PERSONAL CONTACT INFORMATION

Name: _____ What do you prefer to be called? _____

Address: _____ Home phone: _____

City, State, Zip: _____ Cell/other: _____

Email: _____ Work phone: _____

Occupation: _____ Do not contact me at work: ❑

Date of birth: _____ Male: ❑ Female: ❑

Social Security #: _____

Marital status: M S D W Spouse's name: _____

No. of children: _____

Person to contact in case of an emergency: _____

Phone: _____

Primary insurance carrier: _____

Name of policyholder: _____ Policy #:_____

Secondary insurance (if applicable): _____

Name of policyholder: _____ Policy #: _____

Who may I thank for referring you? _____ Relationship: _____

I certify that the above information is true and accurate. I also certify to the truth and accuracy of the information found on the *Initial Intake Form* by signing the bottom of each page. I understand that any and all information that I provide will be held in strict confidence and will not be divulged to others without my authorization.

Patient's signature: _____ Date: _____

Keystone Chiropractic, LLC

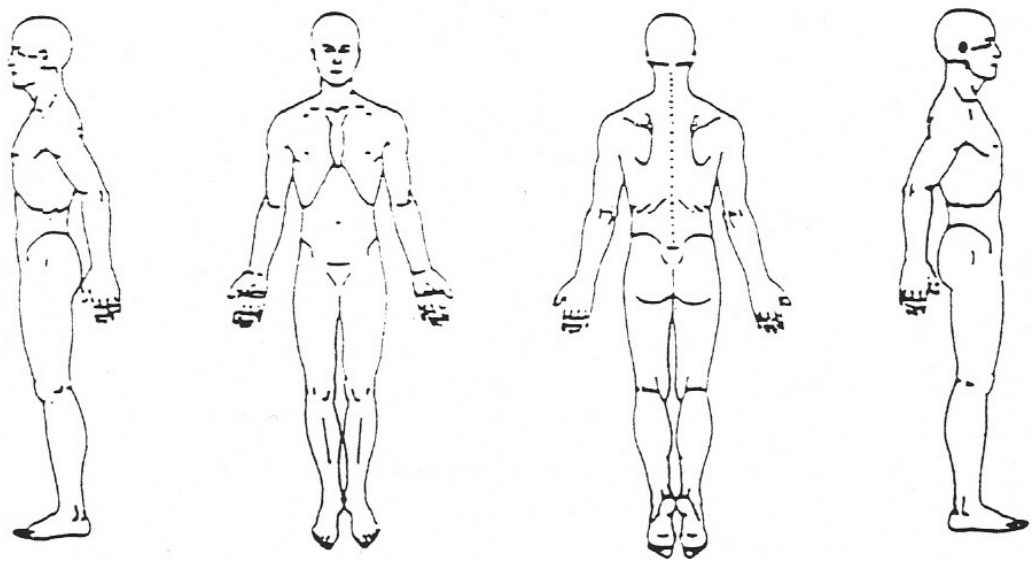
INITIAL INTAKE FORM

Name:_____ Date:_____

PAIN DIAGRAM

Please locate and mark the quality of your pain (*if applicable*) on the body outlines below. Use the code letters as indicated in the box to the right.

Pain Drawing Key
A = Ache
B = Burning
N = Numbness
P = Pins & Needles
S = Stabbing
X = Other



Please mark your current level of pain:

No Pain ├──┤ Worst Pain

Signature: _____

AUTHORIZATION AND PAYMENT RESPONSIBILITY

I authorize the release of any medical or other information necessary in order to process any claims on my behalf. I also authorize the payment of any and all medical benefits for services submitted by Jason B. Richards, D.C. and/or Keystone Chiropractic, LLC, to be made directly to said submitter.

Furthermore, I understand that the office of Jason B. Richards, D.C. will submit my claims and any necessary documentation to my insurance company in a timely manner for reimbursement. However, I am ultimately responsible for payment of all services rendered regardless of insurance reimbursement or lack thereof.

Name: _____

Signed: _____ Date:_____

CONSENT FOR CHIROPRACTIC HEALTH CARE

I have been informed of the nature of my disorder(s) and the nature and purpose of chiropractic procedures and related therapeutics proposed as treatment. I have also been informed of the possible consequences and risks inherent in such treatment. The availability of alternative treatment options has been explained to me. I have also been advised of the possible consequences if I decide not to receive care. I understand that there is no guarantee or warranty for any specific cure or result.

I have read the above paragraph, and I understand the information provided. This information has been explained to me, and all questions that I have asked have been answered to my satisfaction.

I, therefore, authorize chiropractic care and treatment.

Name: _____

Signed: _____ Date:_____

When the patient is a minor or unable to consent:

Patient is a minor of _____ years of age
Other: _____

Patient's name: _____

Person legally authorized to sign for patient (please print name):

_____ Relationship: _____

Signature of
authorized person: _____ Date: _____

Keystone Chiropractic, LLC

INITIAL INTAKE FORM

Name:_____ Date:_____

CHIEF COMPLAINT #1: Pain _____/ 10 Onset: _____

Character of Pain:

How did it begin:

Worsens with:

Improves with:

Affect on ADLs:

Have you seen another doctor for this?

Since onset: ___ increased ___ decreased ___ no change

Present: ___ 75-100% ___ 50-74% ___ 25-49% ___ 0-24%

CHIEF COMPLAINT #2: Pain _____/ 10 Onset: _____

Character of Pain:

How did it begin:

Worsens with:

Improves with:

Affect on ADLs:

Have you seen another doctor for this?

Since onset: ___ increased ___ decreased ___ no change

Present: ___ 75-100% ___ 50-74% ___ 25-49% ___ 0-24%

CHIEF COMPLAINT #3: Pain _____/ 10 Onset: _____

Character of Pain:

How did it begin:

Worsens with:

Improves with:

Affect on ADLs:

Have you seen another doctor for this?

Since onset: ___ increased ___ decreased ___ no change

Present: ___ 75-100% ___ 50-74% ___ 25-49% ___ 0-24%

Type of work:

Exercise program:

Signature: _____

Keystone Chiropractic, LLC

INITIAL INTAKE FORM

Name:_____ Date:_____

REVIEW OF SYSTEMS (Please list any health problems that you currently have.)

Head/neck:

EENT:

Digestive:

Circulatory/heart:

Respiratory:

Liver/kidneys:

Joints/muscles:

Reproductive:

Skin:

Mental/emotional:

PAST MEDICAL HISTORY

1. Allergies (foods, medications, airbornes):
2. Current medications:
3. Major injuries:
4. Hospitalizations/surgeries:
5. Births:
6. Tumors (cancer, benign or malignant):
7. Other health problems:

FAMILY HISTORY (Please list any significant health problems in your family.)

Mom:

Dad:

Siblings:

M Grandmother:

M Grandfather:

P Grandmother:

P Grandfather:

Signature: _____