Cloud Chiropractic Clinic
3400 SE 196th Ave, Suite 106
Ph: (503) 660-8154

ADULT INTAKE FORM

Patient Name: _____ Date: _____
Age: _____ Birth date: _____ Male: _____ Female: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Email Address: _____
Whom may we thank for referring you? _____

Been treated by a Chiropractor before? _____ Date of Last visit: _____

Female Patients:
Are you currently pregnant? ☐Yes ☐No Estimated Due Date: _____

Number of Pregnancies _____ Number of Births_____ Age of Children _____
List any medications/vitamins/supplements (prescribed, or over-the counter) with the reason taken, dosage, and duration: _____

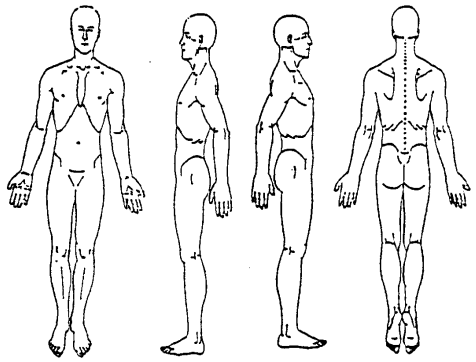
_____
Any diagnosed health conditions? _____

MAIN COMPLAINT

Reason(s) for consulting this office: _____
Date problem began: _____

Does it seem to be getting: ☐ Worse ☐ Better ☐ Staying the same

It interferes with: Sitting ☐ Playing ☐ Sleep ☐ Walking ☐ Hobbies ☐ Leisure ☐ Other ☐
Mark current problem areas on these pictures (if applicable):



Please circle the current level of discomfort your problem causes you, when it is at its worst:

none 1 2 3 4 5 6 7 8 9 10 worst ever

Patient Name: _____ **DOB:** ____/____/____

FAMILY HEALTH HISTORY

Cancer ☐ High Blood Pressure ☐ Heart Problems ☐ Stroke☐ Diabetes☐ Other ☐_____

HEALTH HISTORY

Please check all symptoms you have had, even if they do not seem related to current problem

	YES	Notes		YES	Notes
Surgery/Hospitalization	☐		Kidney infections	☐	
Serious injuries or traumas	☐		Bladder infections	☐	
Allergies	☐		Cancer/tumor	☐	
Headache	☐		Digestive complaints	☐	
Change in bowel habits	☐		Constipation	☐	
Abnormal weight gain/loss	☐		Poor sleep	☐	
Abnormal fatigue	☐		Colic	☐	
Heartburn/indigestion	☐		Neck pain	☐	
Cold/flu often	☐		Jaw pain	☐	
Sinus infection	☐		Arm/elbow/wrist pain	☐	
Asthma	☐		Shoulder pain	☐	
Chronic cough	☐		Mid back pain	☐	
Breathing difficulty	☐		Low back pain	☐	
Dizziness/fainting	☐		Scoliosis	☐	
Ear infection	☐		Hip pain	☐	
Serious illness	☐		Leg pain	☐	
Visual disturbances	☐		Knee pain	☐	
Nausea	☐		Ankle pain	☐	
Balance difficulty	☐		Foot pain	☐	
Rash or hives	☐		Misshaped head	☐	
Slow healing	☐		Bed wetting	☐	
Asocial with others	☐		Highly emotional	☐	
Birth trauma	☐		Vaccinated?		

Anything else you would like to share with the doctor?

_____

_____

_____

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Consent Form, Business Agreement, Insurance Information

1. Consent to Treatment

The nature of Chiropractic care is directed toward balancing the muscles, joints and nerves of your body. To achieve this, the doctor will use her hands or tools to adjust your joints and align your soft tissues. You may hear a "click or pop", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, massage, Craniosacral therapy, traction, taping and exercise/nutritional instruction may also be employed.

There are inherent risks in any and all treatment delivered by any health care provider, ranging from administering a single aspirin to complicated brain surgery. Chiropractic is no exception. Though we take every precaution, there are some risks associated with Chiropractic. The most common is muscle soreness the first couple days after treatment. A list of rare possibilities includes muscular stain, ligamentous strain, and fractures. Injury to the intervertebral discs, nerves or spinal cord is possible, though are considered even less likely. The risks involved with treating the neck may include any of these, but also includes the remote possibility of cerebrovascular injury or stroke. Current literature states the chances of this occurring to be one in one million to one in ten million. The ancillary physical therapy procedures could produce skin irritations, burns or bruising. Other treatment options may include over the counter analgesics, which carry with them the risks of irritation to the stomach, liver, kidneys, and various other side effects. I accept the risks and benefits, and hereby give my full consent to treatment.

2. Privacy Policy

I understand that Cloud Chiropractic may disclose health information about me for purposes of treatment, payment or health care procedures. I have the right to receive a written Notice of Privacy Practices should I request it.

3. Cancellation and No Show Policy

I understand that without giving Cloud Chiropractic 24 hours notice to cancel or change an appointment, a $50 late cancellation/ no show fee will be charged.

4. Release of Records/Payment Policy

Full payment is expected at the time of service. In the case that you are using health or auto insurance to pay for a portion of your care in this office, arrangement may be made to omit payment to await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to six months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize the doctor to release my medical records relating to claim for benefits submitted.

5. Insurance Agreement

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims by your insurance company. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. Please bring your current medical insurance card to every visit and notify us if there is a change in your insurance coverage. If your current insurance card is not on file, full payment for service will be collected at the time of service.

Cloud Chiropractic **DOES NOT** pre check benefits. Please be aware of and provide any required prior authorizations needed in advance of your appointment. If you do not provide these before care is provided, you may be responsible for the cost of the care. When in doubt contact your plan directly for clarification.

Co-payments, Deductibles and Co-Insurance

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure to do so may be considered a breach of your contract with your health plan. Please be ready to pay your co-payment and/ or deductible at each visit. We accept cash, check, and most major credit cards.

Signature of Patient or Guardian_____ Date_____

Patient Name (please print)_____