



Insurance Plan Disclaimer: Please check your insurance benefits prior to your visit. Each policy varies and information we obtain on your behalf is **NOT** a guarantee of coverage. You are responsible to know your benefits and the amount of coverage your policy provides. You are responsible to pay any amount not covered by your insurance policy.

Name: _____
Date of Birth: ____ / ____ / ____ Sex: (circle one) **Male** **Female** **Other:** _____
Cell Phone: (____) _____ - _____ Text: **Y** or **N** Home Phone: (____) _____ - _____
Address: _____
City: _____ State: _____ Zip: _____
Email Address: _____

INSURANCE INFORMATION:

PRIMARY Insurance Co: _____ ID# _____
Relationship to Patient: Parent ___ Guardian ___ Group # _____
Policy Holder/Employee's Name: _____
Address: _____
Employed by: _____ Employee's Birth Date: _____

SECONDARY Insurance Co: _____ ID# _____
Relationship to Patient: Parent ___ Guardian ___ Group # _____
Policy Holder/Employee's Name: _____
Address: _____
Employed by: _____ Employee's Birth Date: _____

By signing below, I attest that I have read and understand the above Insurance Plan Disclaimer and that the information I provided is true and accurate. *Co-payments and Deductibles are due at the time services are rendered. You are responsible for any balance that is not paid by your insurance.

A 24-hour notification is required for any cancellation to avoid a \$50 missed appointment fee.

Parent/Guardian: _____ Date: _____
Parent/Guardian Print Name _____

Patient's Name: _____ Date: _____

Chief Complaint: _____ Start Date _____

Please list any injuries that are associated with your Chief Complaint: _____

Have you sought treatment for this condition before today?: **Y** or **N**
If Yes, who was the provider and when did you get treatment? _____

My pain gets better or goes away when I _____

My pain gets worse when I _____

My pain is at it's worst:: (circle all that apply) **Morning** **End of the work day** **Night** **Constantly**

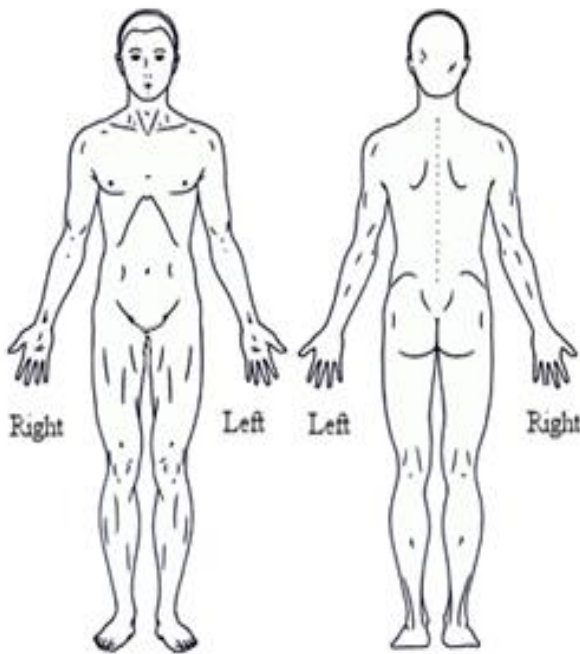
Please circle the degree of pain you are currently in: (0 = no pain, 10 = severe pain)
0 1 2 3 4 5 6 7 8 9 10

Please circle the degree of pain at its worst:
0 1 2 3 4 5 6 7 8 9 10

Please circle the degree of pain at its best:
0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

- Numbness = = =
- Dull Ache O O O
- Burning X X X
- Sharp/Stabbing / / /
- Pins, Needles + + +
- Other _____ ^



Patient's Name: _____ Date: _____

Medical History

Primary Care Physician _____ Location (town) _____

Have you had Chiropractic Care before? (Circle one): **Yes** or **No**

If yes, what is the Dr's name?: _____

When was your last Chiropractic Treatment?: _____

Please circle your insurance Co.:: **Aetna Anthem Cigna CTCARE Harvard Pilgrim Medicare Self-pay United HC**

Please list any past surgeries, medical conditions and/or fractures:

Please list all medications, supplements and vitamins you are currently taking:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there anything else you would like Dr. Inlow to know about your current condition? If so, please use the space below to explain:

HIPPA Acknowledgement:

By signing below, I am acknowledging that I have received a copy of the Privacy Practices Policy for this office.

I understand that my health information may be disclosed to my primary care physician or specialist for health care operations and coordinated care.

If I wish for anyone other than myself to have access to my personal information, I shall list their name and their relationship to me. This will remain in effect until such time as I request a change in writing.

Name(s) of person(s) designated to have access to my personal/healthcare information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Parent/Guardian: _____ Date: _____

Parent/Guardian Print Name _____

VALLEY CHIROPRACTIC AND SPORTS MEDICINE CANCELLATION POLICY:

Please give a 24 – hour notice when canceling an appointment. A \$50 Missed Appointment fee will be charged when 24-hour notice has not been given for a missed appointment