BLAINE CHIROPRACTIC & MASSAGE

Welcome to Blaine Chiropractic and Massage!

Please take a moment to fill out our intake form before your visit. Have your insurance information on hand and bring your card for your first visit.
All information is kept completely confidential.

First and Last Name *Required* _____

Preferred Name (if different) _____ Pronouns: she/her he/him they/them

Prefix / Title: Dr. Mrs. Ms. Miss Mr. Mx.
Date of Birth *Required* _____

Please provide at least one phone number. Your mobile number can be used to receive text message appointment reminders.

Mobile Phone_____
Email_____

A mobile phone and/or email are required if you would like to receive appointment reminders.

Home Phone_____
Street Address_____

City State Zip

Sex *Required* Male Female
Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record. Gender: Male Female Non-binary
Patient Occupation_____

Employer_____

Guardian_____

Emergency Contact_____ Phone_____
Relationship_____

Family Doctor or referring professional_____(if known)Phone_____Email_____

How did you hear about us? Friend Physician / Specialist
Web Search Insurer's Provider List

Marital Status: Married Single Divorced Separated Widowed
Spouse's Name:

If your spouse is the Primary Account holder for your insurance policy, please include a Date of Birth for your Spouse:

Insurer:

BLAINE CHIROPRACTIC & MASSAGE

Policy Number: **Group Number:**

Please note that it is your responsibility to verify insurance benefits and coverage. You are responsible for any charges not covered by your policy.

Women: Are you pregnant?_____Due Date:_____Are you currently nursing?_____

If there is significant history regarding pregnancy and childbirth (including number of children) please share here:

Current Health Conditions

Reason for visit _____

When did it start?_____

Have you received care for this problem? If yes, please explain:

What makes the problem better or worse? _____

Is the condition: Getting Worse Improving No Change

Is the condition: Intermittent (on and off) Constant Unsure

Is the Pain : Aching Dull Deep Sharp Burning

Throbbing Numb Tingling Other

Rate your pain level 0 =none 10 =unbearable

0 1 2 3 4 5 6 7 8 9 10

Describe your Health Goals:_____

What would you like to gain from chiropractic care? Symptomatic Relief Corrective Care Both

Have you ever visited a chiropractor before? Yes No

For what reason did you visit a chiropractor and did it help?_____

Traumas: Physical Injury History

Have you ever had any significant falls, surgeries, accidents, or injuries as an adult?
If yes, please explain:

Have you ever been hospitalized? Yes No
If yes, why?

Notable childhood injuries?_____

Youth or college sports?_____

Describe any car accidents you've been in:

Health History

Indicate if YOU or any IMMEDIATE FAMILY members have any of the following:

Rheumatoid Arthritis	Diabetes	Lupus	Heart Disease
High Blood Pressure	Stroke	Cancer	

Please specify who has/had the condition.

Please circle if you have had the condition in the past or currently:

Headaches	Neck pain	Upper back pain	Back pain	Low back pain
Shoulder pain	Arm pain	Wrist pain	Hand pain	Upper leg pain
Hip pain	Knee pain	Ankle/Foot pain	Jaw pain	Joint swelling
Rheumatoid arthritis		Arthritis	Muscular incoordination	
General fatigue		Vision problems	Ringing in the Ears	
Memory problems		Broken bones	Pacemaker	
High Blood Pressure		Dizziness	Heart Attack/disease	
Chest pain		Stroke	Angina	
Kidney Stones		Kidney disorders	Loss of Bladder Control	
Painful Urination		Bladder infection	Prostate Problems (Men only)	
Abnormal weight change		Loss of appetite	Abdominal pain	
Sensitivity to light		Cold hands/feet	Liver disease	
Thyroid problems		Asthma	Sinus problems	

Drug/Alcohol dependence	Allergies	Depression/Anxiety
Hormonal replacement	Birth Control Pills	Pregnancy
Cancer	Lupus (SLE)	Epilepsy
Dermatitis/Eczema/Rash	Concussion	Loss of concentration
Diabetes	Excessive thirst	Frequent urination	Ulcer
Hepatitis	Tumor	Gall Bladder problems
Anemia	Osteoporosis	Other_____

Exercise Frequency: 1-2x/week 3-5x/week Daily Never
What types of exercise do you perform?

How do you normally sleep? Back Side Stomach
Do you wake up: Refreshed Stiff & Tired

Do you commute to work? Yes No
How many minutes per day do you commute to work?

How many hours per day do you typically spend sitting?

Please rate your CONSUMPTION for each: (1=never, 5=high)

Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5						
Sugar	1	2	3	4	5	Artificial Sweeteners	1	2	3	4	5
Dairy	1	2	3	4	5	Soda	1	2	3	4	5
Gluten	1	2	3	4	5	Cigarettes/ Tobacco	1	2	3	4	5
Caffeine	1	2	3	4	5	Recreational Drugs	1	2	3	4	5
						Fast Food	1	2	3	4	5

List Any Allergies:

Diet, habits, exclusions and supplements:

Medications:

Current Stress Levels Low Medium High

Sports and hobbies, current and past, reasons for quitting?

Expectations of Care: How many visits with Dr. Andruscavage do you anticipate?_____

Is there anything else your provider should know?:

Accuracy of Information

___ **I certify that the above medical information is correct to my knowledge**

Blaine Chiropractic and Massage Intake form — Consents

Initial Each Section and sign where indicated through page 6, Communication Consents

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

___ **I agree**

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit does not allow our clinic the opportunity to fill a vacant appointment. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24

hours notice, or miss their appointment, will be charged a cancellation fee of $40 to the card on file or to be collected prior to the next visit.

____ **I am aware of the Cancellation Policy**

Payment at Time of Service

A Good Faith Estimate (GFE) is an estimate from a health care provider (Blaine Chiropractic and Massage) for the expected costs of items or services. A GFE will be made based on insurance plan information provided by you, the patient. Payment due for copay, deducible, or private pay will be collected on the same day of service. Your estimate is based on services expected to be provided and is based on allowable fee amounts through individual insurance plans, and in reference to deductible amounts that may be owed through your individual plan. As an estimate it is possible that more or less than the amount collected will be owed after insurance billing. You will be invoiced when payment is due. Overpayments can be applied to next visits or refunded by check. We regularly review accounts for overages.

_____ **I am aware of and agree to the GFE policy. I am aware that payment will be collected the same day of services if payment is due**

Signature **Date**

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Initial Each Section and sign where indicated

Communication Consents:

Transactional Email and Texts

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

____ **I would like email and text notifications of new, cancelled, and rescheduled appointments**

Authorization to Leave a Detailed Message

Messages that contain protected health information (PHI) require the patient to sign an authorization form to receive messages by voice mail. Messages that contain PHI would be payment information, treatment plans, and appointment specifics. I understand my HIPPA rights and I request that this office leave messages, including those containing PHI, for me by voice mail. I understand that it is my responsibility to keep the practice informed of any changes to this information. This authorization is in effect until cancelled in writing.

____ **I agree to authorize our staff to leave a detailed message**

Signature **Date**

Staff: Certify the Consents have been signed prior to treatment by initialing below