Bountiful
SPINAL CARE
724 W 500 S #100 West Bountiful, UT 84087

NEW PATIENT INTAKE - HEALTH HISTORY & APPLICATION FOR TREATMENT

Please complete the following information:

Patient's Name: Age: Today's Date:

Sex: □ Male □ Female Birth date: SS#:

Address: City, State, Zip:

(Temp. Address if in college):

Cell Phone: Home Phone:

Email Address: Occupation/work duties:

Height: Weight: Shoe Size: Orthotic? Y N Heel Lift? Y N

Status: □ Married □ Single □ Widowed □ Divorced □ Seperated Ethnicity:

Spouse's Name: # of Children: Ages:

In case of emergency, contact: Relationship: Phone Number:

Whom may we thank for referring you to our office?

How did you hear about us? □ Sign/Location □ Yellow Pages □ Online □ Facebook □ Ins. □ Other:

Health Insurance Carrier: □ check if none Policy #:

Family Medical Doctor: Location/clinic:

Previous Chiropractor:

What is the reason for this visit?

Worst Area (#1) How bad:? □ Mild □ Moderate □ Severe

How did this come about?

How often? □ Comes and goes □ Constant □ AM □ PM □ Nightime □ Other:

Does it interfere with: □ Work □ Sleep □ Self Care □ Daily Routine □ Exercise □ Other:

If headache/migraine, how many per day/week/month? How long before it goes away?

□ Mild □ Moderate □ Severe Any sensitivity: □ Light □ Sound □ Dizziness

Have you seen any other healthcare providers/explain?

Additional Symptom Areas:

#2	□ Mild	□ Moderate	□ Severe
#3	□ Mild	□ Moderate	□ Severe
#4	□ Mild	□ Moderate	□ Severe
#5	□ Mild	□ Moderate	□ Severe
#6	□ Mild	□ Moderate	□ Severe

Family Health History

Any family members with history of cancer, diabetes, heart disease, or neurological disorders?

Parents	□ Cancer	□ Diabetes	□ Heart disease	□ Stroke	□ Neurologic	Who:
Siblings	□ Cancer	□ Diabetes	□ Heart disease	□ Stroke	□ Neurologic	Who:
Grandparents	□ Cancer	□ Diabetes	□ Heart disease	□ Stroke	□ Neurologic	Who:

Personal Health History

Past surgeries:

Past traumas/auto accidents:

Broken bones:

Hospitalized:

Struck unconscious:

Eating disorder:

Past Illnesses:

Other health problems:

Currently taking medications: □ None If yes, list:

Currently taking supplements: □ None If yes, list:

Allergies, including to medications: □ No Known medication allergies. If yes, list:

Vaccination history: □ Current □ Some delayed/reduced □ None

Female Obstetric History

Are you pregnant? Y N	Are you taking birth control? Y N	Do you have irregular cycles? Y N
Are you nursing? Y N	Do you have breast implants? Y N	Do you have painful periods? Y N
Date of Last Menstrual Period?	Date of last PAP/Pelvic exam?	

Social Health History

Exercise:	□ Daily	□ Weekly	□ Occasionally	□ Never
Water:	□ 1 liter daily	□ 2 liters daily	□ 3+ liters daily (100oz)	
Alcohol:	□ Daily	□ Weekly	□ Occasionally	□ Never
Tobacco:	□ Daily	□ Weekly	□ Occasionally	□ Never
Marijuana:	□ Daily	□ Weekly	□ Occasionally	□ Never
Caffeine:	□ Daily	□ Weekly	□ Occasionally	□ Never
Soda:	□ Daily	□ Weekly	□ Occasionally	□ Never

Review of Systems - Mark your Current Issues

□ headaches	□ eye/ear/throat	□ mid-back pain	□ sinus pain/allergies	□ neck pain
□ stressed shoulders	□ leg and hip pain	□ lower back pain	□ depression/anxiety	□ scoliosis
□ sleeping problems	□ thyroid/endocrine	□ frequent colds/flus	□ chest/heart pain	□ numbness

□ wrist or joint pain □ Fibromylagia □ stomach/digestive trouble □ breathing/asthma □ stiffness

□ high blood pressure □ loss of energy □ vertigo/dizziness □ other:

TERMS OF ACCEPTANCE

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. Chiropractic has only one goal: remove subluxation and it's harmful effects on the body. 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 by specific adjustments in the upper cervical spine, extremity joints, and lower segments of the spine.

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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 a vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the 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 primary practice objective is to eliminate a major interference of the expression of the body's innate wisdom. Our primary method is specifically adjusting to correct vertebral subluxation.

INSURANCE & FINANCIAL NOTICE

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. By signing below, I understand and agree that all services rendered to me will be charged to me with payment due at the time of service unless other arrangements are made, and any lapse in time for the office to send billing does not negate my responsibility to pay.

Original Medicare plans are billed electronically when Medicare-covered services are provided. Reimbursement checks from Medicare and MC supplements will then come directly to the patient. Medicare replacements (Advantage, Complete) have an alternate regulatory policy and are subject to the clinic fee schedule.

ECS members (Efficient Care Solutions) must renew annually, and are eligible for our ECS discount rate. ECS waives your right to send a Superbill to an insurance plan for self-reimbursement. You may opt out of ECS at any point with written notice. I understand that fees for professional services will become due immediately upon suspension or termination of my care or treatment. Fees are subject to change without notice. In-Network health insurance plans will be billed according to the insurance carrier regulations.

Outstanding balances will be billed monthly and are considered past due 10 days after the invoice date. Returned check fees will be passed on to the patient. Balances beyond 30 days will be *assessed interest at an 18% APR plus any legal or collection fees*. I understand that a canceled / missed appointment fee (up to cost of appoint.), may be applied if an appointment is missed or sufficient notice is not given within 24 hours.

Good Faith Estimates are always available before any service is performed. (Jan. 1, 2022 No Surprise Act) We do not provide Emergency Care.

PRE-PAID SERVICES POLICY

Pre-paid packages and/or account credits must be used or request a refund in a timely manner, unused credits will expire after 6 months from purchase on accounts that are inactive (no future appointment scheduled). They do not expire for patients on an active care schedule. Refunds can be requested in writing and will be processed within 1 week. For ChiroClub payment plans, see additional terms.

HIPAA NOTICE

The Practice's Privacy Notice has been made available to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice prior to my signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law. The Practice's "Notice of Privacy Practices" is also provided at the front desk of the office or via email. The Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information. By signing below, I have read and understand this notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

CONSENT TO TREAT & X-RAY AUTHORIZATION

I affirm that I am the patient listed and have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I allow the use of the above information by Bountiful Spinal Care. I authorize this office and its staff to examine and give my CONSENT TO TREAT my condition as the doctors see fit, including x-ray examination. If female, I certify that to the best of my knowledge I am not pregnant and the doctor and associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. **If pregnant**, I will notify the doctor and/or staff before proceeding with an x-ray exam.

By signing below, I acknowledge that I have read, understand, and agree to the above listed terms and policies.

Print Name _____ Signature _____ Date _____

Bountiful SPINAL CARE
801-335-7288
724 W 500 S #100
West Bountiful, UT 84087
(Last form update: 1/9/25)