Ehlich
FAMILY CHIROPRACTIC
606-A W. Poinsett Street, Greer, SC 29650
Ph: 864-848-3912 | Fax: 864-801-1470 | EhlichChiro.life

INTAKE & HISTORY

PATIENT INFORMATION

DATE:

ACCT:

Patient Name _____
LAST NAME
_____
FIRST NAME MIDDLE INITIAL

Address _____

City_____State _____Zip_____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age ___ Birthday_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School _____

Occupation_____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

Social Security_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Contact Number _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

How did you hear about us?

Friend_____ ☐ AD ☐ Doctors Recommendation ☐

Google Search ☐ Facebook ☐ Other _____

Insurance Information and Payment Responsibility

Patient is the Same/Self Husband Wife Child Other of Insured

Name of Insurance Co._____

First Name _____ Middle Initial_____ Last Name_____ DOB_____ Sex Male Female Unknown

Address_____City, State, Zip_____ Phone Number_____

Social Security_____

Who is responsible for payment_____

Condition Information

Related to Employment Yes No

Related to Auto Accident Yes No

Related to Other Accident Yes No

HOW CAN WE HELP YOU? Are your present problems due to an injury? YES or NO

What brings you in today? _____

_____

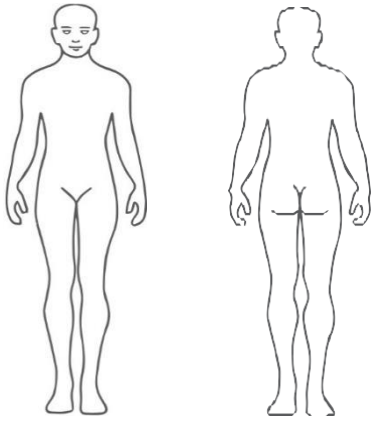
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right on the bodies where you have pain or other symptoms:



What does it feel like? (check where appropriate)

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Stabbing
- ☐ Swelling
- ☐ Other _____

Are your present problems due to an injury? ☐ Yes ☐ No Date of Injury: _____

Was the injury? ☐ Job Related ☐ Auto Accident ☐ Personal Injury ☐ Other: _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITED — VERY COMMITED

Allergies, Medications, Supplements & Surgeries

Allergies (list)	Medications (list)	Supplements (list)	Surgeries (list)

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONGTERM _____

Health & Illness History

Please check the box beside any condition that you have or have had.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Eczema
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Epilepsy
- ☐ Foot/Ankle Issues
- ☐ Goiter
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____
  _____

Current Habits

- ☐ Smoker Current
- ☐ Smoker Former
- ☐ Smoker Never
- ☐ Drinking Alcohol: cups/day _____
- ☐ Soft Drink Bottles or cans/day_____
- ☐ Coffee cups/day_____
- ☐ Water cups/day_____
- ☐ Exercise None_____Moderate_____Daily_____

Family History

- ☐ Diabetes (Maternal/Paternal)
- ☐ Cancer (Maternal/Paternal
- ☐ Back Pain (Maternal/Paternal)
- ☐ Other_____(Maternal/Paternal)

Do you or have you ever had foot orthotics?

- ☐ YES
- ☐ NO

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____ Date_____

Signature of Doctor of Chiropractic: _____Dr. Chris Ehlich_____ _____Dr. Beth Ehlich_____

Dr. Chris Ehlich Dr. Beth Ehlich

Privacy Policies

Our office will safeguard your personal health information and will not release or use it without your written permission except where allowed or directed by law. Your information is not released or sold to outside sources. If you have health insurance we will electronically file those claims for you.
I authorize Chris Ehlich, DC or Beth Ehlich, DC or Ehlich Family Chiropractic, PC to release any information to process insurance claims on my behalf. I understand my insurance may or may not have any benefits for chiropractic services and those benefits are determined by the policy I have chosen. I further understand that my insurance and I have entered an agreement and that does NOT include this office or the doctors at this office
I understand that this office may need to contact me. I authorize this office to leave a message, text or email me. I agree to receive these messages at home, work, cell phone. I understand I can restrict where these messages go and how they are sent in writing.
I understand that this office may send seasonal, birthday cards or other invitations for promotions or events. I agree to receive these mailings. I may restrict this in writing.
I consent to have a family member or designated individual present during my care which may include, exams, reports, adjustments or other services. I understand that I can limit and restrict to whom information is released.
I understand that X-rays remain the physical property of this office
I understand that I am responsible for all charges for services rendered to me in this office. I understand that payment is due and expected at the time services are rendered. I also understand that interest may be applied to any outstanding balances after 30 days.
This is notice of our privacy policies. You have the right to revoke your agreement to these policies at any time in writing. Your signature here is your agreement, authorization and consent to the above policies.
A copy of these policies is available for your convenience.

Privacy Policies

I am aware I am given the option to see the privacy policies

Patient/Guardian Signature_____ Date_____

Name _____Relationship to Patient_____

I give consent to have my information regarding appointments, report of findings and financial information released to my spouse or parent.

Spouse or Parent Name_____ Signature of Patient _____