BOYKIN
CHIROPRACTIC OFFICE, PC

Phone #: 719-578-8820
2575 Montebello West – Colorado Springs, Colorado 80918

New Patient Intake Form

Patient Biography:

CT #:_____ (For Office to Complete*)

First Name: _____ Last Name: _____

Last 4 Digits of you Social Security Number: _____

Street Address: _____

City: _____State: _____Zip: _____

Mobile Phone: _____ Home Phone: _____

Email Address: _____

Date of Birth: _____Gender: _____Sex at Birth: (Male / Female)

Height: _____Weight: _____lbs.

Marital Status: _____ Children: □ Yes / □ No, *If you have children, how many*: _____

Spouse's Name: _____ (N/A)

Your Occupation: _____ Employer: _____

Employer's Address: _____

Are you a Student: □ Yes □ No, *What type of Student?* (High School / College / Post-Graduate)

For Students: Name of Institution: _____

State where the Institution resides in: _____

Town where the Institution resides in: _____

The reason we ask this information for students is so we can plan your care around your schedule and so that we can refer you to another chiropractor in the area of your school if you decide you want to continue seeing a chiropractor during school.

Emergency Contact Information:

Name: _____Phone Number:_____

Relation to you: _____

How Did You Hear About Us?

_____

Were you referred to our office? □ Yes / □ No

If yes, then who referred you? _____

Reason for Visit:

If you have a current complaint, then the next section of this form is particularly important for our evaluation. Please fill it out to the best of your ability and answer honestly. If you think something is not relative to your condition you may leave it blank; however, remember that the body is one functional unit and the more we know about you the better we can understand the nature of your health and the nature of your complaint. Sometimes there are related symptoms that practitioners know about, but patients may not think are related to their case and can mean the difference in proper diagnosis and treatment.

Please Indicate the Location(s) of your Complaint/Symptoms on the Body Diagrams and provide a brief description below.

_____

_____

_____

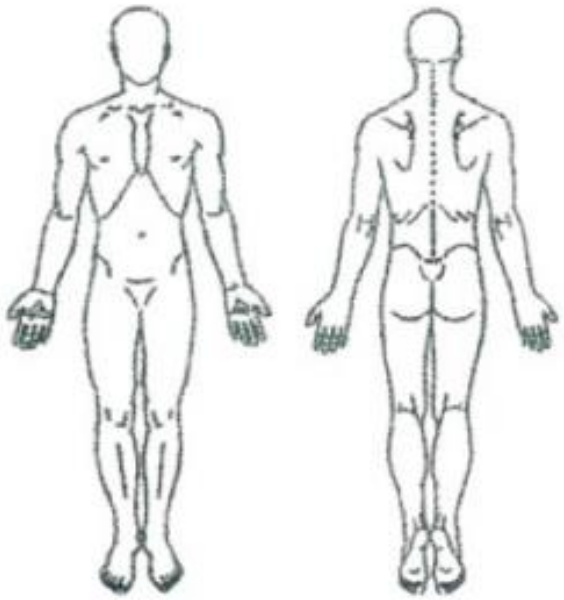
_____

_____

_____

_____

_____



I. **What is your Current Complaint or Condition?** _____

II. **When did this start?** _____

III. **What makes this condition better?** _____

IV. **What makes this condition worse?** _____

V. **What does the complaint feel like?** _____

VI. **On a scale of 0 to 10, with 10 being the worst pain imaginable and 0 being no pain, how do you rate your level of discomfort? (*please mark in a box below*)**

0										10

I. **Is the complaint / pain:** □ Constant / □ Intermittent / □ Occasional

□ **Other (*please explain):*** _____

II. **Has this complaint □ worsened, □ remained the same, or □ improved since you first noticed it?**

_____

III. **Is the nature of the complaint local to one area or does it travel or radiate to any other area of the body?**

_____

a. *If you answered "Yes, the pain radiates" above, then please describe where the pain travels to here:* _____

IV. **When does this complaint bother you the most?**

□ Morning / □ Noon / □ Evening / □ Night

a. Are there any other times the pain/complaint bothers you? _____

_____

V. **Have you ever experienced this complaint before?** □ Yes / □ No

a. If you answered "Yes." above, then please tell us when you last experienced this complaint:

_____

b. Was the previous complaint resolved?

_____

c. What worked to resolve the complaint for you before?

_____

VI. Does this complaint impact your daily life? If yes, then state how:

_____

_____

VII. Have you been able to work?

_____

a. Please state the nature of how the complaint has impacted your work:

_____

VIII. Have you seen any other providers for this complaint? □ Yes / □ No

a. If you answered "Yes." above, then please list the provider here:

_____

IX. Have you had any other symptoms we should be aware of that may be related to your complaint?

_____

a. **Examples:** *Fever, Chills, Tingling, Numbness, Weakness, Headaches, Scapular Pain, Changes in Bladder or Bowel Habits, Changes to Eyesight or Hearing, etc.*

X. Are you on any prescription medications? □ Yes / □ No

a. **Please List ALL Medications you are on:**

_____

_____

_____

_____

_____

b. *Over the Counter Medications and Birth Control are considered a medication and should be listed above**

XI. Have you had any previous Hospitalizations? □ Yes / □ No

a. **If Yes, then please describe what the nature of the hospitalization(s):**

_____

_____

XII. Have you had any previous Surgeries? □ Yes / □ No

a. **If Yes, then please describe what the nature of the operation was and if the operation was an In-Patient Procedure or Outpatient Procedure:**

_____

_____

XIII. Do you have any other diagnosed conditions we should be aware of? □ Yes / □ No

a. **If yes, then please list them:**

_____

_____

b. **Examples:** *Heart Disease, Diabetes, Cancer, Stroke, Lyme Disease, Multiple Sclerosis, etc.*

Social Questionnaire

This is a key section for all patients, please be as honest as possible so we can get a better overview of your health.

Alcohol, Caffeine, Tobacco, and Drug Use:

I. **Do you drink alcohol?** □ Yes / □ No
   a. **How many drinks per week:** _____ drinks.

II. **Do you consume caffeine?** □ Yes / □ No
   a. **How much per week:** _____cups.

III. **Do you use tobacco products?** □ Yes / □ No
   a. **If yes, then how many packs per week do you smoke?** _____ packs
   b. **Are you a previous smoker?** □ Yes / □ No
   c. **If yes, then how many packs per week did you smoke?** _____ packs **and for how many years did you smoke?** _____ years

IV. **Do you use recreational drugs?** □ Yes / □ No

Exercise Habits:

I. **Do you currently exercise?** □ Yes / □ No

II. **How often do you exercise each week?** (1x / 2x / 3x / 4x/ 5x/ 6^{+}x per week)

III. **Can you exercise with your current condition?** □ Yes / □ No

IV. **What type of exercise do you do?**

_____

V. **Do you currently participate in any sports?** □ Yes / □ No
   a. Please List <u>ALL</u> Sports you currently participate in:

   _____

   b. If you previously played sports or had sports injuries, please list them:

   _____

Nutritional Assessment:

I. **How many glasses of water do you drink per day? (Assume 8 oz. Glass): _____glasses**

II. **Are you currently participating in any specific type of diet?** □ Yes / □ No
   What diet/lifestyle are you participating in?

   _____

   a. If there is anything specific we should know about your diet please state it:

   _____

      i. Examples: *Vegan, Vegetarian, Gluten-free, etc.*

III. **Do you take any daily vitamin supplements?** □ Yes / □ No
   a. Please state what product you are taking *(If you know the name*):

   _____

   b. Do you take any other supplements? □ Yes / □ No
      i. Please list them:

      _____

      _____

IV. **How many meals do you typically eat per day?** (0 / 1 / 2 / 3 / 4 / 5^{+})

V. **How many servings of vegetables do you typically get per day?** (0 / 1 / 2 / 3 / 4 / 5^{+})

VI. **How many servings of fruits do you typically get per day?** (0 / 1 / 2 / 3 / 4 / 5^{+})

VII. **How many servings of meat do you typically get per day?** (0 / 1 / 2 / 3 / 4 / 5^{+})

Other:

This section is where you get to tell us about you. Anything that you would like to share with us that has not already been covered on this intake form you can share here. Some examples for this area could be performance goals, dietary concerns, health questions, or other concerns you may have or things you think we should know that could benefit your care. Please share that information below:

_____

_____

_____

_____

_____

_____

_____

Notice of Privacy Practices

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

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This Notice applies to all records of your care generated and maintained by this medical spa.

We are required by law to: 1) make sure that medical information that identifies you is kept private; 2) make available to you this Notice of our legal and privacy practices with respect to medical information about you; and 3) follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may disclose medical information, about you to doctors, nurses, or other personnel involved in taking care of you. We may also disclose medical information to people outside the medical group, such as family members, specialists or others who are involved in providing services that are part of your care.

We may use or disclose medical information about you for operations. These may include use of information to evaluate the performance of our staff, effectiveness of programs, and ways to improve care and services we offer. These uses and disclosures are necessary to ensure that all of our patients receive quality care.

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or care.

- We may use or disclose medical information to tell you about or recommend possible treatment options or alternatives, and about health-related benefits, services, events and activities that may be of interest to you.

We may disclose medical information about you to other healthcare providers in the event you need emergency care.

We may disclose medical information about you as required by federal, state, or local law.

- We may use or disclose medical information to a public health organization or federal organization when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

We may disclose medical information about you in special situations such as for workers' compensation programs, as required by military command authorities or the Department of Veterans Affairs, in response to a court or administrative order, or for public health activities. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may later revoke this permission in writing at any time.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the right to review and receive a copy of medical information that may be used to make decisions about your care. Usually this includes medical and billing records. You must submit a

written request to review and copy your medical information. We may charge a fee for the costs of supplying a copy of the records.

- You have the right to ask us to amend medical information that you feel is incorrect or incomplete. Your request for an amendment must be submitted in writing and must provide a reason that supports your request.

We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information: 1) was not created by us; 2) is not part of the medical information kept by or for us; 3) is not part of the information which you are permitted to inspect and copy; or 4) is accurate and complete

- You have the right to request an "accounting of disclosures." This is a list of disclosures we have made of medical information about you, with some exceptions. The exceptions are governed by federal health privacy law, and include: 1) routine disclosures for treatment, payment and operations conducted pursuant to your signed consent form; and 2) disclosures to-you. You must submit a written request. The request must state a time period that may not be longer than six years and may not include dates before April 14, 2003, when current federal health privacy laws became effective.
- You have the right to request restrictions or limitations on the use or disclosure of medical information about you, You must submit a written request for restriction that specifies: I)-what information you want to limit; 2) whether you want to limit our use, disclosure, or both; and 3) to whom you want the limits to apply. We reserve the right to refuse your restriction if it is in conflict with providing you quality healthcare or in an emergency situation.
- You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, such as only at work or by mail. You must submit a written request for confidential communications restrictions, specifying how or where you wish to be contacted. We will accommodate reasonable requests.
- You have the right to possess a copy of this Privacy Notice upon request. You may receive a paper copy of this notice, or you can also obtain a copy of this Notice at our offices.

You have the right to file a complaint if you believe your rights to privacy have been violated. All complaints must be submitted in writing. All complaints will be investigated. No personal issue will be raised for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We will post a copy of the current notice at our clinical site.

ACKNOWLEDGMENT OF RECEIPT OF HIPPA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers. .

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communication barriers prohibited obtaining the Acknowledgement**
- ☐ **An emergency situation prevented us from obtaining Acknowledgement**
- ☐ **Other (please specify):**

_____

_____

_____

Staff Signature

_____

Date

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: ____/____/____

Parent or Guardian: _____ Signature: _____ Date: ____/____/____

Witness Name: _____ Signature: _____ Date: ____/____/____

Patient Name: _____ Date: _____

COVID 19 FORM

Have you traveled outside of the United States in the past 6 weeks?

□ Yes / □ No

Have you exposed yourself to large groups (more than 10 people) in the last 2 weeks?

□ Yes / □ No

If so where / why? _____

Have you practiced social distancing as recommended by the CDC?

□ Yes / □ No

Have you been exposed to anyone that tested positive for COVID 19?

□ Yes / □ No

Have you experienced any of the following symptoms?

1. Fever: □ Yes / □ No
2. Cough: □ Yes / □ No
3. Shortness of Breath: □ Yes / □ No
4. Sweating: □ Yes / □ No
5. Headache: □ Yes / □ No
6. Lack of Taste and/or Smell: □ Yes / □ No

Patient Signature: _____