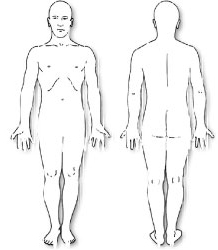
**INTAKE FORM**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please describe your primary reason for visiting our office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Indicate with an X on the drawings where you have pain/symptoms:
   1. If more than one symptom- number (1,2,3...) each ‘X’ to distinguish area of pain with answers below

4. How would you describe the type of pain?

* Sharp
* Shooting
* Diffuse
* Dull
* Achy
* Numb
* Tingly
* Stiff
* Burning
* Throbbing
* Other\_\_\_\_\_\_\_\_

1. When did this problem start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How do you think this problem began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What makes the symptoms worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What makes the symptoms better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

(*Please Circle)* 0 1 2 3 4 5 6 7 8 9 10

1. Does the pain travel to another area of the body?  Yes  No
   1. If Yes, describe the location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Describe any associated symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How often do you experience your symptoms?

* Constantly (76-100% of time)
* Frequently (51-75% of time)
* Occasionally (26-50% of time)
* Intermittently (1-25% of time)

1. How are your symptoms changing with time?

* Getting Worse  Not Changing  Getting Better

1. Has your problem interfered with any of the following?

* Work  Hobbies  Sleep  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What concerns you most about your problem; what does it prevent you from doing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Who else have you seen for this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   1. What type of treatment did you receive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. In your opinion, did it help?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Name and address of other doctors (s) who have treated you for this condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Date of last: Physical Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spinal Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X-Ray\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRI, CT-Scan\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Test\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How would you rate your overall health?

* Excellent  Very Good  Good  Fair  Poor

1. What type of exercise do you do?  Strenuous  Moderate  Light  None
   1. How frequently do you exercise? \_\_\_\_\_\_ x week / month *(Please circle one)*
2. Do you have any of the following habits?

 Smoking Packs/Day\_\_\_\_\_\_\_\_\_\_\_\_  Alcohol Drinks/Week\_\_\_\_\_\_\_\_\_\_\_\_\_

 Coffee/Caffeine Drinks Cups/Day \_\_\_\_\_\_\_\_\_\_\_\_\_  High Stress Level Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Indicate if you have any immediate family members with any of the following:

* Diabetes  Heart Problems  Cancer  Thyroid Disorders  Rheumatoid Arthritis

1. Females: Are you pregnant?  Yes  No
2. List all current prescription/over-the-counter medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List all current Vitamins/Herbs/Supplements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. List all surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you ever been hospitalized?  No  Yes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you ever been in a car accident or experienced any other trauma?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. How much sleep do you get on an average night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hours
   1. Do you fall asleep easily?  Yes  No
   2. How many times do you wake up during the night?  None  Once  2-3 times  >4 times
   3. Do you wake up feeling refreshed in the morning?  Yes  No
5. How would you rate your energy level?  Excellent  Very Good  Good  Fair  Poor
   1. What time of day is your energy the highest? \_\_\_\_\_\_\_\_\_\_\_ the lowest?\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Place a mark on “Yes” or “No” to indicate if you have had any of the following:

AIDS/HIV  Yes  No Diabetes  Yes  No Kidney Problem  Yes  No Rheumatoid Arthritis  Yes  No

Alcoholism  Yes  No Emphysema  Yes  No Liver Disease  Yes  No Rheumatic Fever  Yes  No

Allergy Shots  Yes  No Epilepsy  Yes  No Measles/Mumps  Yes  No Scarlet Fever  Yes  No

Anemia  Yes  No Fractures  Yes  No Migraines  Yes  No STD  Yes  No

Anorexia  Yes  No Glaucoma  Yes  No Miscarriage  Yes  No Stroke  Yes  No

Appendicitis  Yes  No Goiter  Yes  No Mononucleosis  Yes  No Suicide Attempt  Yes  No

Arthritis  Yes  No Gonorrhea  Yes  No Multiple Sclerosis  Yes  No Thyroid Problem  Yes  No

Asthma  Yes  No Gout  Yes  No Osteoporosis  Yes  No Tonsillitis  Yes  No

Bleeding Disorder Yes  No Heart Disease  Yes  No Pacemaker  Yes  No Tuberculosis  Yes  No

Breast Lump  Yes  No Hepatitis  Yes  No Parkinson’s  Yes  No Tumors  Yes  No

Bronchitis  Yes  No Hernia  Yes  No Pinched Nerve  Yes  No Typhoid Fever  Yes  No

Bulimia  Yes  No Herniated Disc  Yes  No Pneumonia  Yes  No Ulcers  Yes  No

Cancer  Yes  No Herpes  Yes  No Polio  Yes  No Vaginal Infections  Yes  No

Cataracts  Yes  No High Blood Pressure Yes  No Prosthesis  Yes  No Whooping Cough  Yes  No

Chicken Pox  Yes  No High Cholesterol  Yes  No Psychiatric Care  Yes  No Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you seen a Chiropractor Before?  No  Yes If yes, how was your visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Anything else pertinent to your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician:**

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_

* *Check here if you do NOT authorize this office to communicate with your primary physician about the care you receive.*

Print Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

Please see attached ‘Notice of Privacy Practice for Protected Health Information’ which describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You may request a copy of the Notice of Privacy Practice at any time.

I have read through and understand the Notice of Privacy Practice:  Yes  No

I request a copy of the Notice of Privacy Practice at this time:  Yes  No

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHIROPRACTIC INFORMED CONSENT TO TREAT**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Renew Chiropractic 39525 W 14 Mile Rd Suite 100 Novi, MI 48377

PATIENT SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Or Patient Guardian/Parent/Representative)

Provide name and relationship if signing for patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CONSENT FORM**

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTCARE OPERATIONS.

1. I understand that, and consent to, the following appointment reminders that will be used by the practice: Postcards mailed to the addresses I have provided, telephoning and text messaging me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.
2. I give Renew Chiropractic permission to treat me in a room that is not fully enclosed. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations
3. This office posts a notice for Patient of the Week. If I receive that designation I authorize Renew Chiropractic to post my name in the office or on social media such as Instagram and Facebook. \_\_\_\_\_\_YES \_\_\_\_\_\_NO

**Authorization and Assignment of Benefits:**

1. 1.You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster to process any claim for reimbursement of charges occurred at this office.
2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services of otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.
3. I give assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill for treatment.
4. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name (s) of which I believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.

**CANCELLATION and NO SHOW POLICY**

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours’ notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours’ notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours’ notification may be subject to a **$25.00** cancellation fee.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (734) 489-1607.

**Please sign that you have read, understand and agree to the above statements.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Print Patient/Client Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Client or Patient Guardian Date