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 #: (_______)_________-_________ Text (Circle one): **Yes** or **No** Home #: (_______)_________-_________

Address:____

City:____ State:_______ Zip:______________

Email Address: ____

INSURANCE INFORMATION:

PRIMARY Insurance Co:______________________________________ ID#___________________________________
Relationship to Patient: Self___ Spouse____ Parent_______ Group #___________________________________

Policy Holder/Employee's Name:____

Address:____

Employed by:____ Employee's Birth Date:___________________

SECONDARY Insurance Co:____________________________________ ID#___________________________________
Relationship to Patient: Self___ Spouse____ Parent_______ 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.

Patient Signature:____ Date:___________________________

Patient's Name: ____ **Date**:_______________________________

Chief Complaint: ____ Date this Started?___________

Please list any injuries you have had associated with your Chief Complaint:__________________________________
____

Have you sought treatment for this condition before today? (Circle one): **Yes** or **No**

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

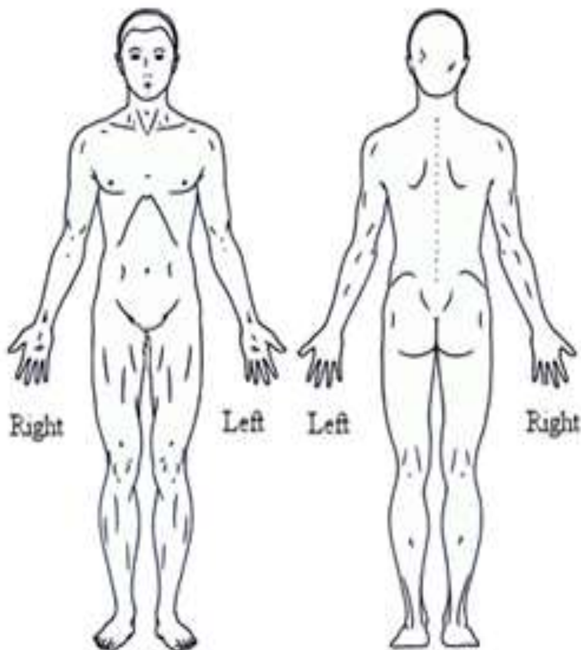
Please circle the degree of pain at its *best:*

0 1 2 3 4 5 6 7 8 9 10

In the past week, on average, how often have your symptoms been present? (Circle one):

0 – 25% 26-50% 51-75% 76-100%

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



Numbness	= = =
Dull Ache	OOO
Burning	XXX
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 list any past surgeries, medical conditions and/or fractures:

____

____

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

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:______________________________

Patient Signature: ____ Date: ________________________________

Printed Name: ____ Date: ________________________________

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