

Patient Intake Form

Office Use only:
Vitals: BP ___/___ Heart Rate: ___
Height: ___ Weight: ___

Date: ___/___/___

PERSONAL INFORMATION

Patient Name: _____ Nickname? _____
Address: _____ City: _____ State: ___ Zip: _____
Driver's License #: _____ State issued: _____ Gender: Male/Female
Marital Status: S/M/D/W Spouses Name: _____ Ages of Children: _____
Date of Birth: ___/___/___ Phone: (____) _____ - _____ Cell: (____) _____ - _____
Email: _____
Preferred Language: _____ Ethnicity: Hispanic or Latino Not Hispanic or Latino
Race: White Am. Indian or Alaska Native Asian Black or African Am. Hispanic or Latino Native Hawaiian or Other Pacific Islander
Who referred you to our office? _____ Relationship: _____

EMERGENCY CONTACT

Name: _____ Phone: (____) _____ - _____ Relationship: _____
Address: _____ City: _____ State: ___ Zip: _____

EMPLOYER INFORMATION

Current Employer: _____ City: _____
Job Title: _____

BILLING

While you are responsible for your bill and our policy is for payment to be made at the time of service, will we be helping you to bill any of the following: Workers Compensation Auto Insurance Medicare
 Other Insurance (be specific): _____

PLEASE GIVE INSURANCE CARD(S)/INFORMATION TO RECEPTIONIST

HISTORY OF PRESENT CONDITON

Chief complaint (why are you here today)? _____

Date and time symptoms began? _____

Describe in your own words how symptoms started? _____

How does this interfere with your life? _____

Have you see other doctors for this condition in the past or present? Yes No

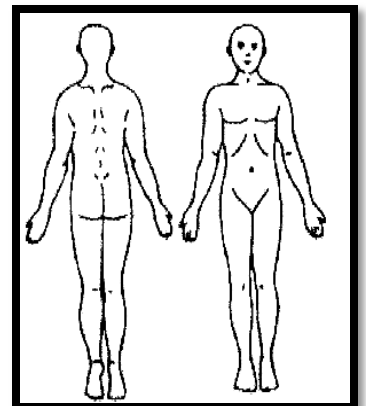
If Yes, whom? _____

May we request records from this doctor? Yes No

Treatment or suggestions given: _____

Were you satisfied with the results of your treatment? Yes No

Explain: _____



On the drawing, please indicate if you are experiencing numbness (N), pain (P), tingling (T), or spasm(S).

The following questions are in reference to the
HEAD AND NECK only

Pain/Symptom Level in Neck:

0 1 2 3 4 5 6 7 8 9 10

Do you have a history of prior symptoms in your head and neck (describe)? _____

Specifically, where in the neck are you feeling symptoms? Left Right Both

Have you noticed any changes in your symptoms since they started? Improving Getting Worse No Change

What is the quality of the pain? Achy Burning Dull Sharp Stiff Throbbing Tingling

Radiating (where) _____ Other: _____

Description of pain: Mild Moderate Severe

When does it feel worse? AM Midday PM Night

What makes it feel worse? _____

When does it feel better? AM Midday PM Night

What makes it feel better? _____

Do you experience headaches? Yes No If yes, describe (specific location, time of day, frequency, and intensity): _____

The following questions are in reference to the
MID-BACK only

Pain/Symptom Level in Mid-Back:

0 1 2 3 4 5 6 7 8 9 10

Do you have a history of prior symptoms in your mid-back (describe)? _____

Specifically, where in the mid-back are you feeling symptoms? Left Right Both

Have you noticed any changes in your symptoms since they started? Improving Getting Worse No Change

What is the quality of the pain? Achy Burning Dull Sharp Stiff Throbbing Tingling

Radiating (where) _____ Other: _____

Description of pain: Mild Moderate Severe

When does it feel worse? AM Midday PM Night

What makes it feel worse? _____

When does it feel better? AM Midday PM Night

What makes it feel better? _____

The following questions are in reference to the
LOW BACK only

Pain/Symptom Level in low back:

0 1 2 3 4 5 6 7 8 9 10

Do you have a history of prior symptoms in your low back (describe)? _____

Specifically, where in the low back are you feeling symptoms? Left Right Both

Have you noticed any changes in your symptoms since they started? Improving Getting Worse No Change

What is the quality of the pain? Achy Burning Dull Sharp Stiff Throbbing Tingling

Radiating (where) _____ Other: _____

Description of pain: Mild Moderate Severe

When does it feel worse? AM Midday PM Night

What makes it feel worse? _____

When does it feel better? AM Midday PM Night

What makes it feel better? _____

ADL's (Activities of Daily Living)

Please check the options that best fit your circumstance.

Mildly Affected means you are able to perform the activity but it can flare up or exacerbate your symptoms.

Moderately Affected means you are limited in this activity because of the symptoms you currently have.

Severely Affected means you are unable to perform this activity due the symptoms you currently have.

	Mildly affected (painful/can do)	Moderately affected (painful/limited)	Severely affected (unable to perform)
Self Care-General			
Walking			
Static Sitting			
Extended Computer Use			
Static Standing			
Yard Work			
Bending			
Changing Position (sitting to standing)			
Lifting			
Lifting Children			
Climbing Stairs			
Kneeling			
Household Chores			
Driving			
Exercise			
Sleeping			
Child Care			

Do your symptoms interfere with any other activities? _____

Job Activity Description: Lifting Sitting Standing Computer Work Twisting Manual Labor

Review of History

Medication:

Are you currently taking any prescription medication? Yes ___ No ___ If yes, list below (be specific)

Medication Name: _____ For: _____ Start date: _____ Frequency: _____

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(If more space is needed for medications, please advise the front desk receptionist)

Allergies

Do you have any allergies? Yes No If Yes, describe cause and symptoms _____

Major Surgeries: (i.e. heart/ blood vessel/ joint/ spine/ abdomen/chest wall etc)

Have you had any surgeries? Yes No If Yes, give details (type and approx date): _____

Hospitalization

Have you been hospitalized in the last 10 years? Yes No If yes, state reason(s) and approximate date(s): _____

Major Illness (i.e. cancer/depression/diabetes/heart disease/kidney disease/liver disease /lung disease/scoliosis etc)

Do you currently have any major illnesses, conditions or concerns? Yes No If yes, describe: _____

Family History

I am unsure of my biological family history.

Father: Alive - Significant diseases? _____ Cause of death: _____

Mother: Alive - Significant diseases? _____ Cause of death: _____

Paternal Grandfather: Alive - Significant diseases? _____ Cause of death: _____

Paternal Grandmother: Alive - Significant diseases? _____ Cause of death: _____

Maternal Grandfather: Alive - Significant diseases? _____ Cause of death: _____

Maternal Grandmother: Alive - Significant diseases? _____ Cause of death: _____

Social History

Lives with: Spouse Lives alone Lives with _____

Smoking Status: Never Former Smoker Live w/ Smoker Current Smoker

If you smoke; number ___ per ___ day ___ week ___ month

Alcohol: None Casual Moderate Drinker Heavy Drinker

Caffeine: None Occasional < 3 drinks/day 3-6 drinks/day > 6 drinks/day

Drug Use: None Recreational Addiction

Exercise: Never Daily Weekly

Highest level of education: _____

INFORMED CONSENT

Chiropractic

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

Analysis

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

Diagnosis

Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed Consent For Chiropractic Care

A patient, in coming to the Doctor of Chiropractic, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that sure care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

Results

The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

To the Patient

Please discuss any questions or problems with the Doctor before signing this statement of policy.

I have read, and understand the foregoing.

Date: _____ Patient/Guardian Signature: _____

NOTICE OF HEALTH INFORMATION PRACTICES

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Please feel free to ask any questions or request copies of any policy.

UNDERSTANDING YOUR HEALTH CARE RECORD/INFORMATION

Each time you visit a specialist, a hospital or other health care provider complimentary and/or alternative, a record of your visit is made. Typically, the records contain your complaints, symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information often referred to as your health or visit record serves as:

- Legal documentation describing the care that you received.
- Basis for planning your care and treatment
- Means of communication between the many health professionals who contribute to your care provided.
- A source of data for health care research.
- A source of data for facility planning and marketing.
- A tool which we can assess and continually work to improve the care we render and the outcomes that we achieve.

Understanding of what is in your record and how your health information is used to help you to:

- Ensure its accuracy.
- Better understand who, what, when, where and why others may access your health information.
- Make informed decisions when authorizing disclosures to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to copies at a reasonable fee to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and copy your health record.
- Amend your health record
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES

This health care office is required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by terms of this notice.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address that you have supplied us with. We will not disclose your health information without your authorization, except as described in this notice.

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation if we have already released your health information before we receive your request. If you were required to give your authorization as a condition of obtaining health insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Print Patient Name: _____

Patient's Signature: _____ Date: __/__/__

Guardian's Signature of Authorizing Care: _____ Date: __/__/__

FINANCIAL POLICY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Mountain View Chiropractic Center, PLLC, will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to the chiropractic center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. Should any amount on this account become delinquent, I agree to pay all interest, court cost, attorney fees, and reasonable collection cost with or without suit. Accounts on which no payment is made in a 30 day period are subject to 1 ½ % per month or 18% annual interest charge.

Date: _____ Signature: _____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made in your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies' proceeds, whether it is all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state, _____ (please initial).
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed are paid in full.

Date: _____ Signature: _____