Wellness 4 Life Chiropractic
11202 Highland Rd.
Hartland, Mi 48353

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one)** Male / Female

Smoking Status:

Do you current smoke? ☐ YES ☐ NO

Have you ever smoked before? ☐ YES ☐ NO

If you are a current smoker:
What type (cigars, chew, cigarettes) ?_____ How much?_____

Have you tried to quit? ☐ YES ☐ NO

If so, what methods have you tried?

_____

CMS requires providers to report both race and ethnicity

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

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter meds)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☑ **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:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____ Pulse_____

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. When did your symptoms start: _____

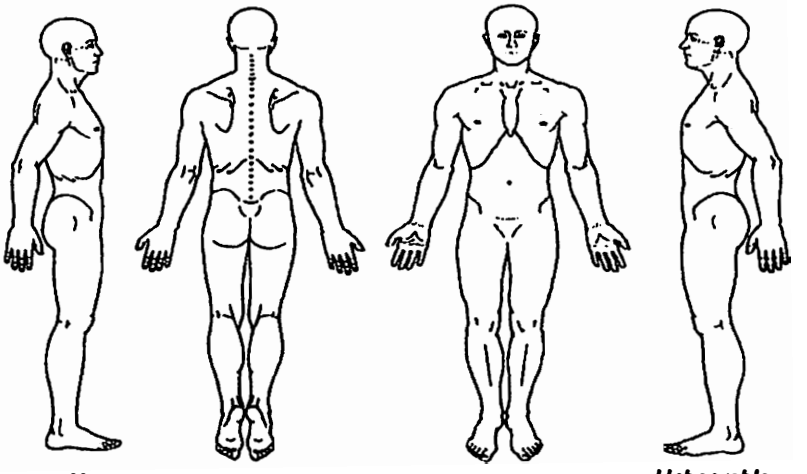
Describe your symptoms and how they began:

_____

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

None — Unbearable

a. worst: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ 1

b. best: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ 1

6. How do your symptoms affect your ability to perform daily activities? 1

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

☐ No One ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
☐ MRI *date:* _____ ☐ Other *date:* _____

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ This Office ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

11. What is your occupation?

_____

☐ Professional/Executive ☐ Laborer ☐ Retired
☐ White Collar/Secretarial ☐ Homemaker ☐ Other
☐ Tradesperson ☐ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Self-employed ☐ Off work
☐ Part-time ☐ Unemployed ☐ Other

12. What do you hope to get from your visit/treatment (select all that apply):

☐ Reduce symptoms ☐ Explanation of condition/treatment ☐ How to prevent this from occurring again
☐ Resume/increase activity ☐ Learn how to take care of this on my own ☐

Patient Signature _____ **Date** _____

Wellness 4 Life Chiropractic

Activities of Daily Living Assessment

Rate your current difficulties by placing the appropriate number in the box.

If an activity does not cause pain or if pain does not affect an activity, put an "N" in the box.

[1] This activity causes some pain, but it is only a minor annoyance.
[2] This activity causes a significant amount of pain, but I can do it.
[3] I cannot perform this activity due to pain and disability.

Self Care and Personal Hygiene

[ ] bathing/showering	[ ] brushing teeth	[ ] putting on shoes	[ ] eating	[ ] doing laundry
[ ] grooming hair	[ ] making the bed	[ ] putting on pants	[ ] dishes	[ ] going to toilet
[ ] washing face	[ ] putting on shirt	[ ] cooking	[ ] taking out trash	

Physical Activities

[ ] standing	[ ] walking	[ ] reaching	[ ] bending right	[ ] twisting right
[ ] sitting	[ ] squatting	[ ] bending forward	[ ] bending left	[ ] twisting left
[ ] reclining	[ ] kneeling	[ ] bending back	[ ] looking left	[ ] looking right

Functional Activities

[ ] carrying small objects	[ ] lifting weights off table	[ ] pushing/pulling while standing
[ ] carrying large objects	[ ] climbing stairs/incline	[ ] exercising upper body
[ ] carrying briefcase/purse	[ ] pushing/pulling while seated	[ ] exercising lower body
[ ] lifting object off floor		

Social and Recreational Activities

[ ] bowling	[ ] jogging	[ ] swimming	[ ] golfing	[ ] dancing
[ ] biking	[ ] hunting/fishing	[ ] competitive sports	[ ] gardening	
[ ] walking	[ ] horse riding	[ ] other:		

_____

Difficulties with Traveling

[ ] driving in car	[ ] driving for long periods of time
[ ] riding as passenger	[ ] riding as passenger for long periods of time

Other activities

Use this scale for the following activities:
[1] This activity is slightly affected by my condition
[2] This activity is moderately affected by my condition
[3] This activity is severely affected by my condition
[4] I cannot perform this activity due to my condition

[ ] concentrating	[ ] listening	[ ] reading	[ ] studying	[ ] writing	[ ] using computer
[ ] sleeping	[ ] sexual relations				

Patient Name: _____ Date of Birth: _____ Doctor Signature: _____

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CHIROPRACTIC
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Informed Consent to X-ray

_____, Authorize the taking of diagnostic X-rays as part of my chiropractic spinal examination by Wellness 4 Life Chiropractic's Doctors and /or Staff. I have been advised and fully understand the potential dangers of radiation. I attest that to the best of my knowledge I am not pregnant, nor do I plan to become pregnant within the next 30 days. Initial please _____

I understand that fees paid for x-ray films are for analysis only and that the films themselves are the property of Wellness 4 Life Chiropractic PLLC. A copy of the films may be released upon written request. The patient is responsible for any and all fees associated with copying films according to Michigan Law.

Patient Signature:_____ Date:_____

Parent Signature:_____ Date:_____

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Office Policy on Collection of Fees

We expect you to honor the financial arrangements you make with our office. If you find that you cannot fulfill the agreement you have made with us, advise our office immediately so new arrangements may be made. Payment is due at the time services are rendered. Insurance balances are not subject to payment at time of service. However, it is ultimately the patient's responsibility to pay their bill not the insurance company. Any individual changes in this policy must be discussed with either the Doctor or Office Manager.

Failure to comply with the above policies or failure to make payment of any overdue account, or to otherwise communicate with our office, will result in collection proceedings and you will be responsible for any legal collection fees. A service charge of $5.00 or .15%, which ever is greater, will be applied to all overdue balances of 60 days and older.

No information provided herein constitutes legal advice. Clients are advised to consult an attorney with regards to any information regarding their rights and legal entitlements. Wellness 4 Life Chiropractic takes no responsibility for any such information reflected herein.

If your account is put into collection, there will be a fee of $50.00 for amount over $100.00 and a fee of $25.00 for any amount under $100.00.

There will be a charge of $25.00 for returned checks.

Please sign your name below indicating that you have read the above and understand it. We appreciate you and are honored you have entrusted your health care needs with our facility.

Name_____ Date_____

Signature_____ Witness_____

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Surprise Medical Billing Disclosure

Your health insurance benefit plan may or may not provide coverage for all the health care services you are scheduled to receive. Your health insurance benefit plan may or may not reimburse our office for all services provided if our office is not in your health benefit plan network. You may be responsible for the costs of the services that are not covered by your health benefit plan.

A nonparticipating provider must provide good faith estimates of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.

You also have a right to request that the health care services be performed by a provider who participates with your health benefit plan network. You also may contact your carrier to arrange for those services to be provided at what may be a lower cost and to receive information on in-network providers who can perform the health care services that you need. For more information regarding services and potential cost please contact our office prior to your first visit.

I have received, read, and understand this disclosure.

_____ Date _____
Patient or Patient's Representative Signature

_____ _____
Type or Print Name of Patient or Patient Representative Date

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Summary of Notice of Privacy Practices

This summary is provided to assist you in understanding the Full Notice of Privacy Practices. If you would like a copy of the full Notice of Privacy Practices. Please ask for a copy.

This attached Notice of Privacy Practices contains a detailed description of how Life University will protect your health Information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further health information

Uses and Disclosures of Health Information – We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization – Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization – In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care
- For purposes of Public Health and safety
- To government agencies for purposes of their audits, investigations and oversight activities.
- To government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects or incidents
- To third party insurance companies
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas and as otherwise required by law

Patient Rights – As our patient, you have the following rights:

- To have access to and/or a copy of your health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

If you have questions, concern or complaint regarding our privacy practices, please refer to Wellness 4 Life Chiropractic Full Notice of Privacy Practices

I understand this is a summary of the Notice of Privacy Practices and not the full version.

Patient
Name(print)_____

Signature_____

Date:_____/_____/_____

11/2013