RYKEN CHIROPRACTIC & WELLNESS CENTER

Ryken Chiropractic & Wellness Center
290 South Alma School Rd. Suite 5
Chandler, AZ 85224
480-857-1991

Patient Intake Form

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our ***Patient Intake Form***. Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

Patient Information

Personal Information

*First Name: _____
Middle Name: _____
*Last Name: _____
*Gender: ◎ Female ◎ Male
*Date of Birth: _____
Social Security #: ___ __ ____
Height: ▾ Feet ▾ Inches
Weight: _____
Marital Status: ▾
Spouse's Name: _____
Number of Children: ▾

Emergency Contact: _____
Relationship: _____
Phone: _____

Contact Information

*Email: _____

(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

*Home Phone: _____
Cell Phone: _____
Work Phone: _____

Country: United States ▾
Address Line 1: _____
Address Line 2: _____
City: _____
State/Province/Region: ▾
*Zip/Postal Code: _____

Insurance & Payment for Care

How do you plan to pay for care?

◎ Personal Insurance ◎ Third-Party Insurance ◎ No Insurance, Self-Pay

Name of Party Responsible for Payment: _____

Responsible Party Phone: _____

Primary Insurance

Insurance Name: _____

Phone: _____

Address: _____

City: _____

State: ▼

Zip: _____

ID/Policy #: _____

Group #: _____

Insured's Name: _____

Insured's Date of Birth: _____

Secondary Insurance

Insurance Name: _____

Phone: _____

Address: _____

City: _____

State: ▼

Zip: _____

ID/Policy #: _____

Group #: _____

Insured's Name: _____

Insured's Date of Birth: _____

If an auto accident, please provide:

Claim #: _____

Insurance Contact Person: _____

Insurance Phone: _____

Attorney's Full Name: _____

Attorney's Phone: _____

Reason for this Visit

Describe the reason for this visit

Please briefly describe, including the impact it has had on your life.

If you're only here for chiropractic wellness services please skip this section.

○ Wellness ○ Sports ○ Auto ○ Fall ○ Home Injury ○ Job ○ Chronic Discomfort ○ Other

Briefly Explain:

_____

When did this concern begin?

_____

Has this concern:

Gotten Worse Stayed Constant Come and Gone

Does this concern interfere with:

Work Sleep Daily Routine Other Activities

Briefly Explain:

_____

Has this concern occured before?

Yes No

Briefly Explain:

_____

Have you seen other doctors for this concern?

Yes No

Doctor's Name:

_____

Type of Treatment:

_____

Results: Good Bad Indifferent

Health Problems & Concerns:

Please select all that you have had or currently have.

- Allergies
- Alcoholism
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Autoimmune Disease
- Back Pain
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Cataracts
- Chest Pain
- CHF (congestive heart disease)
- Cold Extremities
- Constipation
- COPD/emphysema
- Dizziness
- Epilepsy
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Gallbladder disease/stones
- Glaucoma
- Gout
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Menstrual Cycle
- Kidney Infection
- Kidney Stones
- Liver disease/cirrhosis
- Loss of Memory
- Pacemaker
- Parkinson's
- Polio
- Poor Posture
- Prostate Trouble
- Retinal Disease
- Sciatica
- Seizures
- Shortness of Breath
- Sinus Infection
- Sleep Problems/Insomnia
- Skin Sensitivity
- Smoked
- Spinal Curvatures
- Stroke
- Swelling of Ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis

- [ ] Cramps
- [ ] CVA (stroke/TIA)
- [ ] Dementia/Alzheimer's
- [ ] Depression
- [ ] Diabetes
- [ ] Digestion Problems
- [ ] Diagnosed emotional/mental disorders
- [ ] Loss of Balance
- [ ] Loss of Smell
- [ ] Loss of Taste
- [ ] Lung disease
- [ ] Macular Degeneration
- [ ] Migraines
- [ ] Nosebleeds
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other

Other:

Have you had any of these Cardiovascular Diseases? Please select all that apply.

- [ ] Myocardial infarction
- [ ] Hypertension
- [ ] Hypercholesterolemia
- [ ] Bypass surgery
- [ ] Coronary artery disease

Do you have Diabetes? If so what type?

- ( ) Type I
- ( ) Type II
- ( ) Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

- [ ] Ulcers
- [ ] Reflux
- [ ] IBS

Electronic Health Record (EHR) Information

Preferred Language: ▾ Ethnicity: ▾

Race: ▾

Smoking Status: ▾

Type of Tobacco: [ ] Cigarettes [ ] Chewing Tobacco [ ] Cigar [ ] Pipe [ ] Other

Have you tried to quit? ( ) Yes ( ) No How much tobacco do you use? _____

How long have you used tobacco? _____

Current Medications And Dosage:

Medication Name	Dosage

Add Another Medication

Medication Allergies:

Medication Name	Reaction	Date Discovered

Add Another Medication Allergies

[ ] I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature

for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

* ☐ **I agree with this statement of authorization**

Name of the Insured:
(Please Print) _____

Patient's/Guardian's signature: _____ **Date:** _____