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(____)_____-_____
Ethnicity: □ Hispanic or Latino □ NOT Hispanic or Latino **Race:** □ American Indian or Alaska Native
□ African American or □ Black □ Asian □ Hispanic or Latino □ Hawaiian or Pacific Islander □ White
Preferred language: □ English □ Spanish □_____**If minor patient:** Parent/Guardian_____
Relationship _____ Address □Same as above _____
Emergency contact_____ Relationship_____ Phone(_____)_____-_____
Referred by _____ Your primary care physician: _____

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 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** **Please list any Allergies**		
Food	**Environmental**	**Medications**

□ **NONE** **Family History**	Mother	Father	Sister	Brother	Grand mother	Grand father	Child
Cancer							
Heart							
Diabetes							
Kidney							
Autoimmune							
Hereditary							
Psychiatric							
Other							

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 □**none** □ **Y** By whom_____ Starting date_____
Total lost days_____Define:_____
With past and/or present job were/are you exposed to: □ dust □ coal □ other airborne particles □ toxic fumes
□ other _____From _____To _____

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_____

Highest level of Education (circle one): Grade School Middle School HS GED
Vocational School Undergraduate College Graduate College
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:

□ change in personality
□ change in mood/mood swings
□ change in motivation
□ change in outlook on life
□ change in empathy
□ change in concentration
□ change in ability to organize
□ feeling of depression
□ irritability
□ extreme fears or phobias
□ eating disorder
□ suicidal thoughts
□ drop things / lose your grip
□ trip easily
□ loss of strength
□ difficulty on fine motor skills
□ changes in penmanship
□ changes with speech
□ changes with your voice
□ difficulty smiling
□ strange skin sensations
□ bump into corners
□ neglecting one side
□ confused with left and right
□ difficulty with numbers
□ blurring of vision
□ double vision
□ blind spots
□ floaters
□ flashes of lights
□ sensitivity to light
□ other visual changes

□ memory loss
□ difficulty hearing
□ difficulty localizing sounds
□ poor auditory comprehension
□ noise in the ears
□ sensitivity to loud noises
□ seizures

□ tremors of any body part
□ twitching/cramping muscles
□ stiffness with movement

□ changes in coordination
□ clumsiness
□ unsteadiness when walking in the dark
□ chronic joints injury
□ moments of unexplained confusion or disorientation

□ jaw pain
□ grind or clench your teeth
□ jaw click / pop
□ difficulty chewing
□ difficulty opening your mouth
□ fatigue easily
□ hot flashes
□ chills
□ cold hands or feet
□ sweat easily or excessively
□ difficulty with smiling or other facial expression
□ change in smell/taste / appetite
□ wet or dry eyes
□ do you have a drippy nose
□ does your nose bleed easily
□ difficulty swallowing

□ soreness or tightness of throat

□ heartburn
□ choke easily
□ shortness of breath
□ coughing or wheezing
□ dizziness / light-headedness with change of position
□ dizziness / light-headedness with certain positions
□ car sickness
□ unexplained nausea

□ swelling in the legs or feet
□ chest pain
□ irregular heart beats
□ pain legs with walking
□ chest pressure
□ rapid heart beats
□ heart valve problems
□ pacemaker

□ physical abuse
□ sexual abuse
□ emotional abuse
□ do not know

<u>Pain / Numbness / Weakness:</u>
□ head / neck
□ shoulders /arms / elbows
□ wrists / hands / fingers
□ upper - mid - low back
□ pelvis / tail bone
□ hip / groin / thighs
□ knees / legs / ankles / feet
□ joints
□ muscles

□ stomach bloating
□ digestion problems
□ excessive gas
□ stomach cramping
□ irritable bowel symptoms
□ changes in bowel movements
□ blood in bowel movements
□ persistent / recurrent constipation
□ persistent / recurrent diarrhea

□ frequent urination
□ burning or pain when urinating
□ difficulty starting to urinate
□ difficulty emptying bladder
□ leaking urine
□ vaginal dryness
□ erectile dysfunction

□ weight gain of more than 10lbs in the last 6 months
□ weight loss of more than 10lbs in the last 6 months

<u>Skin / Nails / Hair:</u>
□ dry
□ splitting / cracking
□ ridges
□ eczema
□ acne
□ bruise easily
□ excess oil
□ body odor
□ discolored
□ unexplained hair loss

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

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

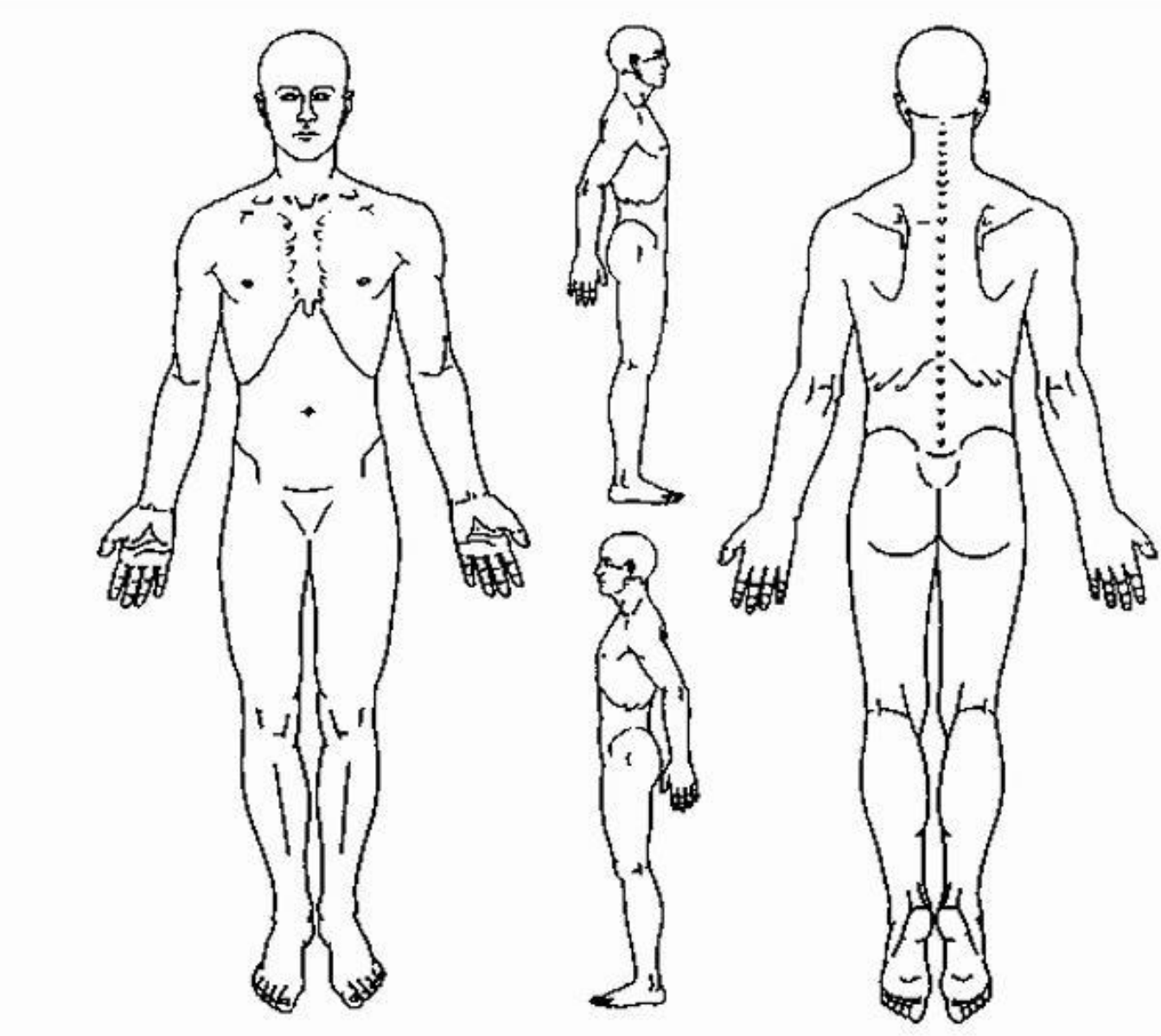
_____
Date

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**



Elmenhurst Chiropractic Clinic

FINANCIAL CONSULTATION

Primary Insurance _____ ID#_____ Group #_____ Subscriber_____

Subscriber ID _____Subscriber DOB _____Patient Relationship to Subscriber_____

Secondary Insurance_____ ID#_____ Group #_____Subscriber_____

Subscriber ID _____Subscriber DOB _____Patient Relationship to Subscriber_____

- ____(Pt. Initials) **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.

- _____(Pt. initials) **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.

- _____(Pt. initials) **DISCOUNT PLANS:** In order to participate in any discount plan offered, payment must be made at time of service.

- _____(Pt. Initials) **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.

- _____(Pt initials) **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.

  - _____(Pt initials) 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.**

  - _____(Pt initials) **After 90 days, unpaid insurance claims will be converted to cash claims.**

  - _____(Pt initials) 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.

- _____ (Patient initials) **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.**

By signing this document, you are authorizing us to bill and receive insurance payments related to your treatment.

Patient signature_____ Date _____

Elmenhurst Chiropractic Clinic

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.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and 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*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____
Employee Name *Today's Date*

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

I have read, or have had read to me, the above consent. 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.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____ _____
witness to patient's signature date

_____ _____
Translated by date