ELEVATED HEALTH

New Patient Intake Form

Please have filled out for your one-on-one with Dr. Tyler Elmore

Basic Patient Information

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Sex: M F Age: _____ Birth date: _____ Height: _____ Weight: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: _____ Hobby: _____

Who may we thank for referring you? _____

Name of M.D. if currently under care? _____

Medical Prescriptions: _____

Has your doctor advised you to lose weight? ☐ Yes ☐ No

Do you have any dietary restrictions? ☐ Yes ☐ No

Check ALL that apply to you: ☐ Heart Condition ☐ Epilepsy/Seizures ☐ Pregnant ☐ Might Be Pregnant ☐ Taking Heart Medication/Blood Thinners ☐ Currently Undergoing Chemotherapy ☐ Breast Feeding ☐ Known Adverse Reactions to Niacin or B Vitamins

Health and Wellness History

Please answer the following questions honestly so we can do our best to help you reach your goals.

Check ALL areas of treatment that interest you:

☐ Weight Loss ☐ Cleansing and Detoxification ☐ Overall Health ☐ Body Wraps

☐ Improving Energy ☐ Stress Reduction ☐ Better Sleep ☐ Other

Did you know that all of the treatments listed above are 100% safe? ☐ Yes ☐ No

Have you received treatment for any of the above? ☐ Yes ☐ No

When was the last time you were at your goal weight? _____

What do you consider your ideal weight? _____

How much weight do you want to lose? _____

How many times a year do you diet? _____

What is stopping you from losing weight all on your own? _____

What have you tried in the past that has failed? _____

Does your weight problem make you physically uncomfortable? ☐ Yes ☐ No

Please explain: _____

Does your weight problem cause physical pain? ☐ Yes ☐ No

Please explain: _____

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Health and Wellness History (Continued)

Are you embarrassed by your excessive weight? □ Yes □ No

Please explain: _____

Does being overweight and unhealthy limit your activities? □ Yes □ No

Please explain: _____

Do you binge eat? □ Yes □ No

Do you suffer from uncontrollable cravings? □ Yes □ No

Do you feel food controls you? □ Yes □ No

Do you eat for emotional reasons (stress, anger, sadness, etc.)? □ Yes □ No

Do you eat between meals? □ Yes □ No

What do you choose to eat between meals? _____

Briefly describe your daily eating behavior: _____

Do you feel your eating behavior is normal? □ Yes □ No

Do you feel tired, run down, and out of energy? □ Yes □ No

Is successful weight loss a top priority? □ Yes □ No

How fast do you want to be slim, trim, and fit? _____

What's more important to you fast or permanent? _____

Does your family support your weight loss efforts? □ Yes □ No

Is your family excited about you coming here for weight loss? □ Yes □ No

Can you remember being your ideal weight? □ Yes □ No

What do you remember most about it? _____

_____

What is the most important element for you in deciding to use our services?
Circle only ONE of the four answers.

EFFECTIVENESS:	"My results are my top priority."
TIME:	"I want results quickly."
SERVICE:	"I need extra support along the way."
AFFORDABILITY:	"What you charge is my concern."

I understand that my entire patient record will remain completely confidential and will not be released without express written consent from me.

Signature: _____ Date: _____

Syracuse Chiropractic and Health Center · Dr. Tyler Elmore
1842 South 2000 West, Suite 2 · Syracuse, Utah 84075 · Phone: (801) 774-7540 · Fax: (801) 774-7542

Patient Registration and History Questionnaire

Name:_____Age:_____ Date of Birth:_____Date:_____
Last First
Address: _____City, State, Zip: _____

Email Address:_____

Social Security #:_____·□Male □ Female · Marital Status: □M □S□W□D · # of children: _____

Home Phone: (_____)_____Work Phone: (_____)_____

Employer: _____Spouse/Guardian's Name:_____

Spouse's Occupation: _____Spouse's Employer: _____

In Case of Emergency, Notify: _____Relationship: _____Phone: (___)_____

Chief Complaint or Reason for Office Visit: _____

Specific Date and Time of Onset of Symptoms:_____

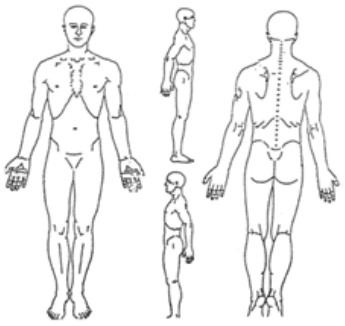
What makes your symptoms **better? _____ Worse?_____**

What is the quality of your symptoms (**ache, burn, dull, sharp, throbbing**): _____

Are your symptoms local or do they travel to another area (If they travel list where)? _____

Are Symptoms: □Constant > 76% □Frequent 51-75% □Occasional 26-50% □Intermittent <25%

Please mark on the diagram to the right the following symbols as they relate to your symptoms:	
SS= spasms	ST= stiffness
DP= dull pain	SP= sharp pain
SH= shooting pain	TI= tingling
NU=numbness	O=other



Please List All Medications and Dosage: **Frequency:** **For What Illness?**

_____

_____

List any allergies to medications, foods or other:_____

Are you pregnant? □Yes □No First day of last menstrual cycle: _____

Do you smoke? □Yes □No; if so, how much?_____

Do you drink alcohol? □Yes □No; if so, how much?_____

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Please list all serious illnesses and serious accidents: **Month and Year** **City, State**

_____

_____

_____

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

_____

_____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?

Tuberculosis	□Yes	Lung Disease	□Yes	Gout	□Yes	Diabetes	□Yes
Kidney Disease	□Yes	Stomach/Ulcer	□Yes	Heart Disease	□Yes	Hepatitis	□Yes
Sciatica	□Yes	Blood Pressure	□Yes	Transfusion	□Yes	Polio/MS	□Yes
Colon disease	□Yes	Stroke	□Yes	Cancer	□Yes	Bleeding	□Yes
Paralysis	□Yes	Seizures	□Yes	Arthritis	□Yes	Asthma	□Yes
Anemia	□Yes	Thyroid Disease	□Yes	Drug Dependence	□Yes	AIDS	□Yes

Any other condition (s) not listed above that the doctor should be made aware of:

_____

Whom may we thank for referring you? _____

YOUR GROUP HEALTH INSURANCE COMPANY: _____

Policy Holder: _____ Relationship: _____

Date of Birth: _____ Policy #: _____ SS#: _____

Telephone: (___) _____ Fax: (___) _____

HIPAA Compliance

Syracuse Chiropractic and Health Center is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A form will be provided to me upon request.

Patient Signature: _____ Date: _____

Patient: _____ Date: _____

REVIEW OF SYSTEMS

0 = NEVER HAD 1= PATIENT PRESENTLY HAS 2=PREVIOUSLY HAD 3=RELATED TO CRASH

GENERAL
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep Loss
___Weight Loss
___Nervousness/Depression
___Neuralgia
___Numbness
___Sweats
___Tremors

EYES, EARS, NOSE, THROAT
___Asthma
___Colds
___Sore Throat
___Deafness
___Dental Decay
___Earache/Noises
___Ear Discharge
___Sinus infection
___Enlarged Glands
___Enlarged Thyroid
___Nose Bleeds
___Failing Vision
___Far Sighted
___Gum Trouble
___Hay Fever
___Hoarseness
___Nasal Obstruction
___Near Sighted

MUSCULOSKELETAL
___Arthritis
___Bursitis
___Foot Trouble
___Hernia
___Low Back Pain
___Lumbago
___Neck Pain/Stiffness
___Shoulder blade pain
Pain or numbness in:
___ Shoulders
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Feet
___Painful Tailbone
___Poor Posture
___Sciatica
___Spinal Curvature

GENITO-URINARY
___Bed-Wetting
___Blood in Urine
___Frequent Urination
___ Inability to control Bladder
___Kidney Infection/Stones
___Painful Urination
___Prostate Trouble
___Pus in Urine
___Painful Menstruation
___Hot Flashes
___Irregular Cycle
___Lumps in Breasts

CARDIOVASCULAR
___Hardening of Arteries
___High Blood Pressure
___Low Blood Pressure
___Pain Over Heart
___Poor Circulation
___Rapid Heart Beat
___Slow Heart Beat
___Swelling of Ankles

RESPIRATORY
___Chest Pain
___Chronic Cough
___Difficult Breathing
___Spitting up Blood
___Spitting up Phlegm
___Wheezing

GASTROINTESTINAL
___Belching or Gas
___ Colitis
___ Colon Trouble
___ Constipation
___ Diarrhea
___ Difficult Digestion
___ Distention of Abdomen
___ Excessive Hunger
___ Gall Bladder Trouble
___ Hemorrhoids
___ Intestinal Worms
___ Jaundice
___ Liver Trouble
___ Nausea
___ Pain Over Stomach
___ Poor Appetite
___ Vomiting
___ Vomiting Blood

Other_____
_____
_____

Physician/Staff Signature:_____

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Office Financial Policy

Cash

1. All patients are on a cash basis until their respective insurance coverage and deductible are verified by our staff.
2. This office may make payment plan arrangement on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

Insurance

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine if proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists, after all insurance billing has been done, we will issue you an overpayment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
5. Any services not covered or coverage reductions by your insurance company will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as an uncovered services and you will be expected to pay such charges on a timely basis.
7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full immediately; regardless of any claims submitted.
8. IF you have any questions concerning this or any other matter, please speak with our insurance department or receptionist prior to seeing the doctor.

Thank you.

I have read and understand the Office Financial Policy and agree to abide by these terms.

Patient Signature _____ Date _____