Bare Foot Chiropractic

New Patient Intake

List all medications/supplements you are taking and why you are taking each one (including o.t.c.)

_____

_____

Have you ever had any surgeries? □ No □ Yes If yes, what type and when? _____

_____

Do you smoke? □ No □ Yes, how much per day? _____

Do you consume alcoholic beverages? □ No □ Yes, how much per week? _____

Do you consume coffee or caffeinated beverages? □ No □ Yes, how much per day? _____

I certify that, to the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform BFCC if I ever have a change in health.

Thank you for choosing Bare Foot Chiropractic as your trusted provider.

BFC will be happy to answer any questions regarding this financial policy. below.

INSURANCE:

As a courtesy to you, BFC will will provide you with a super bill. This has all the necessary information for you to submit the claim to your insurance company and they will reimburse you directly . Initial: _____

PAYMENT AT TIME OF SERVICES:

You will be required to pay the estimated cost of services at the time of service unless prior financial arrangements have been made and agreed upon by all parties. Initial: _____

INDIVIDUALIZED PAYMENT PLANS:

BFC Chiropractors recommend care plans based on exam findings and patient goals. For those plans, we offer time saving discounts based on prepayment of services. . Initial: _____

Our patients have had incredible stories to tell. We hope that, you too, will have a story to tell. In order to help others heal, can we please have your testimony (videos, reviews, ect.)? By signing below, you agree to allow us to share your testimony with other practice members and our audience on any of our platforms.

Patient Name:_____ Patient Signature:_____

Bare Foot Chiropractic

New Patient Intake

Full Name: _____ Today's Date: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Address: _____

Best Phone #: _____ Email: _____

Relationship status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other_____

Emergency Contact: (name & relation)_____ (#)_____

Employer: _____ Occupation: _____

Town of Employer: _____

Who can we thank for sending you to us? _____

☐ Facebook ☐ Internet ☐ Sign ☐ Word of Mouth ☐ Physician ☐ Existing Patient ☐ Other

Have you ever been adjusted by a Chiropractor? ☐ No ☐ Yes If yes, where? _____

If yes, what was the reason for the visit? _____

Describe Reason for Today's Visit: _____

_____

When did you first notice it? _____ What do you think caused it? _____

What makes it worse or becomes difficult to perform:? ☐ Driving ☐ Walking ☐ Sitting ☐ Bending ☐ Standing ☐ Breathing ☐ Coughing ☐ Sleeping ☐ Working ☐ Exercising ☐ Other _____

Have you seen another doctor for this? ☐ No ☐ Yes If yes, how long ago? _____

Doctor or Practice Name: _____ Phone #: _____

Were x-rays or other imaging studies performed? ☐ No ☐ Yes

Type of Treatment/ Results: ☐Medication ☐Physical Therapy ☐Surgery ☐Other _____

Do you exercise? ☐ No ☐ Yes If yes, what type and how often?_____

What activities/sports do you participate in? _____

What position(s) do you sleep in? ☐ Back ☐ Right Side ☐ Left Side ☐ Stomach

Hours per night? _____ Quality? ☐ Good ☐ Fair ☐ Poor

Rate your pain TODAY: 1 2 3 4 5 6 7 8 9 10