Schrickel Health and Wellness Center
Patient Intake Form

Patient Information

Today's Date: _____
Last Name: _____ First Name: _____ Middle Name:_____
I prefer to be called: _____ ☐Mr. ☐Mrs. ☐Ms. ☐ Miss ☐Dr. ☐Prof. ☐Rev.

Date of Birth _____/_____/_____ Age: _____ Social Security Number: _____
☐Male ☐Female
☐Single ☐Married ☐Divorced ☐Widowed ☐Other
Address: _____
City:_____ State: _____ Zip Code:_____

Home Phone: (_____)_____ Cell Phone:(_____)_____ Work Phone:(____)_____
E-Mail Address: _____
Who can we thank for referring you to us? _____

Insurance Policy Holder Information

Name: _____ Birthdate: ____/____/____ Social Security Number:_____
Employer: _____ Cell Phone:_____ Work Phone:_____
Relationship to Patient: _____

Medical History

DATE OF INJURY:____/____/_____ Please be advised that if your current date of injury for this condition is not provided, your insurance company **may not pay for treatment**. If you do not have a specific date of injury please give a date that is the closest to when you started to have back pain.

Are you consulting the doctor due to a Workers Comp or a Motor Vehicle Accident? ☐Yes ☐No

Do you have a primary care physician? ☐Yes ☐No Physicians Name: _____
Date of last visit: _____ Your current physical health is: ☐Good ☐Fair ☐Poor
Are you currently under the care of a physician? ☐Yes ☐No If yes, please explain _____
_____
Do you smoke or use tobacco in any other form? ☐Yes ☐No
Do you consume alcohol? ☐Moderately ☐Excessively ☐Not at all
Please list any allergies: _____

Female Patients

Are you pregnant? ☐Yes ☐No ☐Unsure Week #_____
Are you taking birth control pills? ☐Yes ☐No

Medication List

Medication_____Mg:_____When Taken:_____
Medication_____Mg:_____When Taken:_____
Medication_____Mg:_____When Taken:_____
Medication_____Mg:_____When Taken:_____
Medication_____Mg:_____When Taken:_____
Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above?
☐Yes ☐No If yes, please list each one:_____

Please turn over and complete the back page.

Health

Weight_____ Height _____
I exercise: ☐Moderately ☐Occasionally ☐Rarely ☐Never
I have difficulty with: ☐Standing ☐Walking ☐Riding ☐Bending

Do you have or have you experienced any medical conditions in the past? If so, please list:

_____
_____
_____

Please describe your present complaint:

_____
_____
_____

Have you seen other doctors for this problem? ☐Yes ☐No If so, whom? _____
Were you hospitalized due to this problem? ☐Yes ☐No If so, how long?_____
How many days have you missed work due to this condition? _____

Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for the health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practicies and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the pratice/clinic agrees to my requested restriction, they must follow the restriction(s). I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Please inquire at the front desk if you would like a copy of our HIPAA form.

Signature:_____ Date:_____
Patient, parent or legal guardian
If signed by patient representative, state relationship to patient_____

RELEASE OF INFORMATION:
Please record a name below of the person that you want to disclose information to:
1. _____ Relationship to Patient _____
2. _____ Relationship to Patient _____
3. _____ Relationship to Patient _____

Thank you for entrusting Schrickel Health and Wellness Center
with the care of your most precious assest, your spine.

- Dr. Thad Schrickel

-Dr. Jordan Rozich