**NEW PATIENT INTAKE FORM**

**Altorelli Chiropractic and Wellness**

**125 New Milford Turnpike, New Preston, CT 06777**

**PLEASE COMPLETE THE FOLLOWING INFORMATION. NOTE THAT ALL INFORMATION YOU PROVIDE WILL BE HELD IN STRICT CONFIDENCE AND WILL NOT BE DIVULDGED TO OTHERS WITHOUT YOUR AUTHORIZATION.**

**Personal Information**

**Today’s Date:\_\_\_\_\_\_\_\_\_\_\_Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI:\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_**

**Home Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you wish to receive follow-up calls? Yes □ No □ Where? Home □ Work □ Cell □**

**E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you wish to receive a newsletter? Yes □ No □**

**DOB:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_Sex: Male □ Female □ Status: Married □ Single □ Other □**

**Driver's License Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_**

**Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FULL/PART TIME/RETIRED**

**Emergency Contact Info: Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI:\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_**

**Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If the patient is under the age of 18: IF NOT, PLEASE SKIP THIS SECTION**

**Name of Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Father\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICARE? Yes □ No □ IF NO, PLEASE SKIP TO THE NEXT PAGE**

**MEDICARE ID Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Effective Date:­­­­­­­­\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI:\_\_\_\_\_\_**

**Date of Birth:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_SSN: \_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_Gender: Male □ Female □**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_**

**Home Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT HEALTH QUESTIONNAIRE**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I AM CURRENTLY IN PAIN: Yes □ No □ IF NO, PLEASE SKIP TO THE NEXT PAGE**

**PAIN DRAWING AND SCALE: On a scale from 0-10, how do you rate your current pain?\_\_\_\_\_\_**

**Please mark the quality and location of your pain on the body outlines below.**

**Please use the code letters as indicated below:**

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing X = Other



1. **When did your symptoms start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe your symptoms and how they began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

1. **How often do you experience symptoms?**

**□** Constantly (76-100% of the day)  **□**  Frequently (51-75% of the day)

**□** Occasionally (26-50% of the day) **□** Intermittently (0-25% of the day)

**3. How are your symptoms changing? □** Getting Better **□** Not Changing **□** Getting Worse

**4. How do your symptoms affect your ability to perform daily activities?**

**⓿ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ❿**

No complaints Mild, forgotten Moderate, interferes Limiting, prevents Intense, preoccupied Severe

with activity with activity full activity with seeking relief

**5. What activities make your symptoms worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**6. What activities make your symptoms better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7. Who have you seen for your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**a. When and what treatment?­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**b. What tests were performed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Taken:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**8. Have you had similar symptoms in the past? ………………………………………………………………….Yes □ No □**

**9. Is this condition or problem caused by an auto accident? ……………………………………………….Yes □ No □**

**10. Is this condition or problem related to your current or former job? ..................................Yes □ No □**

**11. DID YOU GO TO THE HOSPITAL OR EMERGENCY ROOM FOR THIS CONDITION? ………………Yes □ No □**

**If “NO”, please skip to the next section. If “YES”, please continue to fill out this section.**

Name of Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you go to the hospital by: **□** Ambulance **□** Car **□** Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were x-rays taken?  **□ Yes □ No** If yes, of what body region(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was your diagnosis?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT HEALTH QUESTIONNAIRE**

**PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:**

The information you provide concerning past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

**N = NEVER PA = PAST PR = PRESENT**

|  |  |  |
| --- | --- | --- |
| **N PA PR CONDITION** | **N PA PR CONDITION** | **N PA PR CONDITION** |
| **General Symptoms:**  **□ □ □** Headache  **□ □ □** Nervousness  **□ □** □ Tension  □ □ □ Anxiety  □ □ □ Irritability  □ □ □ Depression  □ □ □ Cold Hands or Feet  □ □ □ Night Sweats  □ □ □ Cold Sweats  □ □ □ Excessive Thirst  □ □ □ Abnormal Weight Loss  □ □ □ Abnormal Weight Gain  □ □ □ General Fatigue  □ □ □ Sleep Problems  **Musculoskeletal:**  **□ □ □** Neck Pain  **□ □ □** Neck Stiffness  **□ □** □ Jaw Pain  □ □ □ Shoulder Pain  □ □ □ Hand Pain  □ □ □ Upper Back Pain  □ □ □ Lower Back Pain  □ □ □ Pain in ankle or knee  □ □ □ Joint Swelling  □ □ □ Stiffness of Joint(s)  □ □ □ Arthritis  □ □ □ Pain in Upper Leg or Hip  □ □ □ Pain in Lower Leg or Knee  **Neurological symptoms:**  **□ □ □** Numbness in Fingers  **□ □ □** Numbness in Toes  **□ □** □ Pins and Needles  □ □ □ Fainting  □ □ □ Loss of Consciousness  □ □ □ Seizures/Convulsions  □ □ □ Dizziness  □ □ □ Balance Problems  □ □ □ Coordination Problems  □ □ □ Ringing in the Ears  □ □ □ Memory Problems  □ □ □ Eyes Sensitive to Light  □ □ □ Loss of Smell | **Cardiovascular Symptoms:**  **□ □ □** Palpitations (Racing Heart)  **□ □ □** Chest Pains (Angina)  **□ □** □ Shortness of Breath  □ □ □ High Blood Pressure  □ □ □ Low Blood Pressure  □ □ Stroke:  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **□ □**  Heart Attack:  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ □ Coronary Artery Bypass  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ □ Pacemaker for Heart  **Respiratory Symptoms:**  **□ □ □** Asthma  **□ □ □** Chronic Cough  **□ □** □ Chronic Sinusitis  □ □ □ Lung Problems  □ □ □ Allergic Rhinitis  **Urinary System Symptoms:**  **□ □ □** Frequent Urination  **□ □ □** Painful Urination  **□ □** □ Kidney Stones  □ □ □ Bladder Disorder  □ □ □ Kidney Disorder  □ □ □ Prostate Problem  □ □ □ Loss of Bladder Control  **Other Chronic Issues:**  **□ □ □** Skin Problems - Rash  **□ □ □** Diabetes  **□ □** □ Anemia  □ □ □ Other Blood Disorder(s)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ □ □ Cancer:  Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ □ □ Other Condition(s):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Digestive Symptoms:**  **□ □ □** Nausea  **□ □ □** Vomiting  **□ □** □ Loss of Appetite  □ □ □ Upset Stomach  □ □ □ Constipation  □ □ □ Diarrhea  □ □ □ Heartburn Indigestion  □ □ □ Loss of Bowel Control  □ □ □ Ulcer  □ □ □ Colitis  □ □ □ Irritable Colon  □ □ □ Anorexia/Bulimia  □ □ □ Difficulty Swallowing  **General Health:**  Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date of Last:**  Physical Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  X-ray Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Blood Test:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **SOCIAL HISTORY:**  **□ □ □** Tobacco Use  **□ □ □** Alcohol Use  **□ □** □ Recreational Drug Use  **WOMEN – Please fill out this section:**  **□ □ □** Pregnant  **□ □ □** Irregular Menses  **□ □** □ Profuse Menses  □ □ □ PMS  □ □ □ Menstrual cramps  □ □ □ Use Birth Control Pills  □ □ □ Sore Breast(s)/Lump(s)  □ □ □ Endometriosis  □ □ □ Vaginal Discharge  **Date of Last Menses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Notice to Pregnant Women:** All female patients must inform the supervising clinician if they know or suspect they are pregnant as some procedures and therapies may present a risk to the pregnancy.

**PATIENT HEALTH QUESTIONNAIRE**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**­­­­**

**PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.**

**1. Please list all ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. What is the most important reason for making this appointment today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. Please list any current medical conditions you have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**4. Please list any associated family health conditions of immediate family or relatives:**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

**5. Please list all prescriptions, OTC medications, and nutritional/herbal supplements you are taking:**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

**6. Please list any hospitalizations, surgeries, serious trauma, accidents, or falls you have had:**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

**7. Have you ever been exposed to:**

The AIDS virus (HIV) ……………………………...............  **Yes □ No □**

Tuberculosis (TB) ………………………………………………  **Yes □ No □**

Hepatitis virus (A, B, or C)? ………………………………. **Yes □ No □**

**8. Do you currently have a productive cough?.............. Yes □ No □**

**9. How would you grade your overall stress level?**

**□** No Stress **□** Minimal Stress **□** Moderate Stress **□** Greatly Stressed

**10. What is your general physical activity at work?**

**□** Sitting more than 50% of the work day **□** Light manual labor **□** Moderate manual labor

**□** Heavy manual labor

**11. What is your general physical activity outside of work?**

**□** No regular exercise program **□** Light exercise program **□** Strenuous exercise program

**12. How would you rate your overall diet?**

**□** Poor Diet **□** Average Diet **□** Healthy Diet **□** Excellent Diet

**13. On a scale of 1-10. How committed are you to resolving this complaint? \_\_\_\_\_**

**14. On a scale of 1-10. How important is your health to you? \_\_\_\_\_**

**15. How did you hear about Altorelli Chiropractic and Wellness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I HEARBY CERTIFY THAT THE STATEMENTS AND ANSWERS GIVEN ON THIS FORM ARE ACCURATE TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY HEALTH. I AGREE TO ALLOW THIS OFFICE TO EXAMINE ME FOR FURTHER EVALUATION.**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT FINANCIAL AGREEMENT**

I understand the payment is due at the time services are rendered, unless prior financial arrangements have been made. We accept cash, check, and credit card.

**PERSON RESPONSIBLE FOR THE BILL:**

**□** Please check this box if the **patient** is the person responsible for the bill and **do not fill out** this section.

**□** Please check this box if the **parent/guardian** is the person responsible for the bill and **fill out** this section.

**Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI:\_\_\_\_**

**Date of Birth:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender: □Male □Female**

**Street:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the above information and information on the following page (page 6) and I understand the information provided within this document. This information has been explained to me and all questions which I have asked have been answered to my satisfaction.**

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

**Signature** **Date**

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

**Print name here**

*If the patient is a minor or unable to consent:*

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

**Signature of person legally and/or financially responsible for the patient** **Date**

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

**Print name of person legally authorized here**

***Insurance & Payment: Altorelli Chiropractic and Wellness, LLC***

All new patients must have an initial examination and consultation before receiving chiropractic treatment. The initial visit is a comprehensive physical examination consisting of a detailed history, orthopedic, neurological, and chiropractic evaluations. Expect to spend 45 minutes to an hour for the first visit. The cost is $185.

For all visits, payment is made directly to the office at the time of your visit. We will gladly accept cash, checks, debit and credit cards (except American Express). If you have health insurance, we will provide you with a computer-generated form that is properly coded with our procedures and your diagnosis which you can submit for reimbursement to your carrier.

Fees paid to doctors of chiropractic are allowable deductions as expenses for "medical care" for Federal income tax purposes.

If you have an **HSA**, you can deduct payment for chiropractic services using your linked debit card or checking account.

**All Medicare Patients:** Chiropractic manipulation of the spine is the only covered service. Physical examinations, including the initial exam, and all other therapies/services are not covered by Medicare.

**Cancellation Policy:**

Altorelli Chiropractic and Wellness, LLC has a 24 hour cancellation/ rescheduling policy. If you miss or cancel your appointment with less than 24 hours notice, you will be charged $50.

This policy is in place out of respect for our Doctor and our patients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot. Thank you for your understanding and cooperation.