

Confidential Patient Intake Form

Date: ___/___/___

Personal Information

Patient Name: _____ DOB: ___/___/___ Gender: Male/Female
Home Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____ Marital Status: M, S, D, or W
Address: _____ City: _____ State: _____ Zip: _____
Driver's License #: _____ State: _____ Spouses Name: _____ Ages of Children: _____

Who referred you to our office? _____

Emergency Contact

Name: _____ Phone Number: (____) ____ - ____
Address: _____ Relationship: _____

Work Information:

Current Employer: _____
Job Performance Requirements: _____

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 Comp ___ Auto Insurance ___ Medicare ___ Other (be specific): _____

PLEASE GIVE INSURANCE CARD (S) TO RECEPTIONIST

CURRENT HEALTH CONDITION

Chief Complaint (Why are you here today): _____

When did Symptoms Start: _____

Mechanism of Onset:

___ Auto ___ Work ___ Fall ___ Lifting ___ Overexertion ___ Repetitive Motion ___ Cause Unknown
___ Slept Wrong ___ Slip or Fall ___ Other (Explain) _____

Please describe in your own words what happened: _____

Please indicate on the diagram to the right where the problem area(s) is/are.

Have you seen other doctors for this condition? Yes/No If yes, Who? _____

Treatment or suggestions given: _____

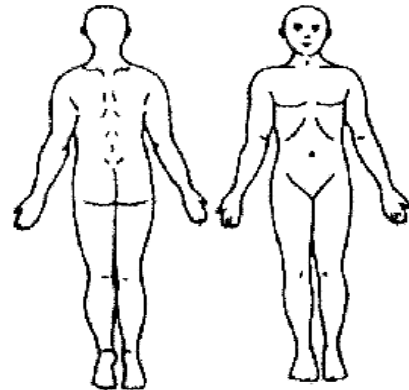
Were you satisfied with the results of your treatment? Yes/No Explain: _____

Have you injured this area of the body at any time in the past? NO YES
If yes, please describe: _____

Did you have symptoms prior to this injury? NO YES
If yes, please describe: _____

Are you currently taking any prescription medications? Yes/No If yes, please mark or list below (please be specific)
___ Allergy Medication ___ Anti-Depressants ___ Blood Pressure Medication ___ Insulin ___ Muscle Relaxers
___ Nerve Pills ___ Pain Killers ___ Other: _____

Do you wear any of the following: Yes/No ___ Heel Lifts ___ Innersoles ___ Arch Supports ___ Orthotics



Due to record keeping requirements the following questions are broken into two sections head/neck and spine/ribs/pelvis area. Please indicate the selections that best describe the issues you have with the area indicated. You may skip the sections that do not apply.

HEAD AND NECK

(This section would also include any problems you may be having with numbness or tingling in your hands)

Main Symptoms: ___ Pain ___ Numbness ___ Stiffness ___ Weakness (where) _____

Quality: ___ Burning ___ Diffuse ___ Dull/Aching ___ Localized ___ Sharp ___ Shooting ___ Stabbing
___ Throbbing ___ Tightness ___ Tingling ___ Radiating to _____
___ Other: _____

Associated Signs and Symptoms: ___ Blurred Vision ___ Depression ___ Dizziness ___ Irritability/Mood Swings
___ Localized Tingling ___ Nausea ___ Ringing in Ears ___ Stiffness ___ Aches ___ Cold Limb ___ Panic
___ Shortness of Breath (SOB) ___ Echymosis/ Bruising ___ Fatigue ___ Fever ___ Heartburn
___ Muscle Spasm ___ Pale Bluish Skin ___ Pins and Needles ___ Runny Nose ___ Sweating (more than usual)
___ Swelling ___ Vomiting

Headaches:

Location: ___ Back of head ___ Front of Head ___ Side of Head ___ Top of Head ___ Sinus
Quality of Headache: ___ Dull ___ Sharp ___ Throbbing ___ Stabbing ___ Aura ___ No Aura
Types: ___ Hat Band ___ Cluster ___ Migraine ___ Tension

Duration: Symptom(s) Started: _____ Symptom(s) Worsened: _____ Symptom(s) Last Occurred: _____

Timing: Worse in the: ___ Morning ___ Afternoon ___ Night ___ Activity ___ Constant ___ Intermittent

Modifying Factors:

Head/Neck Symptoms are better with: ___ Activity ___ Bending ___ Cold ___ Heat ___ Massage ___ Movement
___ Over the Counter Medications ___ Rx Medications ___ Rest ___ Stretching ___ Sitting ___ Standing
___ Twisting ___ Walking ___ Nothing Helps

SPINE, RIBS AND PELVIS AREA

(This section would also include any problems you may be having with your legs (tingling, numbness etc))

Main Symptoms: ___ Pain ___ Numbness ___ Stiffness ___ Weakness (where) _____

Quality: ___ Burning ___ Diffuse ___ Dull/Aching ___ Localized ___ Sharp ___ Shooting ___ Stabbing
___ Throbbing ___ Tightness ___ Tingling ___ Radiating to _____
___ Other: _____

Associated Signs and Symptoms: ___ Blurred Vision ___ Depression ___ Dizziness ___ Irritability/Mood Swings
___ Localized Tingling ___ Nausea ___ Ringing in Ears ___ Stiffness ___ Aches ___ Cold Limb ___ Panic
___ Shortness of Breath (SOB) ___ Echymosis/ Bruising ___ Fatigue ___ Fever ___ Heartburn
___ Muscle Spasm ___ Pale Bluish Skin ___ Pins and Needles ___ Runny Nose ___ Sweating (more than usual)
___ Swelling ___ Vomiting

Duration: Symptom(s) Started: _____ Symptom(s) Worsened: _____ Symptom(s) Last Occurred: _____

Timing: Worse in the: ___ Morning ___ Afternoon ___ Night ___ Activity ___ Constant ___ Intermittent

Modifying Factors:

Spine/Ribs/ Pelvis Symptoms are better with: ___ Activity ___ Bending ___ Cold ___ Heat ___ Massage ___ Movement
___ Over the Counter Medications ___ Rx Medications ___ Rest ___ Stretching ___ Sitting ___ Standing
___ Twisting ___ Walking ___ Nothing Helps

Past Health History - Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: I.... Deny Any Childhood Illness (es)

- Scoliosis Diabetes Hepatitis Asthma Headaches Eczema HIV
 Ear Infection Other (please describe)

Adult Illness: I... Deny Any Adult Illness (es)

- Alzheimer Cystic Kidney Disease Fibromyalgia Multiple Sclerosis
 Anemia Depression Hepatitis Parkinson's Disease
 Asthma Diabetes (Insulin) HIV Lung Disease
 Cancer Diabetes (no insulin) Hypertension Pleurisy
 Crohn's/Colitis Ear Infections (frequent) Liver Disease Pneumonia
 CRPS (RSD) Emphysema Lung Disease Psychiatric Problems
 CVA (stroke) Eye Problems Lupus Scoliosis
 Shingles STD's (unspecified) Suicide Attempt(s) Thyroid Problems
 Vertigo Other Illness (please be specific):

Surgeries: I... Deny Any Surgery (ies)

- Angioplasty Cosmetic Joint Reconstruction Tonsillectomy
 Appendectomy D & C Joint Replacement Spinal Fusion
 Caesarian Section Dental Surgery Laminectomy Hysterectomy
 Cardiac Catheterization Gallbladder Mastectomy Repair Artery Bypass
 Coronary Hemorrhoidectomy Pacemaker Insertion Rotator Cuff
 Carpal Tunnel Hernia Repair Other:

Injuries:

- Back Injury Head Injury Mild/Moderate Soft Tissue Injury Fracture
 Broken Bones Industrial Accident Severe Soft Tissue Injury Disability
 Severe Fall Joint Injury Motor Vehicle Accident Severe Laceration

OB/GYN:

I have never been pregnant I am currently pregnant
I have been pregnant a total of _____ times. Out of that number of pregnancies I had _____ number of complicated pregnancies and _____ number of uncomplicated pregnancies. During delivery I had _____ number of epidural injections _____ number of C-Sections and _____ number of vaginal deliveries.

Non-Drug Allergies:

- Animals Dairy Eggs Food Coloring Latex Mold Pollen Wheat Peanuts
 Other (please specify)

FAMILY HISTORY

I am adopted and so therefore am unsure of my biological family history.
Father: Alive Normally Developed No significant Disease Had/Have
Mother: Alive Normally Developed No significant Disease Had/Have
Paternal Grandfather: Alive Normally Developed No significant Disease Had/Have
Paternal Grandmother: Alive Normally Developed No significant Disease Had/Have
Maternal Grandfather: Alive Normally Developed No significant Disease Had/Have
Maternal Grandmother: Alive Normally Developed No significant Disease Had/Have

SOCIAL HISTORY

Alcohol: Never Social Consumption Only Tobacco: Never Do use cigarettes, cigars or a pipe I chew tobacco
Live with a smoker Quit Smoking
If you smoke; Number _____ per _____ day _____ week _____ month.
Education: (please indicate the highest level completed)

Activities of Daily Living

RATE THE AVERAGE INTENSITY OF YOUR SYMPTOMS BY CIRCLING A NUMBER ON A SCALE OF 1 TO 10.

1, 2, 3= Mild pain that is uncomfortable, but you are still able to continue with daily activities. **4, 5, 6** = Moderate pain that prevents you from doing some daily activities. **7, 8, 9** = Severe pain that prevents you from taking care of yourself. You are dependent on others. **10**=Extreme pain. You should be in the hospital.

Pain/Symptom Level When Resting:

0 1 2 3 4 5 6 7 8 9 10

Pain/Symptom Level When Active:

0 1 2 3 4 5 6 7 8 9 10

Daily Activities: Effects of Current Condition on Performance (check only those that apply)

- Bending: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Care –Infirm Family: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Carrying Groceries: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Change Posn–Sit–Stand: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Climb Stairs: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Driving: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Extended Computer Use: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Feeding: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Household Chores: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Kneeling: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Lift Children: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Lifting: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Pet Care: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Reading (Concentration): **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Self Care –General: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Self Care–Bathing: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Self Care–Dressing: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Self Care–Shaving: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Sexual Activities: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Sleep: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Static Sitting: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Static Standing: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Walking: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Yard Work: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform

Recreational Activity: Effects of Current Condition of Performance (check only those that apply)

- Basketball: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Church: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Cycling: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Dancing: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Exercise: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Gardening: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Golf: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Hiking: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Hunting: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Running: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Sewing: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Snow Skiing: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Soccer: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Swimming: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Tennis: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform
- Weightlifting: **No Effect** **Mild Painful** (Can do) **Mod Painful** (Limited) **Sev Unable** to Perform

OTHER (s): _____

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 contraindicated. 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:** _____