New Patient Intake

Patient Name: _____ Today's Date: ___/___/___

Birth Date: ___/___/___ Age: ____ Gender: F M

Email: _____

If you are under 18 years of age, who are your legal parents or guardian?
Parent/ Guardian _____ Date of Birth: ___/___/___ Phone: (_____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone-mobile/ work (_____) _____ Phone-home (_____) _____

Your Occupation _____

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Phone (_____) _____

Who should we contact in the event of an emergency? _____

Relationship of emergency contact to patient: _____ Phone (_____) _____

How did you learn about us? _____

Do you have **health insurance**? ☐ YES ☐ NO ☐ Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/____

Health insurance Id: _____Group number: _____Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO If yes, who is the employer? _____

Health History

Height_____ Weight_____ Blood Pressure if known_____

Have you had any surgeries? _____ When? _____

Explain_____

Smoking History (how long and #/day)_____ Alcohol use:_____

Allergies_____

What medications or drugs are you taking? _____

_____

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Please Check if you **have or had** any of the listed conditions.

Musculoskeletal		**Cardiovascular**		**Endocrine**		**Genitourinary**		**Integumentary**	
No Issues		No Issues		No Issues		No Issues		No Issues	
Arthritis		High Cholesterol		Thyroid Issues		Kidney stones		Skin Cancer	
Scoliosis		High Blood Pressure		Immune Disorders		infertility		Psoriasis	
Osteoporosis		Poor circulation		Hypoglycemia		Bed wetting		Eczema	
Numbness		Heart attack/ stroke		Frequent infections		Prostrate issues		Acne	
Sensory		Chest pain		Poor Appetite		Erectile dysfunction		Rash	
Blurred vision		Difficulty breathing		Diabetes		PMS symptoms		Other	
Ringing in ears		Dizziness		Other		Other			
Other		Other							

Any Other Serious illness or conditions? _____

Have you noticed any recent change or difficulty in the following? Please Explain

Weight		Bowel/ Bladder function	
Vision		Headaches	

Significant Family History: _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Current Condition

Approximately, when did your injury or condition occur? ___/___/____

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO Explain: _____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Date of accident: ____/____/____

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO Please check ALL that apply.

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

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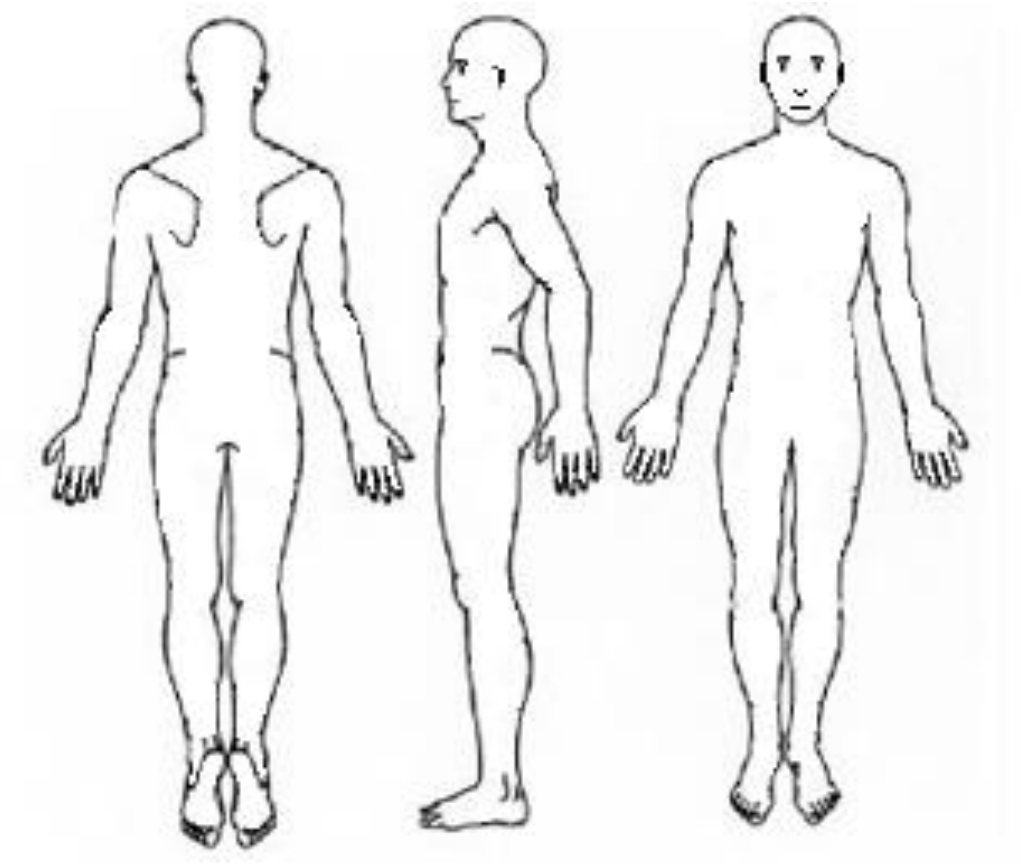
Mark the location and type of discomfort you are experiencing below using the symbols and diagram provided.

Achy: <<<<<<	Burning: oooooo	Sharp: ▲▲▲▲	Shooting: □□□□□
Dull: //////////	Muscle spasms: ++++++	Numbness: #####	Weakness: !!!!!!!!

Pain level (Circle): 1-2-3-4-5-6-7-8-9-10



Informed Consent

I understand that, as in all health care, there are some risks to chiropractic treatment. Treatment may include *chiropractic manipulation, electric muscle stimulation, therapeutic ultrasound, moist heat, traction, manual/ instrument assisted soft tissue and, exercise/ stretching*. The risks include but are not limited to bruising soreness, worsening of symptoms, muscle strains, sprains, fractures, disc injuries, and strokes. 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 judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. There will be time to ask questions about proposed care or alternative treatment options.

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your
name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

****

By signing below, I agree that the medical information on this form is accurate and correct to the best of my knowledge as well as giving my consent to chiropractic treatment. My signature also indicates that I have read and understood this HIPAA Notice.

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

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