CHIROPRACTIC INTAKE & HISTORY

HOUSE FAMILY CHIROPRACTIC

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Cell Phone _____
Email _____
Sex ❑ M ❑ F Age ____ Birthday _____
Social Security Number _____
❑ Married ❑ Widowed ❑ Single ❑ Minor
❑ Separated ❑ Divorced ❑ Partnered
Primary Care Physician: _____

Employer/School _____
Occupation _____
Spouse's Name _____
Spouse's Employer _____
Spouse's Occupation _____
IN CASE OF EMERGENCY, CONTACT
Name _____
Relationship _____
Contact Number _____
Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

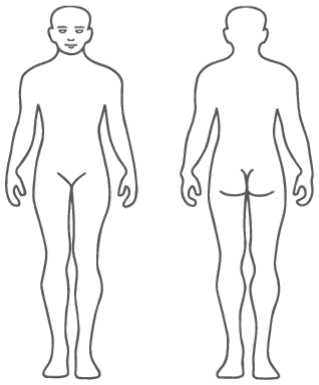
_____

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

How bad is it? How intense are your symptoms? (circle) ⓿ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿

NO SYMPTOMS — INTENSE SYMPTOMS

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



What does it feel like? (check where appropriate)

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

For office use only:

Height _____ Weight _____ Blood Pressure _____

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? ⓿ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿

NOT COMMITTED — VERY COMMITTED

PATIENT WELLNESS ASSESSMENT

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 _____

LONG TERM _____

CHILDREN & PREGNANCY

How many children do you have? _____ Are you currently pregnant? ❑ No ❑ Yes, I am due _____

Children's ages? _____ Number of past pregnancies? _____

Children's health concerns? _____ Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

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

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

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES	MEDICATIONS/DOSAGE/FREQUENCY	SUPPLEMENTS

ELECTRONIC HEALTH RECORDS INTAKE

In compliance with requirements for the government EHR program

Race: (circle) American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity: (circle) Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer Preferred Language: _____

Smoking Status: (circle) Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

❑ **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.)

Patient Signature: _____ Date: _____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

SIGNATURE: DATE:

GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE: DATE

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ MEDICARE ❑ HEALTH INSURANCE

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

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 to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral Subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advice you. If you desire advice, diagnosis or treatment for those 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 ONLY PRACTIC OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral Subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic car e on this basis.

SIGNATURE: DATE:

WITNESS SIGNATURE DATE

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT): RELATIONSHIP TO PATIENT:

SIGNATURE: DATE:

ACCESS TO MEDICAL RECORDS

Please list any person below that you would like to authorize having access to your medical records, appointments, or financial information. (Please check what information you are allowing access for.)

- ❑ _____ *Medical Records*
- ❑ _____ *Appointments*
- ❑ _____ *Financial Information (statements, balances, credits or insurance information if applicable)*
- ❑ _____ *Please do not release my information to anyone*

Would you like us to contact this person in case of an emergency? _____ *Yes* _____ *No*

NAME: RELATIONSHIP TO PATIENT:

PHONE NUMBER: ADDRESS: