

# 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 \_\_\_\_\_

## **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? \_\_\_\_\_

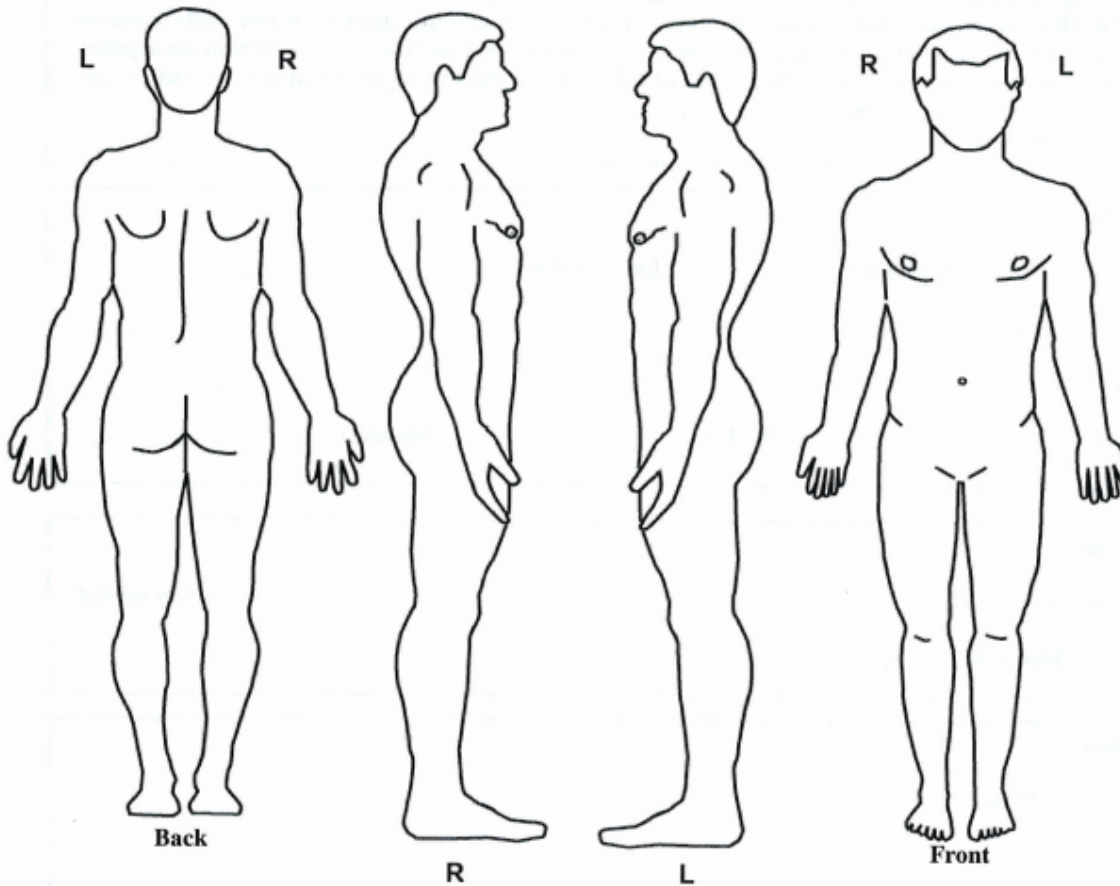
Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(H,I,O) PAIN CHART**

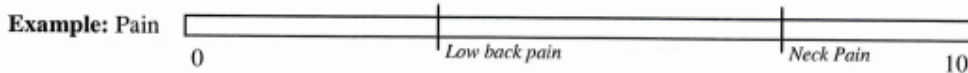
☐ Section N/A

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 : ooo ooo ooo	Burning: xxx xxx xxx	Ache: ^^^ ^^^ ^^^	Stabbing : /// /// ///
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(F) Please indicate your current pain level by placing a line below; best "0" = no pain and "10" = worst pain imaginable.



Right now 0 | | 10

Pain at its Worst 0 | | 10

Pain at its Best 0 | | 10

Pain on Average 0 | | 10

PATIENT'S NAME: \_\_\_\_\_ Please list your current medications on the Medical List form provided in your packet. Be sure to spell correctly and list the dosage and amount of medication you are taking as listed on your prescription bottle. Bringing in your medications for our review would be greatly appreciated.

REVIEW OF SYSTEMS	Y	N		Y	N		Y	N
<u>GENERAL</u>			<u>STOMACH</u>			<u>NEUROLOGICAL</u>		
Headache			Trouble swallowing			Stroke		
Lethargy/Weakness			Heartburn/Indigestion			Seizures		
Chills/Night sweats			Change in bowel habits			Head injury		
Fever			Loose Stool/diarrhea			Memory loss		
Fainting spells/unconscious			Black/Bloody Stools			Confusion		
Weight loss			Frequent stomach pain			Trouble speaking		
Dizziness			Vomiting blood			Trouble swallowing		
<u>EYES</u>			Constipation			Unsteady gait		
Wears glasses			Irritable bowel			Trouble walking		
Eyesight worsening			Ulcers			Arm/leg weakness		
Double vision			Stomach/bowel cancer			Arm/leg tingling		
Eye pain			<u>KIDNEY PROSTATE</u>			Arm/leg numbness		
<u>EARS/NOSE/THROAT</u>			Frequent voiding			<u>PSYCHIATRIC</u>		
Deafness			Burning on urination			Nervous breakdown		
Noise in ears			Pus/blood in urine			Panic attacks		
Congestion/sneezing			Trouble starting urination			Cry often/depressed		
Sinus trouble/hay fever			Dribble with cough/sneeze			Worry a lot		
Nose bleeds			Loss of urine control			Considered suicide		
Sore throat or tongue			Prostate disease/cancer			Loss of interest in eating		
Hoarse voice			Sexual difficulty			Anxiety/tension		
Dental problem			<u>SKIN</u>			Loss of energy/fatigue		
<u>HEART</u>			Rashes			<u>ENDOCRINE</u>		
Chest pain with exertion			Birthmarks			Unwanted weight change		
Heart attack			Sores			Change in skin		
Heart murmur			Dry/oily skin			Breast discharge		
Heart racing/palpitations			Hair growth/loss			Excessive thirst		
Irregular heart beat			<u>MUSCLE/BONE</u>			Excessive tiredness		
Mitral valve prolapsed			Back pain			<u>BREAST/MENSTRUAL</u>		
High blood pressure			Neck pain			Endometriosis		
Swollen feet/ankles			Back surgery			Are you pregnant?		
Heart valve replacement			Arthritis			Irregular menstrual period		
Atrial fibrillation			Fibromyalgia			Breast discharge		
<u>LUNG</u>			Aching muscles/joints			Lumps in breast		
Lung cancer			Shoe lift or brace			<u>SLEEP</u>		
Shortness of breath			Bone/joint injury			Dreams/sleep walk		
Chest pain			Osteoporosis			Legs twitch		
Coughing up phlegm			<u>HETATOLOGIC</u>			Insomnia		
Cough up blood			Blood disease			Daytime drowsiness		
Wheezing/cough			Enlarged glands			Snores		
Pneumonia			Bleed/bruise easily			Breath holding/gasping		
			Anemia/low blood			Restless sleep		

## 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)?

### **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:

**OCCUPATIONAL HISTORY**

Current Occupation:

Hours worked a week sitting?

Hours Standing?

Any past work related injuries?

**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 \_\_\_\_\_