Cousineau Chiropractic Center PLLC

Patient Intake Form

1 Patient Information Date:

Legal Name: (Last) _____ (First) _____ (M.I) _____

Address: _____ City: _____

State: _____ Zip: _____ Sex: ☐ M ☐ F

Age: _____ Birth Date: _____ Marital Status:

Social Security #: _____ - _____ - _____ ☐ Married ☐ Divorced ☐ Single ☐ Widow/er

Email: _____ Primary Phone: _____

Occupation: _____ Patient Employer/School: _____

Emp. Address: _____ Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Military Status: ☐ N/A ☐ Active ☐ Marines ☐ Navy

Height? _____ Weight? _____ ☐ Retired ☐ Army ☐ Coast Guard

How did you hear about us? _____ ☐ Reserve ☐ Air Force ☐ Space Force

2 Medical History

Name & Address of Primary Provider(s):

_____

Date of Last: Physical Exam: _____ Spinal X-Ray: _____ Spinal Exam: _____

Chest X-Ray: _____ MRI, CT-Scan, Bone Scan: _____ Blood Test: _____ Urine Test: _____

Mark '**X**' to indicate whether you have experienced any of the following (past or present) and complete the information below:

☐	AIDS/HIV	☐	Chemical Dep./ Alcoholism	☐	Hernia	☐	**Pinched Nerve**
☐	Allergies			☐	**Herniated Disk**	☐	Pneumonia
☐	Anemia	☐	Chicken Pox	☐	Hypertension	☐	Prostate Problem
☐	Anxiety/Dep.	☐	**Clotting Dis.**	☐	Kidney Dis.	☐	Psychiatric Care
☐	Appendicitis	☐	Diabetes	☐	Liver Disease	☐	Rheum. Arthritis
☐	Arthritis	☐	Eating Dis.	☐	Migraines	☐	STD
☐	Asthma	☐	Emphysema	☐	Mononucleosis	☐	Stroke
☐	Autoimmu. Dis.	☐	**Epilepsy/Seizure**	☐	**MS**	☐	Thyroid Dis.
☐	**Bleeding Dis.**	☐	Headaches	☐	Osteoporosis	☐	Tuberculosis
☐	Bronchitis	☐	Heart Dis.	☐	Pacemaker	☐	Tumors, Growths
☐	Cancer	☐	Hepatitis	☐	Parkinson's	☐	Ulcers

Are you pregnant? ☐ **N/A** | ☐ **Yes** ☐ **No** **If 'Yes', how many weeks?** _____

Other: _____

3 Family History

Autoimmu. Dis.	☐ **Yes** ☐ **No**	Diabetes	☐ **Yes** ☐ **No**	Migraines	☐ **Yes** ☐ **No**
Bleeding Dis.	☐ **Yes** ☐ **No**	Heart Disease	☐ **Yes** ☐ **No**	Osteoporosis	☐ **Yes** ☐ **No**
Clotting Dis.	☐ **Yes** ☐ **No**	High Blood Press.	☐ **Yes** ☐ **No**	Stroke	☐ **Yes** ☐ **No**
Cancer	☐ **Yes** ☐ **No**	Kidney Disease	☐ **Yes** ☐ **No**	Thyroid	☐ **Yes** ☐ **No**

4 Payment/Insurance Information

Who is financially responsible for this account? ☐Self-Pay or ☐Other _____
If 'Other, state relationship to patient: _____
If insured, who is the main subscriber/policy holder? _____
Birth Date: _____ Phone: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Ins. Co. Name: _____ ID# _____ Group# _____
Secondary Ins. Name: _____ ID# _____ Group# _____

Is this policy associated with an ☐HSA ☐FSA ☐HRA ☐N/A

Assignment and Release

On behalf of yourself and any patient for whom you are the parent or legal guardian, you **1)** Certify that the information on this form is accurate and up-to-date, **2)** Consent to treatment by *Cousineau Chiropractic Center*, **3)** Assign to *Cousineau Chiropractic Center*, any healthcare insurance or reimbursement benefits to which you are entitled for the care provided by *Cousineau Chiropractic Center* (other than those included in any prior agreement made in writing), including attorney fees, court costs, and other expenses of collections, **4)** Allow *Cousineau Chiropractic Center* to appeal all denials from my insurance on my behalf, **5)** Give Cousineau Chiropractic Center and its staff permission to contact me about my "protected health information" (PHI) via E-Mail, text, and/or call, **6)** Consent to *Cousineau Chiropractic Center* releasing any PHI as defined by Federal **Health Insurance Portability and Accountability Act** (HIPAA) regulations, for the purposes allowed by Federal and State law, and **7)** Acknowledge receipt of and **Accept** the *Cousineau Chiropractic Center's* **Insurance Assignment Program** and **Terms of Acceptance for Chiropractic Coverage** (Page 4).

_____ _____
Printed name of Patient, Parent, Guardian or Personal Representative — Signature of Patient, Parent, Guardian or Personal Representative

RelationShip: _____ Date: _____

5 Medications Vitamins/Supps Allergies ☐N/A

Medications	Vitamins/Supps	Allergies
1)	1)	1)
2)	2)	2)
3)	3)	3)
Pharmacy:		4)
Pharmacy Phone:	☐Daily ☐Weekly ☐Occas.	How often do they occur?
☐ None		

6 Physical & Trauma Information

Work Activities: ☐ Sitting ☐ Standing ☐Light Labor ☐Heavy Labor ☐Retired _____
Work Injuries: ☐ Yes ☐ No If 'Yes': _____
Sport Activities: _____
Sport Injuries: ☐ Yes ☐ No If 'Yes': _____

Motor Vehicle Accident: ☐ Yes ☐ No If 'Yes', when: _____
Exercise: ☐ None ☐ Light ☐ Moderate ☐ Heavy What exercise do you do?:

Home Injuries: ☐ Yes ☐ No If 'Yes': _____
Habits: ☐ Nicotine ☐ Alcohol ☐ Coffee/Caffeine Drinks ☐ High Stress Level ☐ None
How Much?: _____
Fall: ☐ Yes ☐ No If 'Yes': _____
Head Injuries: ☐ Yes ☐ No If 'Yes': _____
Dislocation: ☐ Yes ☐ No If 'Yes': _____
Broken Bones: ☐ Yes ☐ No If 'Yes': _____
Surgeries: ☐ Yes ☐ No If 'Yes': _____

7 Primary Complaint

The Primary Complaint is your chief complaint or most problematic.

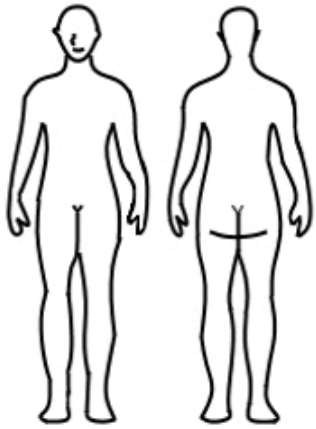
Primary Complaint: _____

Please describe the condition: _____

When did your symptoms first appear? _____

Most recent occurrence date: _____

What do you think caused this problem? _____



Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an 'X' on the picture were you have pain, numbness or tingling:

Rate the severity of your pain: …at its worse: **0 1 2 3 4 5 6 7 8 9 10**

0 being Least …at its least: **0 1 2 3 4 5 6 7 8 9 10**

10 being Severe …at present: **0 1 2 3 4 5 6 7 8 9 10**

Type of Pain: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numb** ☐ Aching ☐ **Shooting**
☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness ☐ Swelling

Does the pain travel from one location to another? ☐ N/A If so, from where to where?

How often do you have this pain? ☐ Constantly ☐ Comes & goes ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ N/A
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down

Past Treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None

Pain Worsens With: _____ Pain Improves with: _____

Notes: _____

8 Additional Complaint I

The Additional Complaint is any complaint other than your primary.

Additional Complaint: _____

Please describe the condition: _____

How often does this occur? _____

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Rate the severity of your pain at the present moment: **0 1 2 3 4 5 6 7 8 9 10**

Type of Pain: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numb** ☐ Aching ☐ **Shooting**
☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: _____

Does the pain travel from one location to another? ☐ N/A If so, from where to where? _____

How often do you have this pain? ☐ Constantly ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ N/A
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down

Past Treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None

Pain Worsens With: _____ Pain Improves with: _____

9 Additional Complaint II

Additional Complaint: _____

Please describe the condition: _____

How often does this occur? _____

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Rate the severity of your pain at the present moment: **0 1 2 3 4 5 6 7 8 9 10**

Type of Pain: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numb** ☐ Aching ☐ **Shooting**
☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: _____

Does the pain travel from one location to another? ☐ N/A If so, from where to where? _____

How often do you have this pain? ☐ Constantly ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ N/A
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down

Past Treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None

Pain Worsens With: _____ Pain Improves with: _____

Cousineau Chiropractic Center, PLLC

Insurance Assignment Program

It is our desire to assist our patients whenever possible. The following assignment program allows you, our patient, to receive the care you need without undue financial strain. Waiting for insurance payment is a courtesy provided by this clinic. This clinic does not promise that an insurance company will pay. It is *<u>your</u>* responsibility to:

1. **Supply us with a copy of your most recent insurance card on the first day service is rendered. If multiple insurances are involved; all information must be received at our clinic within 5 (Five) days.**
2. **Inform our office of any insurance changes within timely notice. 30 (Thirty) days is considered within this notice.**
3. **Pay all Deductibles and Copays.**
4. **Bring the check and EOB (Explanation of benefits) to this office within One Week of receipt with an endorsement to our office if you receive payment from your insurance carrier during the period of assignment. If the check is not received by this clinic, you will be solely responsible for the Full Amount Billed.**
5. **Pay <u>all</u> of the charges and pursue reimbursement from his/her/their insurance company in the event that the insurance company disputes or rejects the claim.**

Please be advised this is a summary of plan benefits and does not guarantee payment by your insurance company. Benefits are subject to all plan terms, provisions, limitations, and exclusions, including any limitations or exclusions relating to pre-existing conditions, waiting periods, and/or elimination periods. Upon receipt, claims may be subject to investigation which may affect the availability and extent of benefits available. All expenses are limited by the plans usual and customary allowance and 'medical or chiropractic' necessity guidelines. Experimental treatment is NOT covered. The eligibility provided is the most accurate data available to us from the employer, but may not reflect the changes in status known to the employee.

Terms of Acceptance for Chiropractic Treatment

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is: apply specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 (Twenty-four) vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than chiropractic problems per State of Michigan standards. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire to be; advised, diagnosed, or treated for those findings, we will recommend that you seek services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.