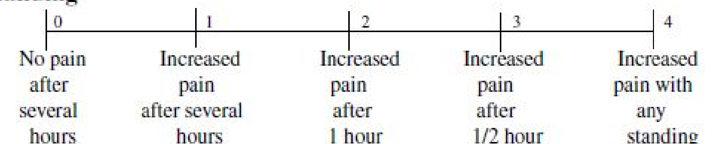
8. Lifting



9. Walking



10. Standing



Name ______________________________
PRINTED

Total Score __________

____
Signature

____
Date

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www.chiroevidence.com

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ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF LEWIS CHIROPRACTIC PC

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Lewis Chiropractic PC to ensure the privacy of my personal health information. I understand that this form will be placed in my patient chart and maintained for six years.

____

Print Patient Name

____ Date:____________________

Signature of Patient, Parent, Guardian or Legal Representative

120 6th Avenue
Coon Rapids, IA 50058
Office Phone: (712) 999-2447
Office Fax: (888) 990-2407
Email: dr.lewis@lewis-chiro.com
www.lewis-chiro.com
Natalie Lewis DC, CCSP, Cert Acupuncture

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary diagnostic x rays of myself (or the patient names below for whom I am legally responsible: ____________________) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Lewis Chiropractic PC and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with a staff member of Lewis Chiropractic PC about the aforementioned procedures and understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all other health care, the practice of chiropractic carries some very rare risks to treatment; including but not limited to : fractures, disc injuries, strokes (CVA), dislocations, and sprains. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interests at this time, based upon the fact then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my chiropractic physician. I intend to consent to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

______________________________	______________________________
Print Patient Name	Print Name of Representative
______________________________	______________________________
Signature of Patient	Signature of Representative
__________________	__________________
Date	Date

____
Signature of Staff

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Financial Policy Form

In order to help determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment for your account. Please notify this office if the status of your insurance changes.

HEALTH INSURANCE:

☐ I would like Lewis Chiropractic PC to bill my insurance. I understand I am responsible for the cost of treatment should my insurance company deny coverage for all or part of the claim(s) submitted on my behalf. I understand that I will be required to pay all copays or coinsurance percentages as stated in my insurance plan contract, along with any uncovered services provided by Lewis Chiropractic.

*Acupuncture, herbs, and homeopathics are not currently covered by insurance.

I certify that I, and/or my dependent(s) have insurance coverage with ________________________________ and assign directly to the above named clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Patient Signature ____ Date___________________

PRIVATE PAY:

☐ I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered. As allowed by the state of Iowa law, I am requesting a "Time of Service Discount" when I pay for my services on the same day that services are performed.

TIME OF SERVICE DISCOUNT AGREEMENT

By my signature below, I am requesting the above selected Private Pay option and a Time of Service Discount, as allowed by the Iowa state law. I understand that to qualify for this discount, I must pay in full for all services that I receive on each day of treatment. Lewis Chiropractic PC hereinafter referred to as the Clinic will provide me with a receipt for my payment which details the services provided to me as well as the diagnosis codes necessary for submission to an insurance company. I understand that should I submit an insurance claim for these services, the Clinic will not appeal any claims that are denied and will not work with my insurance company to overturn any appeals. Should I or my insurance company request copies of my treatment notes, I will be required to pay for these copies. I understand my responsibilities for payment and have an opportunity to have my questions be answered.

Print Name: _____________________________________

Patient Signature ____ Date___________________