InMotion
Health & Wellness

4425 East Agave Road
Building 9, Suite 150
Phoenix, AZ 85044

Name _____ Address_____

City _____ State _____ Zip _____ Home ph# _____

Cell# _____ Email Address _____

SSN _____/_____/_____ Date of Birth _____/_____/_____ Age _____ Height _____ Weight _____

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Emergency Contact Name & Phone # _____

Employer _____ Occupation _____

How did you hear about us? _____

What is the name of your family physician? _____ Their location _____

Have you had Chiropractic care before? _____ If yes, doctor name: _____ Date of last visit _____

If you are experiencing any pain (neck pain, low back pain, etc), health problems, symptoms, and/or complaints, please list in order of severity

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

4. _____ For how long? _____

Has this problem been getting worse ☐ staying the same ☐? Currently or in the past have you ever experienced any of these complaints while working? _____ If yes, please describe what activities at work may be causing you these complaints: _____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____

_____

Have you at any time in the past ever suffered a work injury? _____ If yes, what is the date of the injury? _____/_____/_____

Do you have an attorney representing you for this work injury? Yes ☐ No ☐ If yes, who is your attorney?_____

Have you been involved in an auto accident in the last 12 months? Yes ☐ No ☐ If yes, what is the date of the injury? _____/_____/_____

Do you have an attorney representing you for this auto injury? Yes ☐ No ☐ If yes, who is your attorney? _____

How many other passengers were in the car with you? _____

List other doctors consulted for these conditions: _____

If due to an auto accident, what is the name of your auto insurance company? _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any current or past injuries and illnesses not listed above: _____

Please check all medications (over the counter and/or prescribed) you are currently taking: NSAID/Aspirin/Tylenol ☐ Pain killers ☐

Muscle Relaxers ☐ Insulin ☐ Birth Control ☐ Sleeping pills ☐ Anti depressants ☐ Others_____

_____

Health Insurance Company _____Policyholder name & ID# _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. **Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.**

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.

0 means no disability at all, and a score of 10 meants that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function with NO pain or limitations

Able to function but with some discomfort or pain

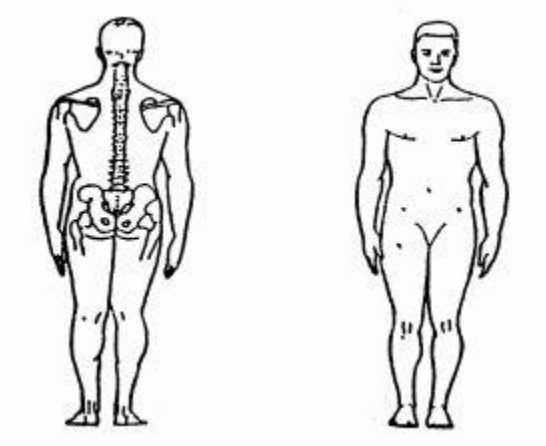
Totally unable to function

RATE:

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc) _____
2. RECREATION: hobbies, exercise, sports, and other similar leisure time activities _____
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members Including parties, theater, concerts, dining out, and other social functions. _____
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs, such as that of a homemaker or volunteer worker. _____
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

If you are experiencing any health problems, please **mark the exact location of your pain on the diagram below.** Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, etc.

COMPLETE THESE DIAGRAMS



Patient Name: _____ Date: _____/_____/_____

Symptom Intake Form

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:

  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
  - Did the symptom begin ***suddenly*** or ***gradually***? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply)
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
    _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):
    _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):
    _____
- Does the symptom radiate to another part of your body (circle one) YES NO
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:

  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
  - Did the symptom begin ***suddenly*** or ***gradually***? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply)
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
    _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):
    _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):
    _____
- Does the symptom radiate to another part of your body (circle one) YES NO
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:

  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
  - Did the symptom begin ***suddenly*** or ***gradually***? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply)
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
    _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):
    _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):
    _____
- Does the symptom radiate to another part of your body (circle one) YES NO
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:

  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____
  - Did the symptom begin ***suddenly*** or ***gradually***? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply)
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
    _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe):
    _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, other (please describe):
    _____
- Does the symptom radiate to another part of your body (circle one) YES NO
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life.

ACTIVITIES:	EFFECT:			
Carry children/groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Lift children/groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Sit to standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Getting dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Prolonged sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Prolonged standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Sweeping/vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to perform

Patient Signature: _____

Printed Name: _____

Today's Date: _____/_____/_____

Patient Name: _____ Date: _____/_____/_____

Please mark **P** for in the **Past**, **C** for **Currently** have, or **Leave Blank** if **Never**

____Headache	____Pregnant	____Dizziness	____Prostate Problems	____Ulcers
____Neck Pain	____Frequent colds/flu	____Loss of balance	____Erectile dysfunction	____Heartburn
____Jaw Pain,TMJ	____Convulsions/Epilepsy	____Fainting	____Digestive problems	____Heart Problem
____Shoulder Pain	____Tremors	____Double vision	____Colon trouble	____High Blood Pressure
____Upper back pain	____Chest pain	____Blurred vision	____Diarrhea/constipation	____Low Blood Pressure
____Mid back pain	____Pain w/ cough/sneeze	____Ringing in ears	____Menopausal problems	____Asthma
____Low back pain	____Foot or Knee problem	____Hearing loss	____Menstrual problems	____Difficulty breathing
____Hip pain	____Sinus/Allergy problem	____Depression	____PMS	____Lung problems
____Back Curvature	____Swollen/painful joints	____Irritable	____Bed Wetting	____Kidney trouble
____Scoliosis	____Skin problems	____Mood changes	____Gallbladder trouble	____Trouble sleeping
____Numb/Tingling arms, hands, fingers		____ADD/ADHD	____Eating Disorder	____Liver trouble
____Numb/Tingling legs, feet, toes				

Family History

☐ Cancer: ☐Sibling ☐Mother ☐Father ☐Grandfather ☐Grandmother

- ☐ Osteoporosis / Osteopenia / Decreased Bone Mass
- ☐ Degenerative Disc Disease / Spinal Arthritis / Spinal Stenosis

Previous Spinal / Neck Surgery (explain) _____

☐ Diabetes ☐ Stroke / TIA ☐Genetic Disorders (explain) _____

Social History

☐ Alcohol ☐Tobacco / Smoking ☐ Recreational Drugs ☐ Medical Marijuana

Medications

☐ Birth Control ☐ Blood Thinner (Coumadin, etc) ☐NSAID ☐Narcotic Pain Medication ☐Muscle Relaxers

☐Fluoroquinolones antibiotics (examples: Cipro, Factive, Levaquin, Avelox, Noroxin, floxin medications)

☐Statin Drugs (example: Lipitor, atorvastatin, Pravochol, Crestor, Zocor, Lescol, Vytorin, simvastin, etc)

Authorizations and Releases

Patient Name: _____

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its healthcare providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian and grant my consent for the treatment of the child as provided for herein. I acknowledge that I may refuse treatment at any time.
Initial ____

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.
Initial ____

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.
Initial ___

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus.
Initial ____

Females: Consent to X-ray During Pregnancy

This is to certify that I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be used over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.
Initial ____

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.
Initial ____

Signature _____ Date _____/_____/_____

Printed Name _____

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information
("Consent Form")

For this purposes of this Consent Form, "Office" shall refer to: InMotion Health & Wellness.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any prior time signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Signature _____ Date _____/_____/_____

Patient Name (please print) _____

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it is applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We request that 100% of the each visit be paid at the time of the visit. We offer a time of service discount to patients that either do not have insurance or choose not to bill their insurance. Payment must be made in full on the date of service.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payments of any non-covered services, deductibles, or copays. You may also pay the full amount due each day therefore qualifying for our Time of Service reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request for more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us. By signing below, you understand and acknowledge that those checks are property of InMotion Health & Wellness and are due to us upon receipt.

MEDICARE

We do accept assignment from Medicare. Reimbursement is sent directly to our office in payment for chiropractic services that Medicare will cover. Medicare will ONLY cover manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining fees for services Medicare does not reimburse. These non-covered services include, but are not limited to – x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will file and collect from your secondary insurance for services covered by the secondary payer.

By signing below, I acknowledge and understand InMotion Health & Wellness' financial policy and agree to the terms outlined.

Patient Signature: _____ **Date:** _____

Patient Name: _____

Appointment Cancellation Policy

We want to thank you for choosing us as your chiropractic health provider. We strive to render excellent care to you and the rest of our patients. Your care and treatment is a priority to us. We also ask that you respect your chiropractor's and therapist's time as well.

In an attempt to be consistent with this, we have an Appointment Cancellation policy that allows us to schedule appointments for our patients, with respect for your time, the next patient's time, and the doctor's time.

We request that you have 24 hours notice in the event that you cannot make it to your scheduled appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. If a patient misses an appointment without contacting our office, it is considered a "missed" or "no show" appointment. **The first missed appointment is forgiven, but each appointment missed or cancelled within 24 hours thereafter you will be charged a $25.00 fee.**

I have read and understand the Appointment Cancellation Policy of InMotion Health & Wellness and agree to be bound by its terms. I am aware that my credit card will be charged for the missed appointment, and I agree to these terms.

Patient Signature: _____ **Date:** _____

Patient Name: _____