Westcott Chiropractic Center

"Your Spine Is The Key To Good Health"

29671 Six Mile Rd. Ste 110C, Livonia, Mi 48152 ➢(734)427-1579

Dr. Jennifer L. Westcott

Patient Intake

Today's Date_____

Name_____Age_____Date of Birth___/___/____

Address_____City_____St____Zip_____

Marital Status: Single Married Other Sex_____ S.S.#_____/_____/_____

Home Phone(____)_____ Cell Phone(____)_____Work Phone(____)_____

Email Address_____

Employer_____Occupation_____

Employment Status: Employed Unemployed Full Time Student Part Time Student Other

Spouse Information

Name_____Date of Birth_____/_____/_____

Cell Phone(_____)_____ Work Phone(_____)_____

Emergency Contact

Name_____Relationship to Patient_____

Contact Home Phone(_____)_____Cell Phone(_____)_____

How Did You Hear About Our Office?_____

Health Insurance Information

Primary Insurance_____Policy Holder's Name_____D.O.B_____

Policy Holder's Relationship to Patient_____Policy Holder's Employer_____

Secondary Insurance_____Policy Holder's Name_____D.O.B_____

Accident Information (SKIP this Section if you were not involved in an accident)

Is your condition due to an **Auto Injury** **Work Injury** **Slip and Fall** **Other Accident (describe below)**

Date of Accident_____Place (City/State)_____

Insurance_____Addresss_____

City_____St_____ZipCode_____Phone_____

Contact Person_____ Claim#_____

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Patient Assessment

Primary reasons for seeking chiropractic care:

Primary reason_____

Secondary reason_____

Chief Complaint:

Location of Complaint_____

Complaint Began When and How_____

Please Circle the Quality of the complaint/Pain **dull aching sharp shooting burning throbbing deep nagging other**_____

Does this complaint/pain radiate or travel(shoot) to any area of your body? Where?_____

Do you have numbness or tingling in your body? Where?_____

How frequent is complaint present, how long does it last?_____

Does anything aggravate or make the complaint better?_____

_____

Rate your pain

No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Previous interventions, treatments, medications, surgery, or care you have sought for your current complaint_____

_____

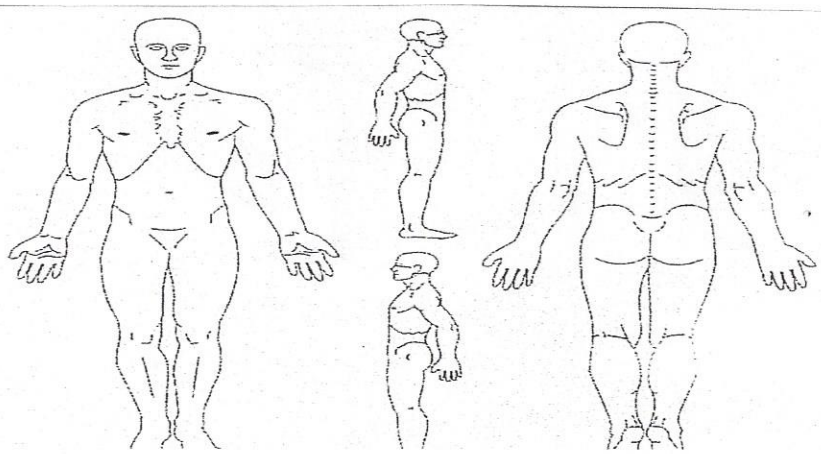
_____

How Often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=numbness B=burning S=sharp T=tingling A=Dull Ache



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Patient Past Health History

What accidents, falls, injuries have you had in the past?(This includes old injuries, contact sports, etc...) Please include the date _____

_____

_____

_____

Have you broken any bones? Which Ones? How? When?_____

_____

_____

_____

Have you ever had chiropractic care? If yes, last date of treatment_____
By Whom?_____
Similar or different condition:_____Results:_____

List any operations, surgeries, or medical procedures:
Date:_____Procedure:_____Date:_____Procedure_____

Date:_____Procedure:_____Date:_____Procedure_____

Please list any significant family illnesses_____

Have you had any spinal X-rays or MRI's in past 5 years? If yes, when and where_____
I acknowledge that the above information is true and complete to the best of my knowledge

_____ _____
Patient Signature/Date Doctor Signature

Medicare Patients (check one): Would you like to be able to ☐ Bend and lift with no pain ☐ Get up from sitting with no pain ☐ Get a good night's sleep with no pain ☐ Read with no pain ☐ Work at a computer with no pain ☐ Do your housework with no pain ☐ Do your yardwork with no pain ☐ Play sporting activities with no pain

Do Not Write Below This Line

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For Women and Children

Any complications during pregnancy or birth? If yes describe_____
_____
_____
_____

Any problems during infancy/first year of life? (e.g. colic, ear infections, respiratory problems, etc...)_____
_____
_____
_____

Was your child an early walker?_____Did they crawl?_____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and that the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:_____

_____ _____

Signature **Date**

Doctor's
Signature_____Date_____

Do not write below this line

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Informed Consent For Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient , to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is the science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 movable vertebrae in the spinal column become misaligned and/or do not move properly thus causing and alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or it may be entirely asymptomatic.

Subluxations are corrected and /or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine. In addition to adjustments, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Today we will determine if we can help you. In order to do that, we need to do the following:

1) Review your health history
2) Perform an examination
3) Perform an X-Ray examination
4) Explain how chiropractic can help you

_____ _____ _____
Print Name **Signature** **Date**

Consent to evaluate and adjust a minor child:

I, _____being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____ _____
Print Name **Signature** **Date**

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Patient Current Health History

Current Health

Name and phone number of your family doctor_____

List all CURRENT illnesses or diseases you have been diagnosed with (cancers, tumors, infections, diabetes, aneurysms, etc...)_____
_____

If you are currently taking any prescription or nonprescription medications, please list them below with dosages:
Medication:_____Dose:_____Medication:_____Dose:_____

Medication:_____Dose:_____Medication:_____Dose:_____

List any allergies_____

Indicate your height and weight_____What is your normal B.P._____/_____

Occupational Activities: (Circle one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment Operator	Day Care/Child Care	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Housekeeper
Heavy Manual Labor	Light Manual Labor	Executive Legal	Other_____

Any current loss of bowel or bladder control:☐Yes ☐No Any current seizures, paralysis, speech, vision problems: ☐Yes ☐No

Any unexplained recent weight loss: ☐Yes ☐No Current Fever: ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No **If yes, please let us know**

Do you have any blood or lymph disorders? ☐ Yes ☐ No If yes, please list_____

Do you have osteoporosis or rheumatoid arthritis? ☐ Yes ☐ No

Please circle one: I have never smoked Former smoker Current smoker, if so how much:_____pk/day

Please circle one: I do not drink alcohol Rarely drink Social drinker Heavy drinker(___oz. Per day/week)

What are your overall expectations from your treatment with the doctor today:_____
_____

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Financial Policy

We strive to provide you with excellent and affordable Chiropractic care. Please read and sign in the space below.

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes
- Your account is kept current. All self pay or insurance copayments and deductibles will be collected at the time of service payable by cash, check, Visa, Mastercard, or Discover.
- If you are unable to keep your appointment please notify us 24 hours in advance to avoid a $30.00 missed appointment fee. We understand there are exceptions in certain circumstances. Speak with the receptionist if you have a concern.
- You will only be sent a statement if you balance exceeds $5.00.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will bill your insurance company to try to collect fees payable by that particular insurance company. There is no guarantee of payment. **We are not in network with all insurance companies and there is no guarantee that you have chiropractic coverage. As medical providers, our relationship is with you, not your insurance company.**

By signing below you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that we can file a claim in a timely manner. If we do not receive your most current insurance information, this may result in you being responsible for those claims as insurance companies have a filing time limit.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance plan.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions, and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- If you are a **MEDICARE PATIENT,** please be advised that Medicare **only covers** Spinal Adjustments in a Chiropractor's office. All other services outside of the adjustment in our office will be your financial responsibility.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we urge you to contact us promptly for assistance in managing your account. **WE ARE HERE TO HELP YOU.**

By signing below, you have read and understood the above Financial Policy and agree to meet all financial obligations.

_____	_____	_____
Printed Name	Signature of Patient/Legal Guardian	Date