PATIENT INTAKE PAPERWORK

Home Phone _____ Cell Phone _____
Name _____
Address _____City _____State _____Zip_____
Date of Birth _____/_____/_____ Age _____ **Circle One:** Married Single Other
Height _____ Weight _____
Email address _____
Occupation _____ Employer _____
Work Contact Phone Number: _____

Emergency Contact Information:
Name of Emergency Contact: _____
Phone Number: _____
Relationship: _____

Primary Care Physician Information:
Name of PCP: _____
Name of Practice: _____
Phone Number: _____

Insurance:
Current Insurance Carrier: _____
Are you the Primary Policy Holder? Yes / No
If No, Please list Primary Policy Holder's:
Name: _____
Date of Birth: _____
Address: _____
Relationship: Father Mother Spouse Child

Chief Complaint _____
Is this complaint related to an Auto Accident or Work Injury? Yes / No
If Yes, please list Auto Insurance Carrier or Workman's Comp Carrier:_____

Previous chiropractic care? **Circle One:** Yes No If yes, Doctor's name_____
How did you hear about our office? _____

Patient Signature: _____ Date: _____

REVIEW OF SYSTEMS
HEALTH QUESTIONNAIRE

Please check each of the conditions below that you are currently experiencing.

Date: _____

Patient: _____ **File No:** _____

MUSCULO SKELETAL SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITO-URINARY SYSTEM

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?

_____YES _____ NO

GASTRO-INTESTINAL SYSTEM

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

CARDIO-VASCULAR RESPIRATORY

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

EYE, EAR, NOSE AND THROAT

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus problems
- ☐ Allergy
- ☐ Jaw pain

LEAST 1 2 3 4 5 6 7 8 9 10 **WORST**

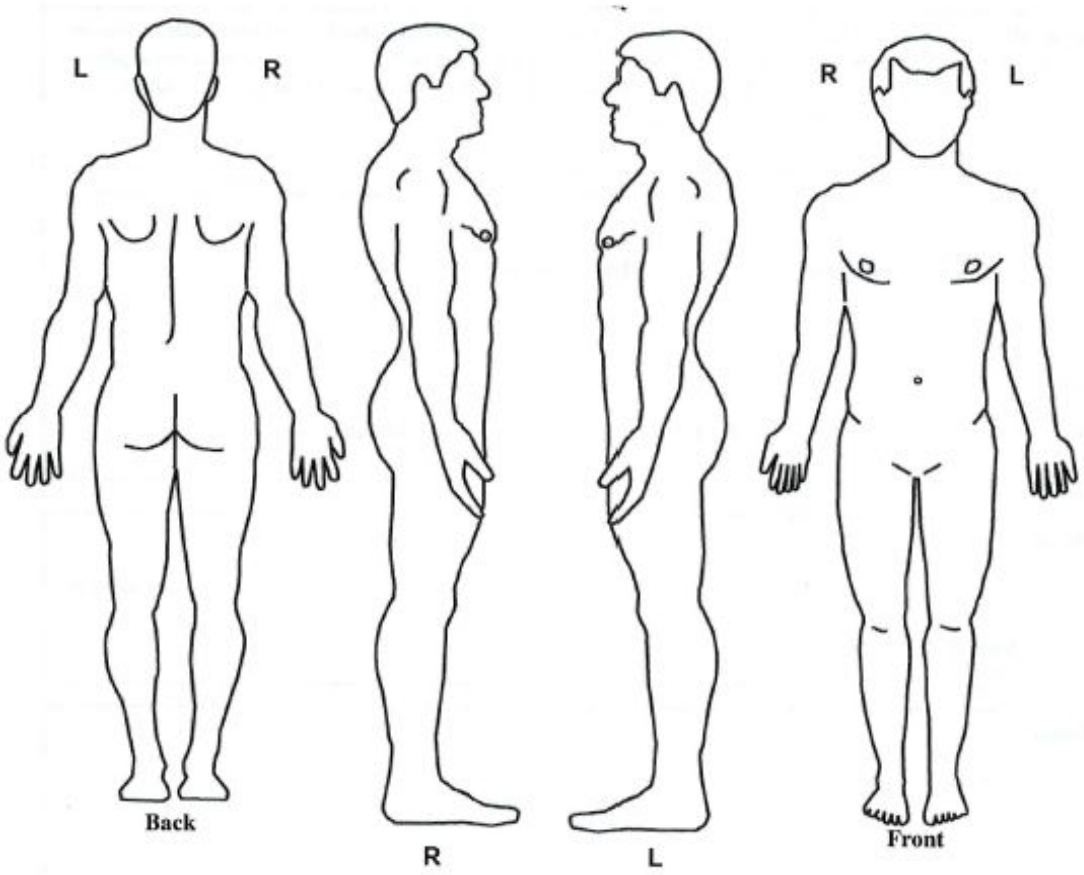
Patient's Signature: _____

(H,I,O) PAIN CHART

☐ *Section N/A*

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensations. Include all affected areas. You may draw on the face as well. Pay attention to right and left sides.

Numbness : = = = = = = = = =	**Pins & Needles :** o o o o o o o o o	**Burning:** x x x x x x x x x	**Ache:** ^ ^ ^ ^ ^ ^ ^ ^ ^	**Stabbing :** / / / / / / / / /



(F) Please indicate your current pain level by placing a line below; best "0" = no pain and "10" = worst pain imaginable.

Example: Pain

0 — *Low back pain* — *Neck Pain* — 10

Right now

0 — 10

Pain at its Worst

0 — 10

Pain at its Best

0 — 10

Pain on Average

0 — 10

(Continued on next page)

Patient's initials _____

History of Present Illness

Patient Name:

Date:

Please answer the following questions as they relate to your current complaint. If you have more than one current complaint please list more than one answer as pertains to the individual complaints.

ONSET:

When did you first notice the symptoms?
Did the pain begin suddenly or gradually?
What were you doing when the pain started?
If an injury please describe what happened?
Have you had this complaint before, if yes when and how many recurrences?

PROVOKES or PALLIATIVE:

What makes your pain better?
What makes your pain worse?
Is your complaint worse at any particular time of day (morning, evening, sleeping, ect.)?

QUALITY:

What words would you use to describe your pain (what does it feel like)?

RADIATING:

Is your pain in a central spot, if yes where?
Does your pain seem to radiate or refer out from that point, if so where?
Do you have any pain/numbness/tingling shooting down your arms or legs?
Do you have any numbness in your hands or feet (even if not associated with your current complaint)?

History of Present Illness Continued

SEVERITY:

On a scale from 0-10, 0 being no pain at all, and 10 being the worst possible pain, please list at what level your current complaint is:

Your complaint at its best:

Your complaint at its worst:

PAST MEDICAL HISTORY:

Is this complaint related to an injury or accident, if yes please explain?

Please list ALL past surgeries you have had:

Last full physical exam with your PCP:

Have you seen your PCP for this complaint:

Have you seen any other medical providers for this complaint:

Please list any previous imaging (CT, Xrays, MRI, PET Scan, Ultrasound):

Do you currently have or have you ever been diagnosed with any type of seizure disorder?

MEDICATIONS & ALLERGIES:

Do you have any allergies to medications, latex gloves, ect?

Are you currently taking any pain relievers, muscle relaxers, or neurontin/gabapentin?

Please list all current medications:

Are you currently taking supplements, if yes please list:

SOCIAL AND FAMILY HISTORY:

Do you smoke, use recreational drugs, or alcohol?

Do you have a family history of: (circle those that apply) arthritis, diabetes, hypertension, stroke, heart disease, cancer, or any other disease or condition?

Patient Signature: _____ Date: _____

All information contained in this packet has been thoroughly reviewed by Physician:
Physician Signature: _____ Date: _____

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operation. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- § Protected health information may be disclosed or used for treatment, payment, or health care operations.
- § The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- § The Practice reserves the right to change the Notice of Privacy Practices.
- § The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- § The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- § The Practice may condition receipt of treatment upon the execution of the Consent.

This consent was signed by: _____

Printed Name-Patient or Representative

_____ _____/_____/_____

Signature **Date**

INFORMED CONSENT TO TREAT

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 diagnostic or examination procedures if indicated. These may include: physical examination, palpation, reflex testing, neurological evaluation, blood pressure, pulse oximetry, temperature,

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.

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, fractures (broken bones), disc injuries, arterial dissections, dislocations, strains, and sprains. ALL efforts and clinical diagnostics will be taken to ensure if any predisposition or risk for injury exist prior to treatment, then treatment will be altered to ensure the lowest possible risk.

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:

DISCOUNTED SERVICES

Some services today are being provided to you at a discounted rate. Your evaluation may consist of a: consultation, complete case history, and chiropractic, orthopedic, neurological assessment and examination. The chiropractic and orthopedic evaluation may include, but is not limited to: visual inspection, motion palpation, active, passive, and resisted range of motion, and orthopedic tests specific to the localized area. The cervical, thoracic, lumbar, and sacroiliac regions will be assessed. The neurological evaluation may consist of: muscle testing, deep tendon reflexes, and bilateral sensory assessment. If insurance coverage exists, your insurance will not be billed for the examination portion of today's visit.

Patient Signature _____ Date _____

INSURANCE VERIFICATION

I authorize Discover Health & Wellness to verify my insurance benefits for future services at this facility. This authorization does not authorize any charges to be billed, only my benefits to be verified for possible future services should I choose to receive future treatments. This verification includes Auto Insurance should I be seen for injuries related to an Auto accident, Workman's Comp Insurance should I be seen for work related injuries. Be aware that if your injuries are related to either workplace injuries or an auto accident you are entitled to additional benefits under those insurance policies and that may limit your out of pocket expense and regular Health Insurance Companies have the right to request those policies be used as the primary.

Patient Signature _____ Date _____

DISCOVER HEALTH & WELLNESS UPTOWN

NO SHOW AND CANCELLATION POLICY

Patients are responsible for the appointments that they schedule.

Twenty-four hour notice is appreciated and required when canceling or rescheduling an appointment.

Patients who do not provide twenty-four (24) hour cancellation notice are expected to pay a $45.00 missed appointment fee.

We are mindful that personal emergencies do arise, and in those instances we understand that life is not always in our control. This will be considered on a case-by-case basis.

I acknowledge that I have read and understand the above terms.

_____ _____

Patient Signature **Date**