PATIENT CASE INFORMATION

Date: _____ **Patient No:** _____

Patient Information

Name :*(First MI Last)* _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Cell Carrier:** _____ **Home Phone:** _____

Email Address: _____ **Gender:** M / F **Marital Status:** Single / Married / Other

Social Security #: _____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N **Where:** _____

Ethnicity: Hispanic or Latina / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: _____

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

Smoker: Everyday / Some Days / Former / Never

**** Referred By:** _____ Family / Friend / Co-Worker / Doctor/ Other Source

Emergency Contact Information

Name: (First MI Last) _____ **Primary Care Physician:** _____

Phone: _____ **Doctor's Phone:** _____

Relationship: Child / Parent / Spouse / Other: _____

Insurance / Financial Information

Who is responsible for payment? Self / Other - Name: _____ **Relationship:** _____

☐Insurance☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury / Auto ☐ Other (please explain): _____

Primary Insurance Name: _____ **Secondary Insurance Name:** _____

***** (Please supply insurance cards to office staff so that they can be copied)***

Consent to Treat, Authorization to Release & HIPPA

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation, examination, chiropractic care, diagnostic testing, and/or therapeutic services on the above, in accordance with this state's statutes. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient: _____ ***Signature of Parent or Guardian:*** _____ ***Date:*** _____

(It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged)

COMPLAINT INFORMATION

Date: _____ **Patient No:** _____

History of Current Condition

Major Complaint: _____

Secondary Complaint: _____

When and How this began? _____

_____

_____

Intensity of Pain/Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore

How frequent is the complaint? Off & On / Constant

Does the complaint radiate? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Temple L / R / Both Leg - Hip / Thigh-Knee / Calf / Toes L / R / B

Arm - Across Shoulder / Elbow / Hand-Fingers L / R / Both Other Area: _____

What makes it Better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

What makes it Worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected? (*Describe*) _____

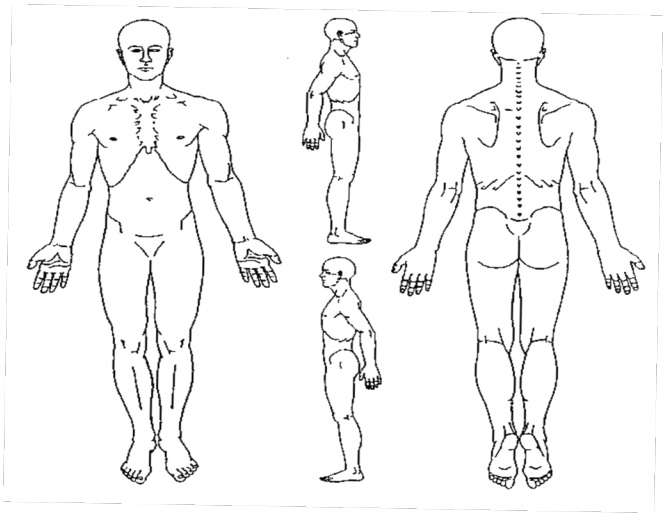
For this condition, have you:

Other Treatment? None / DC / MD / PT / Massage / Other: _____ Where: _____

Other Diagnostic Testing? None / X-rays / MRI / CT / Other: _____ Where: _____

Pain/Complaint Diagram

SYMPTOM DIAGRAM



T ___ Tender

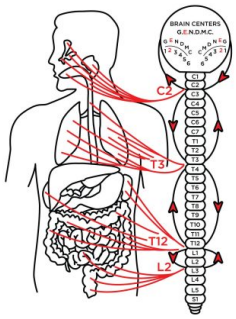
P___ Pain

N ___ Numb

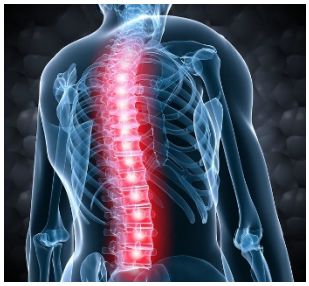
H ___ Hypoesthesia

S ___ Spasm

Patient Signature: _____ ***Physician's Initials:*** _____



SYSTEMS REVIEW QUESTIONNAIRE



NAME:	DATE:

The six sections of this form deal with the SIX HEALTH ZONES (Glandular, Eliminative, Nerve, Digestive, Muscular, Circulatory). By completing this form, it will assist us in determining which Zone / Function of the body is causing or contributing to your pain or problem. Since all six Zones are interrelated, an improvement in any one Zone would also affect the others.

INSTRUCTIONS

Circle the appropriate number for each question according to the following scale:

0- NONE at all; not a problem
1- - SLIGHT amount, or rarely
2- MODERATE; some
3- ACUTE; a lot; frequently

GLANDULAR SYSTEM

1. Sensitive or tender skin 0 1 2 3
2. Cuts in skin heal slowly 0 1 2 3
3. Face flushes easily 0 1 2 3
4. Perspire a great deal 0 1 2 3
5. Itchy scalp, dry skin or rash 0 1 2 3
6. Lack of energy 0 1 2 3
7. Poor memory 0 1 2 3
8. Dry, brittle hair or oily hair/scalp 0 1 2 3
9. Lose control of bladder 0 1 2 3
10. Enlarged glands 0 1 2 3
11. Get upset, irritated or short temper 0 1 2 3
12. Poor concentration 0 1 2 3
13. Spells of exhaustion or fatigue 0 1 2 3
14. Get up tired and exhausted 0 1 2 3
15. Tire easily or nervous exhaustion 0 1 2 3

TOTAL _____

ELIMINATIVE SYSTEM

1. Abnormal or excessive foot odor 0 1 2 3
2. Abnormal or excessive body odor 0 1 2 3
3. Frequent clearing or lump in throat 0 1 2 3
4. Excessive spells of sneezing 0 1 2 3
5. Nose bleeds 0 1 2 3
6. Have colds or chest colds/infections 0 1 2 3
7. Cough or spitting up mucus 0 1 2 3
8. Soaking sweats during sleep 0 1 2 3
9. Chronic chest condition 0 1 2 3
10. Diminished urination 0 1 2 3
11. Trouble with complexion 0 1 2 3
12. Congested breathing or wheezing 0 1 2 3
13. Inflamed or irritated bladder 0 1 2 3
14. Constipated 0 1 2 3
15. Runny nose (not during a cold) 0 1 2 3

TOTAL _____

CENTRAL NERVE SYSTEM

1. Eyes blink or water 0 1 2 3
2. Sties, pain, or red eyes 0 1 2 3
3. Draining, loss of hearing, ear noises 0 1 2 3
4. Double vision or loss of sight 0 1 2 3
5. Lack of sensation in the body 0 1 2 3
6. Loss of smell or taste 0 1 2 3
7. Headaches 0 1 2 3
8. Hot or Cold spells 0 1 2 3
9. Dizzy spells or faint feelings 0 1 2 3
10. Twitching sensation in you body 0 1 2 3
11. Fingernail biting 0 1 2 3
12. Stuttering or stammering 0 1 2 3
13. Difficulty falling or staying asleep 0 1 2 3
14. Inability to relax 0 1 2 3
15. Loss of sex drive 0 1 2 3

TOTAL _____

MUSCULAR SYSTEM

1. Painful swelling in joints 0 1 2 3
2. Muscle or joint stiffness 0 1 2 3
3. Pain in joints 0 1 2 3
4. Pain in arms 0 1 2 3
5. Pain in legs 0 1 2 3
6. Pain in feet 0 1 2 3
7. Back pain 0 1 2 3
8. Neck pain 0 1 2 3
9. Tremors or shaking 0 1 2 3
10. Pain or head pressure 0 1 2 3
11. Muscle cramping 0 1 2 3
12. Muscle spasm 0 1 2 3
13. Pains in Back 0 1 2 3
14. Weak knees or ankles 0 1 2 3
15. Muscle twitches 0 1 2 3

TOTAL _____

DIGESTIVE SYSTEM

1. Coated tongue 0 1 2 3
2. Poor appetite 0 1 2 3
3. Do not eat regular meals 0 1 2 3
4. Ear sweets between meals 0 1 2 3
5. Snack between meals 0 1 2 3
6. Must be careful what you eat 0 1 2 3
7. Feel bloated 0 1 2 3
8. Indigestion 0 1 2 3
9. Heartburn 0 1 2 3
10. Nausea 0 1 2 3
11. Bad breath 0 1 2 3
12. Bad taste in mouth 0 1 2 3
13. Brownish spots on skin 0 1 2 3
14. Pains in lower abdomen 0 1 2 3
15. Drink sweet drinks between meals 0 1 2 3

TOTAL _____

CIRCULATORY SYSTEM

1. High blood pressure 0 1 2 3
2. Low blood pressure 0 1 2 3
3. Pains in chest 0 1 2 3
4. Thumping of the heart 0 1 2 3
5. Heart races 0 1 2 3
6. Out of breath easily 0 1 2 3
7. Swelling of hands/ankles 0 1 2 3
8. Cold hands in hot weather 0 1 2 3
9. Cold feet in hot weather 0 1 2 3
10. Cramps in legs 0 1 2 3
11. Numbness or tingling 0 1 2 3
12. Bruise easily 0 1 2 3
13. Poor circulation 0 1 2 3
14. Varicose veins 0 1 2 3
15. Headaches 0 1 2 3

TOTAL _____

HEALTH HISTORY

Patient Name: (First MI Last) _____ **Patient No:** _____

Medications and Supplements:

Allergies to Medications: ☐**NONE**

Name	Reaction

Current Medications & Supplements: ☐**NONE**

Name	Dosage

Past Health History:

Surgeries: ☐**NONE**

Date	Describe

Major Injuries / Traumas / Hospitalizations: ☐**NONE**

Date	Describe

Family Health History: ☐**NONE**

List major health problems of 1st degree relatives:

Problem	Relation (Parent, Sibling, Child)

Social and Occupational History:

Smoking: ☐Every Day☐Some Days ☐ Former☐Never

Habit	Type / Amount / Year Started
Smoking	
Tobacco	
Alcohol	
Caffeine	
Rec. Drugs	

Women:** ***Are you pregnant?

- ☐ No *Last Menstrual Period:* ___/___/____
- ☐ Yes *Due date:* ___/___/____

Informed Consent

Chiropractic Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so. Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, chiropractor, staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

○ Yes ○ No

PATIENT and/or PARENT/GUARDIAN SIGNATURE FOR NAMES ABOVE:

_____ **DATE**: _____

COVID-19 HEALTH QUESTIONNAIRE

Patient Information

FIRST AND LAST NAME: _____ **DATE:** _____

CHILDREN NAMES IF UNDER 18: _____

Health Questionnaire

Have you, your child, or others accompanying you to today's appointment or other recent acquaintances tested positive for or been diagnosed as having COVID-19 or any other communicable disease?

Yes No If Yes, When? _____

Do you, your child, or others accompanying you to today's appointment or other recent acquaintances have any of the following symptoms:

Fever (defined as above 99.6 degrees)?

Yes No

Cough?

Yes No

Shortness of breath and/or trouble breathing?

Yes No

Persistent pain, pressure, or tightness in the chest?

Yes No

Other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?

Yes No

Recent loss of taste or smell?

Yes No

Have you/they traveled in the past 14 days to any regions affected by COVID-19?

Yes No

I understand that if the answer to any of these questions is yes, I will be asked to reschedule today's appointment.

Yes No