

Patient Intake



Today's Date ____/____/____

This information is confidential. If, after gathering the necessary information, we do not believe your problem will respond favorably with chiropractic care, we will discuss our findings with you and make the necessary referrals or recommendations. In order for us to fully understand your health problems and be able to give you our best care and advice, please complete this form neatly, accurately, and thoroughly. Thank you.

Legal Name: First _____ Middle _____ Last _____

Preferred or nickname _____ Date of Birth ____/____/____ SS# ____ - ____ - ____

Local address _____ City _____ State _____ Zip _____

Other address _____ City _____ State _____ Zip _____

Gender: **M** **F** Height ____' ____" Weight ____ lbs

Please check box for preferred communication means ☐ E-Mail _____

☐ Home Phone(____) ____ - ____ ☐ Work Phone(____) ____ - ____ ☐ Cell Phone(____) ____ - ____

Preferred language: ☐ English ☐ Spanish ☐ _____ **If minor patient:** Parent/Guardian _____

Relationship _____ Address ☐ Same as above _____

Referred by _____ Your primary care physician: _____

Emergency contact: _____ Relationship _____ Phone(____) ____ - ____

Current Complaints	Date of Onset	Probable cause

History of Current Complaints ☐ **NONE** If this is a recurrent problem please describe the **initial cause**, the frequency, how you have treated in the past, and if past treatment was successful:

☐ NONE For the PRESENTING CONDITION and OTHER CURRENT CONDITIONS which you are treating, please list ALL providers, treatments and outcomes		
Recommended by Self / Doctor / therapist	Treatment / Testing PT, exercises, medications, ice, heat, x-ray, MRI, CT, labs	Outcome partial or temp relief, no help, etc.

☐ NO Have you received care from a Chiropractor in the past?		
Who & Where	When & Reason	Outcome

☐ NONE Please list any Allergies to the following:		
Food	Environmental	Allergies to any Medication

☐ NONE Please list any other <u>serious</u> illnesses or conditions which you have been diagnosed and/or treated (cancer, heart, diabetes, mental, TB, high blood pressure, high cholesterol, HIV, asthma etc.)			
Condition	Date diagnosed	Treatment – if hospitalized please write <u>H</u>	Outcome

☐ NONE Prescription or over the counter medications AND supplements you are currently taking					
Name	Reason	Dosage	Frequency	How long	Side effects

☐ NONE Please list all significant trauma (auto, lifting, fracture, dislocation, sport)				
Type of trauma	Date	Body parts injured	Treatment please if hospitalized write <u>H</u>	Residual problems

☐ NONE Please list all surgeries or prostheses			
Surgery if hospitalized please write <u>H</u>	Date	Surgeon & location	Results

☐ NONE Family History	Mother	Father	Sister	Brother	Grand mother	Grand father	Child
Cancer							
Heart							
Diabetes							
Other							

Any additional Information:	
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Do you wear ☐ heel lifts or ☐ sole lifts in shoes - ☐ No ☐ right ☐ left ☐ both
 Who prescribed _____ date _____

WORK HISTORY

Present occupation _____ Retired from _____

Employer _____ Job description _____

☐ Presently unemployed – Unemployment due to injury ☐ Y ☐ N Explain _____

Disability: ☐ N ☐ Y Date _____ By whom _____ Due to _____

Work restrictions ☐ N ☐ Y Explain: _____

SOCIAL HISTORY

Marital Status S M W D Sep Name of Spouse _____
No. of Children _____ ☐ No Children Ages _____ **Currently pregnant** ☐ Y ☐ N ☐ possibly

Tobacco use: ☐ cigarettes ☐ cigars ☐ smokeless _____ Pk-can./day _____ Years
☐ never ☐ non-user since _____ but when used _____ Pk-can./day _____ Years

Alcohol consumption: ☐ never ☐ rare ☐ daily _____ days per week ☐ recovering alcoholic

Caffeine ☐ coffee ☐ tea ☐ soda _____ cups/day Recreational drug use: ☐ none _____

Exercise: ☐ I do not exercise on a regular schedule.

My exercise consists of _____ times per week _____ for _____ minutes

Stress level: currently rated (circle one) high - medium – low : major stress factors _____

Sleeping posture (circle all that apply): back sides stomach

Diet: ☐ vegan ☐ vegetarian ☐ well balanced ☐ could use some help ☐ could use lots of help

Average number of serving of fruits and vegetables per day _____

Review of Systems: Please check the box if you have experienced or others have observed in you:

X	<u>Constitutional</u>	X	<u>ENMT</u>	X	<u>Genitourinary</u>
	Unexplained fever, chills, or night sweats		Hearing loss, ringing in ears or ear pain		Pain or burning during urination
	Unexplained weight loss or weight gain		Frequent nasal congestion, sinus pressure, or nosebleeds		Increased frequency or urgency with urination
	Unusual fatigue, weakness, or generalized malaise		Sore throat, bleeding gums, or persistent hoarseness		Loss of urinary control
X	<u>Cardiovascular</u>	X	<u>Gastrointestinal</u>	X	<u>Neurological</u>
	Chest pain, pressure, or discomfort		Nausea, vomiting, or loss of appetite		Frequent or severe headaches
	Sensation of a racing or fluttering heart		Frequent heartburn, difficulty swallowing, or abdominal pain		Dizziness, lightheadedness, or spinning sensations
	Swelling in your hands, ankles, or feet		Notable constipation or diarrhea		Numbness, tingling, or loss of sensation in your hands or feet
	Leg pain when walking that stops when you rest		Frequent bloating or gas		Sudden weakness, tremors, or difficulty with balance
	Shortness of breath at rest or with mild exertion		Loss of bowel control	X	<u>Psychological</u>
X	<u>Eyes</u>				Persistent feelings of anxiety, panic, or nervousness
	Changes in your vision				Ongoing feelings of depression, hopelessness, or loss of interest
	Eye pain, redness, or excessive tearing				Trouble sleeping or major changes in mood

THE ABOVE INFORMATION IS ACCURATE AND COMPLETED TO THE BEST OF MY KNOWLEDGE.

signature of patient

date

witness

date

patient's representative name printed

signature of patient's representative

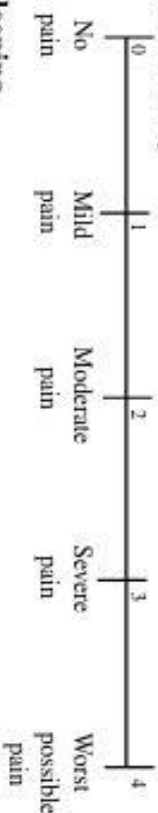
date

Functional Rating Index

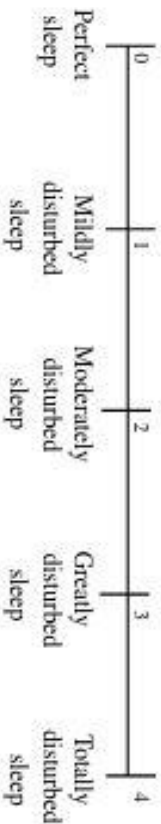
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

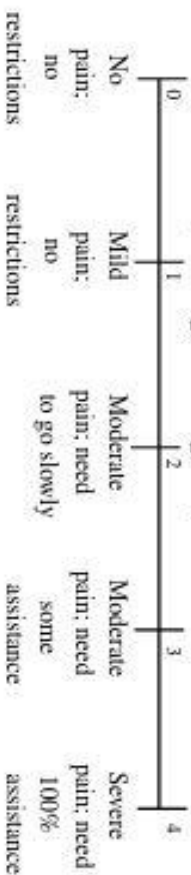
1. Pain Intensity



2. Sleeping



3. Personal Care (washing, dressing, etc.)



4. Travel (driving, etc.)



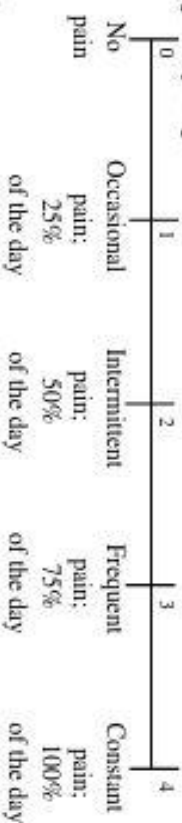
5. Work



6. Recreation



7. Frequency of pain



8. Lifting



9. Walking



10. Standing



PAIN CHART

Name _____ DOB _____ - _____ - _____ Date _____ - _____ - _____

Please mark on the body diagrams all areas of pain, discomfort, or altered sensation, and use the key below to identify quality of each.

A = ache

B = burning

E = electrical

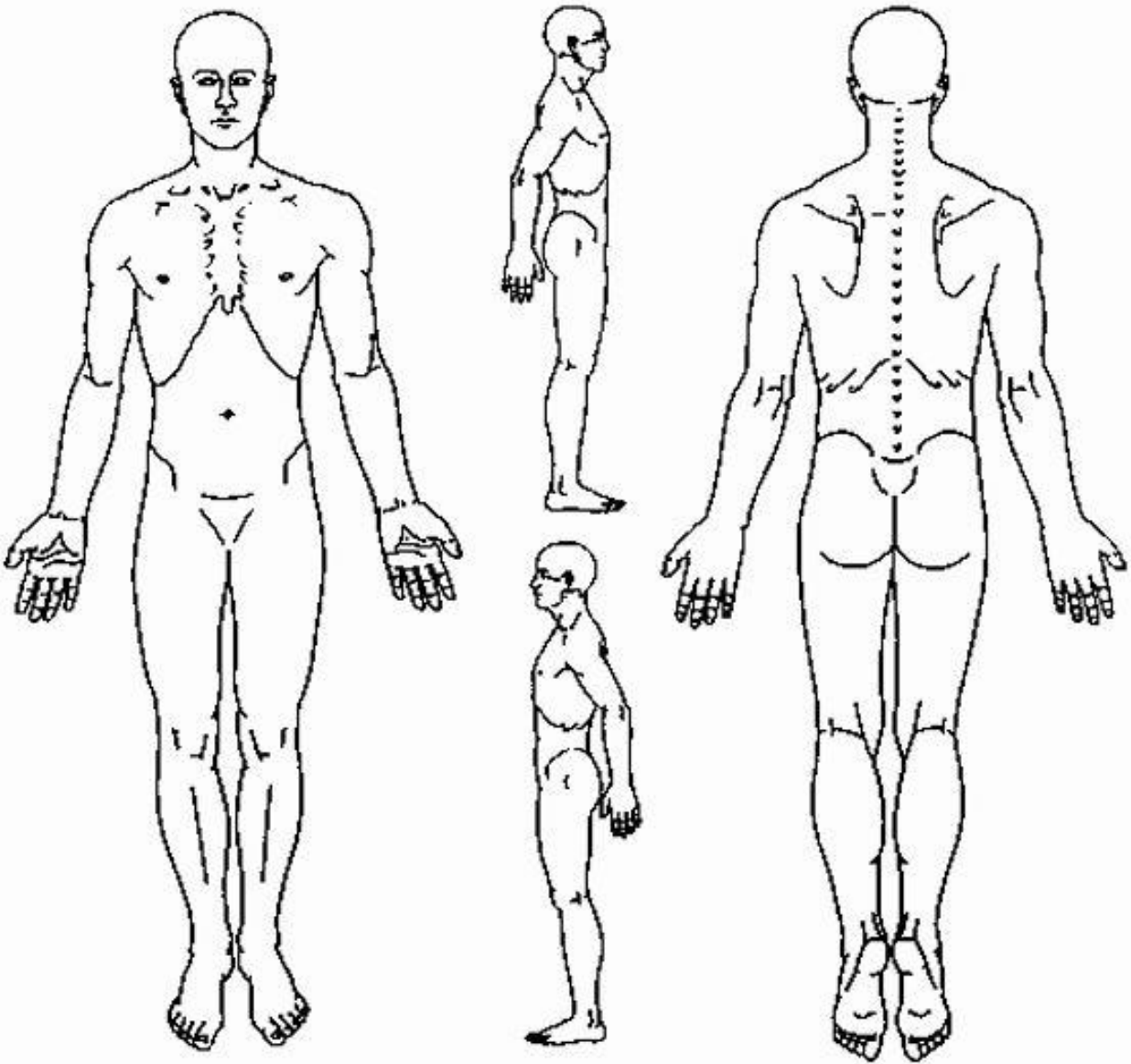
S = stabbing

P = pins & needles

N = numb

O = other

Th = throbbing



Financial Agreement

- ☐ **OUR FEES:** All fees for services are based on the degree of complexity, the number of areas involved, and the time spent evaluating, treating, and instructing (do's & don'ts, exercises, etc.)
Evaluation fees for new patients range from \$80.00 - \$287.00.
Standard treatment fees range from \$45 - \$82.
- ☐ **MISSED APPOINTMENT FEE:** The fee for a missed appointment is a minimum of \$40 for a basic chiropractic follow-up visit. It will be more for longer appointment times. Please provide 24 hours notice if you need to cancel or reschedule an appointment.
- ☐ **DISCOUNT PLANS:** In order to participate in any discount plan offered, payment must be made at time of service.
- ☐ **BILLING STATEMENTS:** Statements are generated the first Tuesday of the month and mailed out within 1-2 days. Balances over 90 days are past due and a 9% (annual) interest charge will be assessed. If required for recovery of past due accounts, you will be charged the collection and/or legal fees. A \$20 fee will be charged for returned checks.
- ☐ **GENERAL INSURANCE PAYMENT POLICY:** Your portion of the services (full amount, co-pay, deductible, etc.) is due on the day of service. Per your insurance plan, evaluation on this day may not be covered by insurance and will be your responsibility.
 - ☐ If your insurance covers chiropractic treatment, we will provide for your insurance company all necessary documentation, but we cannot accept responsibility for non-payment, late payment, or for negotiating a disputed claim. Your insurance policy is a contract between you and your carrier. **Even though we may have been given information by your insurance company regarding the benefits of your plan, this is not a guarantee of payment.**
 - ☐ **After 90 days, unpaid insurance claims will be converted to cash claims.**
 - ☐ We cannot reach the insurance company at this time (after hours, weekend, other). Until we can determine and discuss limitations on your plan, you will be responsible for payment on any excluded services.
- ☐ **3RD PARTY OR WORK INJURY:** Bills will be submitted to the **PI or L&I** insurance carrier. I understand that if the claim is denied by the insurance, I will be responsible for payment.
- ☐ **Payment is expected at Time of Service unless prior arrangements are made. If you are unable to pay your portion at time of service, please alert the front desk.**

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss my diagnosis, the nature and purpose of my treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- | | |
|--|---|
| ☐ Broken bones | ☐ increased symptoms and pain |
| ☐ Dislocations | ☐ No improvement of symptoms or pain |
| ☐ Sprains/strains | ☐ Worsening/aggravation of spinal conditions |
| ☐ Burns or frostbite (physical therapy) | ☐ Other _____ |

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

Acknowledgement of Financial Agreement
Acknowledgement of Consent for Chiropractic Treatment

I have read, or have had read to me, the financial agreement. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I am authorizing Elmenhurst Chiropractic Clinic to bill and receive insurance payments related to my treatment.

I have read, or have had read to me, the consent for chiropractic treatment. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment. I intend this consent form to cover the entire course of treatment for my current condition and for future conditions for which I may seek treatment.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

**Acknowledgement of Receipt of
Notice of Privacy Practices**

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have **had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of:

Elmenhurst Chiropractic

I understand that the Notice describes the uses and disclosures of my protected health information by **Elmenhurst Chiropractic** and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship