Dr. Sarah Ragan, DC
118 N. Orange St.
Albion, IN 46701

Phone: (260) 357-4488
or (260) 636-7959
www.ragancc.com

Patient Intake Form

Date _____

Patient Information

- Full Name _____ What do you prefer to be called?_____
- Address _____
- City _____ State _____ Zip _____
- Birthdate ____/____/____ Age _____ Partner/Spouse's Name _____
- How did you hear about Ragan Chiropractic? _____
- Have you been to a Chiropractor before? _____
  - If yes, which doctor and for what reasons?_____
    _____

Emergency Contact

- Full Name _____ Relationship to Patient_____
- Home Phone _____ Cell Phone _____

Primary Care Physician

- Doctor/Practice Name _____
- City _____ State _____ Zip _____
- Phone _____ Fax _____
- Is it acceptable to correspond with your primary care physician regarding the care you are receiving at Ragan Chiropractic? ____ Yes ____ No

I wish to be contacted in the following manner:		**Is it ok to leave a detailed message?**	**Leave message with contact number only?**	
Home Phone:	(____) ____ - _____	Y or N	Y or N	Do Not Use
Cell Phone:	(____) ____ - _____	Y or N	Y or N	Do Not Use
Work Phone:	(____) ____ - _____	Y or N	Y or N	Do Not Use
Email:	_____	Y or N	Y or N	Do Not Use

Acknowledgement of Notice of Privacy Practices (HIPAA)

I, _____, hereby acknowledge the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature of Patient/Guardian_____ Date _____

Financial Policy

Ragan Chiropractic Clinic, P.C. is an ***out-of-network provider*** and ***does not accept assignment of benefits*** for insurance. Therefore, please note ***payment is due at time of service*** unless further financial arrangements have been made. This allows us to keep expenses manageable and to pass savings on to you by way of affordable rates. Ragan Chiropractic Clinic, P.C. will be happy to generate the appropriate insurance forms for you to seek reimbursement from your insurance provider. Further, Ragan Chiropractic Clinic, P.C. will gladly offer any assistance necessary to get your claim processed.

Review the following options and *initial* the payment agreement which best suits your needs.
(Please note you may change your payment option at any time.)

_____ I will pay for all services at each visit, as they are rendered.

_____ I will pay the weekly balance every: (circle one) Mon Tues Wed Thur Fri Sat

via: (circle one) cash check debit/credit card.

Signature of Patient/Guardian_____ Date _____

If you would like to be supplied with documentation for your insurance reimbursement, please provide the following information:

_____ I will not be seeking reimbursement from my insurance provider

OR

Patient Name _____ Social Security No. _____

Name of Insured _____ Social Security No. _____

(if different from patient)

Insured's relationship to patient _____

Insured's employer _____

Insurance Co. _____ Phone No. _____

Policy No. _____ Group No. _____

Authorization (to release information & settle insurance appeals or disputes)

I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor (Dr. Sarah Ragan, DC) and clinic (Ragan Chiropractic Clinic, P.C.) any and all plan documents, insurance policy, and / or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and / or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and / or employee health care plan any claim, chose in action, or other right I may have to such insurance and / or employee health care benefits coverage under any applicable insurance policies and / or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, choice in action or right against my insurers and / or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Patient/Guardian _____ Date _____

Signature of Insured (if different) _____ Date _____

Ragan Chiropractic Clinic, P.C.

What is the reason for your visit today? _____

What specific event brought about your symptoms?_____

When did your symptoms first appear?_____

Is the condition getting progressively worse? Yes No Unknown

Describe how it feels? Circle all that apply: Numb Aching Pins & Needles Burning Stabbing
Dull Throbbing Cramps Stiffness Sharp

What makes the pain/condition worse?_____

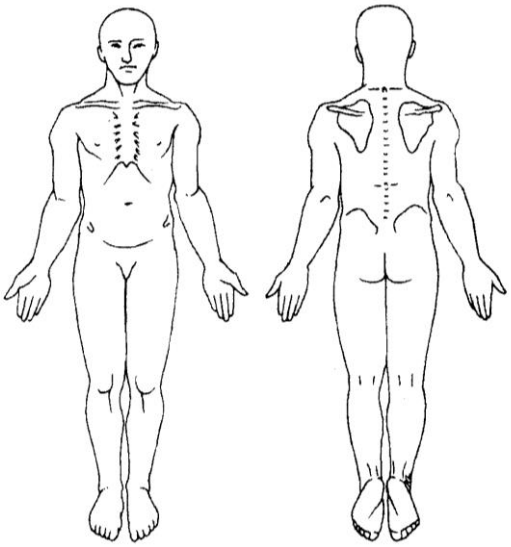
What makes the pain/condition better? _____

How does the pain/condition change throughout the day? _____

Which daily activities are affected by the pain/condition (ie.walking, cleaning, driving, sitting, etc.)? _____

_____

Please mark area(s) of complaint below **and** indicate any of the following:



A= Aching B= Burning S=Stabbing C=Cramps
N=Numbness P=Pins & Needles ST=Stiffness

Please rate your pain on the scale below:
(0= No Pain / 10=Severe Pain)

Today's Pain
0 1 2 3 4 5 6 7 8 9 10

Pain when it's at its worst
0 1 2 3 4 5 6 7 8 9 10

Typical Pain
0 1 2 3 4 5 6 7 8 9 10

Review of Systems: (Indicate if you have in the past or currently experience issues with any of the following.)

____Anxiety
____Depression
____Weight loss/gain
____Headaches
____Neck Pain
____Arm Issues
____Low Back Pain
____Leg Issues (ie.Sciatica)
____Numbness/Tingling
____Arthritis

____Diabetes
____Thyroid issues
____Autoimmune Disorder
____Constipation
____Diarrhea
____Gallbladder issues
____Liver issues
____Difficulty Breathing
____COPD
____Asthma

____High Blood Pressure
____High Cholesterol
____Heart Attacks
____Strokes
____Swelling of Ankles
____Kidney Stones
____Bladder Infections
____Sexual Difficulties
____Cancer:_____
____Other:_____

Women:
____Currently Pregnant
Date of PAP:_____
& Mammogram:_____

Men:
____Prostate Issues
____Testicular Pain/Numb
Date of last PSA test/
Prostate Exam:_____

Family History:

____Cancer
____Heart Disease
____High Cholesterol
____High Blood Pressure
____Autoimmune Disorder
____Bone Disease
____Nerve Disease
____Muscle Disease
____Arthritis
____Other:_____

Social History:

Occupation_____
Work Activity: Sit Stand Light Labor Heavy Labor
Exercise: None Moderate Heavy
Tobacco: Y or N
Alcohol Use: Y or N

Medications:_____
_____
_____
_____

Supplements:_____
_____
_____
_____

Surgeries:_____
_____
_____
_____

Patient Signature_____Date_____

Office Use: Patient Name:_____File #:_____Date:_____Rev. 01/18

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Informed Consent for Care

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, _____, the patient/guardian of patient, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. I agree to the performance of these procedures by my doctor.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks/complications associated with these procedures as follows:

Soreness: I am aware that like exercise, I may experience minor muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur, but are relatively rare.

Fractures/Joint Injuries: I understand that in isolated cases with underlying physical defects, deformities or pathologies (like weak bones from osteoporosis) may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are exceedingly rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor immediately.

Exams have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that practicing the art of medicine, including chiropractic, is not an exact science. I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of use, but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disc rupture. Surgical risks may include unsuccessful outcomes, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to by satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient/Guardian _____Date _____