PATIENT INTAKE FORM

Last Name _____ First Name _____ Middle Initial ___ Preferred First Name_____

Address: _____ City_____ State_____ Zip_____

Cell Phone _____Home Phone _____ Work Phone_____

Email_____*Email will not be shared and will only be used for occasional office announcements and appointment reminders*

Sex ◻ M ◻ F Date of Birth _____ Age _____Social Security # _____

Marital Status _____ # Children ____ Occupation _____ Employer _____

Spouse's Name _____ Spouse's Date of Birth_____ Spouse's Employer_____

In Case of An Emergency Contact _____ Phone #_____

How did you hear about our office? _____ Name of person who referred you: _____

Current Complaints

Nature of Injury: ◻ Automobile ◻ Work ◻ Other

Please describe your Complaints.

_____

_____

What caused the problem? _____

Date of Injury _____ Date symptoms appeared _____

Did your pain come on: ◻ Suddenly ◻ Gradually Is the pain: ◻ Mild ◻ Moderate ◻ Severe

Do you experience pain every day? ◻ Yes ◻ No Do changes in the weather affect your symptoms? ◻ Yes ◻ No

Do your symptoms affect your daily life? ◻ Yes ◻ No Do You wear Orthotics? ◻ Yes ◻ No

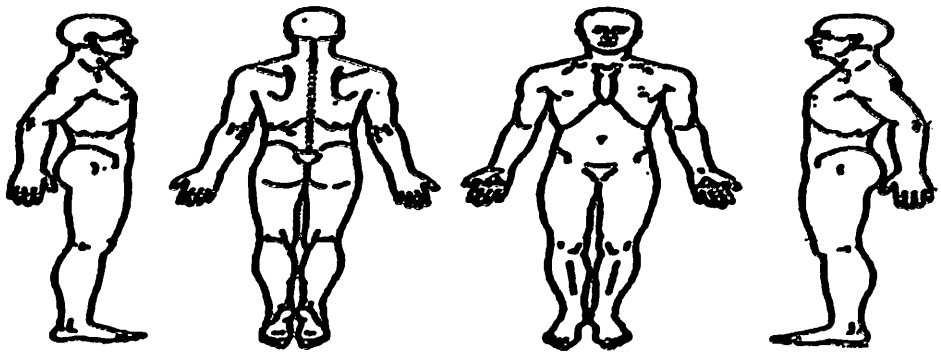
Does your pain wake you up at night? ◻ Yes ◻ No Do you take vitamins or supplements? ◻ Yes ◻ No

Are your symptoms worse at certain times of the day? ◻Yes ◻ No If so, when? _____

What activities aggravate your symptoms? _____

Have you had this same condition before? ◻ Yes ◻ No If yes, how long ago? _____

Indicate on the drawings below where you have pain/symptoms



How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time)
- ☐ Frequently (51-75% of the time)
- ☐ Occasionally (26-50% of the time)
- ☐ Intermittently (1-25% of the time)

How would you describe the type of pain?

- ☐ Burning
- ☐ Dull Ache
- ☐ Radiating
- ☐ Sharp
- ☐ Stabbing
- ☐ Tightness
- ☐ Tingly
- ☐ Numbness
- ☐ Throbbing
- ☐ Shooting
- ☐ Other: _____

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

Who else have you seen for your problem?

- ☐ Chiropractor
- ☐ Neurologist
- ☐ Primary Care Physician
- ☐ ER physician
- ☐ Orthopedist
- ☐ Other: _____
- ☐ Massage Therapist
- ☐ Physical Therapist
- ☐ No one

What is your current: Height: _____ Weight: _____ Occupation: _____

List all prescription medications you are currently taking: _____

_____

List all over-the-counter medications you are currently taking: _____

_____

List all surgical procedures you have had: _____

_____

List any allergies you may have _____

_____

For each of the conditions listed below, place a check in the "**PAST**" column if you have had the condition in the ***PAST***. If you ***CURENTLY*** have a condition listed below, place a check in the "**CURRENT**" column.

PAST	CURRENT		PAST	CURRENT		PAST	CURRENT	
☐	☐	Neck	☐	☐	Diabetes	☐	☐	High Cholesterol
☐	☐	Upper Back	☐	☐	Pre-Diabetes	☐	☐	Congestive Heart Failure
☐	☐	Middle Back	☐	☐	High Blood Pressure	☐	☐	Lupus
☐	☐	Low Back	☐	☐	Cancer	☐	☐	Parkinson's
☐	☐	Shoulder	☐	☐	Arthritis	☐	☐	Neuropathy
☐	☐	Arm	☐	☐	Fibromyalgia	☐	☐	Liver/Gallbladder
☐	☐	Elbow	☐	☐	Epilepsy	☐	☐	Multiple Sclerosis
☐	☐	Wrist	☐	☐	Depression/Anxiety	☐	☐	Stomach Problems
☐	☐	Hand	☐	☐	ADD/ADHD	☐	☐	Ulcers
☐	☐	Fingers	☐	☐	PTSD	☐	☐	Kidney Stones
☐	☐	Hip	☐	☐	Neurological Disorder	☐	☐	Hepatitis
☐	☐	Leg	☐	☐	AIDS/HIV	☐	☐	Endometriosis
☐	☐	Knee	☐	☐	Neuropathy	☐	☐	Menstrual Issues
☐	☐	Ankle	☐	☐	Scoliosis	☐	☐	Pacemaker/Defibrillator
☐	☐	Foot	☐	☐	Epidural Steroid Injections	☐	☐	Prosthetics
☐	☐	Toes	☐	☐	Pregnancy/Infertility	☐	☐	Incontinence/Freq.
☐	☐	Headaches	☐	☐	Smoking/Tobacco	☐	☐	Allergies
☐	☐	Migraines	☐	☐	Drug Dependence	☐	☐	Birth Control
☐	☐	Ribs	☐	☐	Hormone Replacement	☐	☐	Asthma
☐	☐	Chest						
☐	☐	Jaw	Other_____					

REVIEW OF SYSTEMS (Check those which you currently have)

Constitutional:
□ None □ Fever □ Night Sweats □ Chills □ Fatigue □ Weight Loss/Gain
□ Changes in Appetite

SLEEP:
□ None □ Snoring □ Gasping □ Insomnia □ Restless Legs □ Difficulty Sleeping

Ears:
□ None □ Difficulty Hearing □ Hearing Loss □ Hearing Aides □ Vertigo

Eyes:
□ None □ Change in Vision □ Loss of Vision □ Blurred Vision □ Double Vision
□ Glass/Contacts □ Eye Pain

NOSE, MOUTH AND THROAT
□ None □ Change in Smell □ Runny Nose □ Nose Bleeds □ Sores in Mouth
□ Sore Throat □ Problem Swallowing

CARDIOVASCULAR
□ None □ Chest Pain □ Palpitations □ Swollen Legs □ Fainting □ Shortness of Breath

RESPIRATORY
□ None □ Cough □ Coughing up Blood □ Coughing up Phlegm □ Wheezing □ Trouble Breathing

GASTROINTESTINAL
□ None □ Abdominal Pain □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Heartburn □

MUSCULOSKELETAL
□ None □ Muscle Pain □ Bone Pain □ Joint Pain □ Swollen or Red Joints □ Broken Bones

GENITOURINARY
□ None □ Difficulty urinating □ Vaginal or Penile Discharge □ Kidney Stones

SKIN
□ None □ Rash □ Ulcers that will not heal □ Moles that are changing

ENDOCRINE
□ None □ Heat or Cold Intolerance □ Frequent Urination □ Unusually thirsty
□ High Blood Sugar □ Low Blood Sugar

NEUROLOGICAL
□ None □ Headaches □ Weakness □ Seizures □ Dizziness □ Tremors □ TIA □ Stroke

LYMPH AND BLOOD
□ None □ Easy Bleeding □ Swollen Lymph Nodes

PSYCHIATRIC
□ None □ Depression □ Anxiety □ Hallucinations □ Depression □ Bipolar □ Schitzophrenia

What activities do you do outside of work?

_____

Have you ever been hospitalized? □ No □ Yes
If yes, when, and why?

_____

Have you ever been to a chiropractor before? □ No □ Yes How long ago?

_____

Have you had significant past trauma? □ No □ Yes

Anything else pertinent to your visit today?

_____

Patient Signature_____ **Date:** _____

Consent to Treatment

1. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, and there may be an audible "pop" or "click" as a result of joint movement.
2. The practice of health care is not an exact science, but relies upon information related by the patient, information gathered during the examination (and the doctor's interpretation thereof), as well as the doctor's judgment and expertise. Chiropractic health care is no different.
3. It is not reasonable to expect my doctor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedures which he/she feels at the time to be in my best interest.
4. Though infrequent, as with any health procedure, there are certain complications which may arise during chiropractic health care. These complications include soreness, sprains/strains, dislocations, fractures, disc injuries, cerebral-vascular accidents, physiotherapy burns, or soft tissue injuries. These complications are extremely rare occurrences.
5. Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will give you our best care.
6. I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.

I have read the above consent, or it has been read to me. I have had the opportunity to ask questions and receive answers, am comfortable with the information provided, and consent to chiropractic treatment and management on that basis. In signing this document, I in no way compromise my protection against negligence.

I, undersigned, hereby authorize Nicole Halkovic, D.C. and whomever she may designate as her assistants to perform diagnostic test but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

Patient Name:_____

Patient Signature: _____

(If patient is a minor please print child's name and sign your name beside it)

Electronic Communication Consent Form

I consent that the staff of ZACHARY CHIROPRACTIC CLINIC can communicate with me via mobile phone, messages, email and any kind of online communications, provided that these communications comply with privacy regulations.

Appointment Reminders, Reschedules and Cancellations

I understand that ZACHARY CHIROPRACTIC CLINIC can contact me at any time to remind me of my appointments or let me know in case of any changes about my appointments. And I understand that ZACHARY CHIROPRACTIC CLINIC may employ and use a third-party automated system to reach out to me for the purpose to "confirm", "reschedule" or "cancel".

Electronic Patient Billing

I give ZACHARY CHIROPRACTIC CLINIC permission to email any billing statements regarding my account instead of paper billing.

Consent Cancellation

I know that I can revoke this consent at any time by contacting ZACHARY CHIROPRACTIC CLINIC.

Name: _____

Signature: _____

Date: _____

AUTHORIZATION AND RELEASES

NAME_____ DATE_____

FINANCIAL POLICY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that the amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES ARE RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient Signature_____ Date_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claims and certify that all insurance information provided to this clinic is correct and complete.

Patient Signature_____ Date_____

PAYMENT OF BENEFITS TO PROVIDER OF CARE AND RESPONSIBILITY OF BALANCE

I hereby **AUTHORIZE** any Insurance Company/Insurance Administrator for which I have coverage, to pay Zachary Chiropractic Clinic directly, any expense benefits allowable and otherwise payable to me under my current policy, as payment for professional service rendered. I have agreed to pay, in a current manner, any balance of said professional charges. I agree that this office be given power of attorney to endorse/sign my name on all drafts for payment of my bill. By filing my medical insurance, I will be responsible for any Co Pay and/or deductible allowed amounts per the contract with my medical insurance.

Patient Signature_____ Date_____

X-RAY/MEDICAL RECORDS RELEASE

I hereby request and authorize you, your employees and agents to furnish to the persons listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photo static copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.
Please forward to: **Zachary Chiropractic Clinic 1121 Church Street Ste B, Zachary, La 70791**
Fax: (225) 654-9906 or Email: Records@zacharychiropractic.com

Patient Name_____

Patient Signature_____ Date_____

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Nicole Halkovic, D.C., and whomever she may designate as his/her assistants to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as she deems necessary to my child: _____). Relationship to Child_____

Childs Name: _____

Parent/Guardian Signature_____ Date_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

Name_____

Signature_____

Date_____