Patient Intake Form

Rehab 2 Wellness
Chiropractic

Patient Information

Name _____ Date of Birth _____
First Last Middle Initial (if applicable) MM/DD/YY

Email _____

Phone (check preferred)
☐ Home Phone _____
☐ Cell Phone _____

Address _____
Street
_____
City Zip

Whom may we thank for referring you? _____

Primay Care Physician/Practice _____

Sex ☐ M ☐ F Age _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced

Employer _____ Occupation _____

Emergency Contact

Emergency Contact _____ Phone _____

Insurance Information

Account holder ☐ Self or ☐ Other _____ Date of Birth _____
Name ...of account holder

Relationship to patient _____

Address (if diffferent from patient's) _____

Person responsible employed by _____ Occupation _____

Phone _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance company listed above. I assign directly to my provider (chiropractor), all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hearby authorize the doctor to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

Sign _____ Date _____

Primary Complaint Form

Rehab 2 Wellness Chiropractic

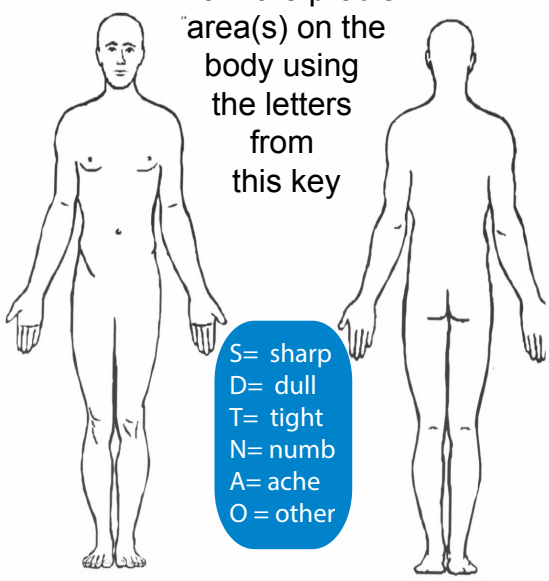
Describe the problem you are currently experiencing:

Height_____ Weight_____ Handedness ☐R ☐L

1. circle your pain level, below

most 10 9 8 7 6 5 4 3 2 1 least

2. Mark the problem area(s) on the body using the letters from this key



S= sharp
D= dull
T= tight
N= numb
A= ache
O = other

3. When did this problem start? _____ approximate DATE

4. Have you ever had this problem before? ☐ Yes ☐ No

5. What do you think caused the problem?_____

_____

_____

6. What makes your pain worse? (check)

☐ work ☐ sleep ☐ sitting ☐ cough/sneeze ☐ Standing ☐ heat or cold

7. Is it getting: ☐ better ☐ worse ☐ not changing

8. Have you ever been to a chiropractor before? ☐ Yes ☐ No

Past health history

Have you...	Yes	No	If yes, explain briefly
1... been hospitalized in the last 5 years?	☐	☐	_____
2... been in any auto accidents?	☐	☐	_____
3... had any broken bones?	☐	☐	_____
4... had any strains or sprains?	☐	☐	_____
5... ever used orthotics?	☐	☐	_____
6. Do you take minerals, herbs or vitamins?	☐	☐	_____

7. How is most of your day spent? ☐ standing, ☐ sitting, ☐ other: _____
8. How old is your mattress? _____
9. When was your last physical exam? _____

Lifestyle

	None	Light	Mod.	Heavy
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Water	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep		☐	☐	☐

Medications - Please list and state why you're taking them:

1_____ 5_____
2_____ 6_____
3_____ 7_____
4_____ 8_____

Do you have any other health issues or concerns that our staff should be made aware of? _____

Medical History Form

Your responses are important to help us better understand the health issues that you face and ensure the delivery of the best possible treatment. Patient information contained within this form is considered strictly confidential.

Please Check and indicate past 'P' or current 'C'

Allergic-Immunologic
- ☐ Hives/ Eczema
- ☐ Frequent colds/ Flu
- ☐ Frequent sinus trouble
- ☐ HIV/ Aids
- ☐ Allergies
- ☐ Fever
- ☐ Mental Illness

Cardio-vascular
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Fainting Spells
- ☐ Palpitations
- ☐ Irregular Heart Beat
- ☐ Perfuse Sweating
- ☐ Low Blood Pressure
- ☐ High Triglicerides
- ☐ Swollen ankles
- ☐ Murmur
- ☐ High Blood Pressure
- ☐ Dizziness
- ☐ Pressure in chest
- ☐ Nausea
- ☐ Difficulty Laying Flat
- ☐ Shortness of Breath
- ☐ Pain Down Left Arm
- ☐ Vomiting

Ear, Nose Throat
- ☐ Difficulty hearing
- ☐ Hearing Loss
- ☐ Frequent Sore Throat
- ☐ Buzzing in Ears
- ☐ Ear Pain
- ☐ Diffuculty Swallowing
- ☐ Ringing in Ears
- ☐ Mouth Sores
- ☐ Vertigo
- ☐ Horseness
- ☐ Sinus Trouble
- ☐ Nose Bleeds
- ☐ Nasal Stuffiness
- ☐ Dental Problems

Endocrine
- ☐ Heat/cold Intolerance
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Diabetes
- ☐ Goiter

Eyes
- ☐ Glasses/Contacts
- ☐ Eye Pain
- ☐ Light Sensitivity
- ☐ Double Vision
- ☐ Cataracts
- ☐ Vision Problems
- ☐ Glaucoma

Gastro Intestinal
- ☐ Heartburn
- ☐ Black/Bloody stools
- ☐ Ulcers
- ☐ Colon Cancer
- ☐ Pain over Stomach
- ☐ Nausea/Vomiting
- ☐ Gallbladder Problems
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Liver Problem
- ☐ Hiatal Hernia
- ☐ Change in Bowels
- ☐ Hepatitis
- ☐ Colitis
- ☐ Pancreatitis
- ☐ Diarrhea
- ☐ Jaundice

Genito-Urinary
- ☐ Burning/ Frequent
- ☐ Kidney infection
- ☐ Bloody Urine
- ☐ Sexual Difficulty
- ☐ Erectile Dysfunction
- ☐ Kidney Stones
- ☐ Abnormal Discharge
- ☐ Leakage
- ☐ Incontinence

Hematology/Lymph
- ☐ Easy Bruising
- ☐ Enlarged Glands
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Sickle Cell Anemia

Neurological
- ☐ Strength Loss
- ☐ Disorientation
- ☐ Disc Problem
- ☐ Numbness/ Tingling
- ☐ Multiple Sclerosis
- ☐ Loss of Coordination
- ☐ Lightheaded
- ☐ Headaches
- ☐ Parkinson's
- ☐ Epilepsy/ Seizures
- ☐ Stroke
- ☐ Tremors
- ☐ Consussion
- ☐ Memory Loss
- ☐ Migraines
- ☐ Weakness

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ Difficult Sleeping
- ☐ Nervousness
- ☐ Tension

Respiratory
- ☐ Cough
- ☐ Asthma
- ☐ Diffuculty Breathing
- ☐ Coughing Blood
- ☐ Superficial Breathing
- ☐ Lung Cancer
- ☐ Wheezing
- ☐ Chest Pain
- ☐ Chills
- ☐ Tuburculosis
- ☐ Bronchitis
- ☐ Peumonia
- ☐ Emphysema

Integumentary/ Skin
- ☐ Rashes/ Sores
- ☐ Psoriasis
- ☐ Lesions
- ☐ Change in moles
- ☐ Itching/ Burning
- ☐ Change in Skin color
- ☐ Skin Problem
- ☐ Skin Cancer
- ☐ Slow Healing
- ☐ Scars
- ☐ Bruise Easily
- ☐ Discolorations

Females ONLY
- ☐ Hot Flashes
- ☐ Lumps in Breast
- ☐ Vaginal Discharge
- ☐ Hysterectomy
- ☐ Nipple Discharge
- ☐ Menstural Cramps

Males ONLY
- ☐ Difficulty Urinating
- ☐ Dripping Urination
- ☐ Prostate Trouble

General
- ☐ Recent Weight Gain
- ☐ Polio
- ☐ Loss of Sleep
- ☐ Rheumatic Fever
- ☐ Recent Weight Loss
- ☐ Cancer
- ☐ Loss of Appetite
- ☐ Fatigue

Family history *If a blood relative has had any of the following conditions, please check and indicate which relative(s)*

- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Liver Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure
- ☐ Stroke

Informed Consent / HIPAA notification

Medical doctors, Chiropractic doctors, osteopaths and physical therapists who perform manual therapies are required by law to obtain your informed consent before starting treatment.

I _____, Do hearby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. Physical therapy and exercises may be used. Although spinal manipulation/adjustment is considered to be one of the safest, most cost-effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:
Soreness: Like exercise, it is fairly common to experience general muscle soreness.
Bruising: Although rare, it may be possible with some soft tissue massage procedures.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint injury: In isolated cases underlying physical defects, deformities or pathologies like weak bones (from osteoporosis) may render the patient susceptible to injury. When osteoporosis or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our society, strokes from chiropractic adjustments are rare. Nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of asprin or Tylenol causing death.
Physical Therapy burns: Some of the therapies used in this office generate heat and may cause a burn (rarely). Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment.

Alternative Treatments to Chiropractic

Reasonable alternatives to these chiropractic procedures include, rest, home application ice/heat therapy, over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate short-term relief, undesirable side effects, physical or psychological dependence, and may have to be condinued indefinitely. Some medications may involve serious risks.
Rest/Exercise: Simple rest is not likely to reverse pathology, although it may termpoarily reduce inflammation and pain. The same is true of heat or other home tharpy. Prolonged bed rest contributes to weakened bones and joint stiffness.
Surgery: This may be necessary for certain serious spinal injuries. Surgical risks can be serious.
Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology.

Treatment Results

I also understand that there are beneficial effects associated with these treatments including decreased pain, improved mobility and function, and reduced muscle spasm. However I am aware that there is no guarantee that I will achieve these benefits. I realize that the practice of medicine, including chiropractic is not an exact science and I acknowledge that no guarantee has been made to me regarding outcome of these procedures.

Please **sign** indicating your consent to treat and acknowledgement of HIPAA privacy policy

I acknowledge that I have the right to request either a long, full version of the practices privacy policy or a summary short form at any time. I am aware that the office has a privacy policy that complies with the 2003 federal HIPAA guidelines and by my signature, accept and acknowledge my rights and conditions under this posted and available policy upon request.

Signature _____Date_____

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction. I have made my decision freely and voluntarily.

Signature _____Date_____

<u>Cancellation/ No-show policy</u>:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving much-needed treatment. Conversely, we want to remain accessible, and this policy helps to ensure our availability for you as well. ;)

Appointments not cancelled > 24 hours in advance may incur a twenty dollar ($20.00) cancelation fee- this will not be covered by your insurance company.

Initials:_____

<u>Late policy</u>:

We understand that delays can happen however we value all of our patients' time and our doctor usually runs on time.

Lateness more than 5 minutes past the scheduled time may require rescheduling **chronic lateness may incur a cancellation fee**

Initials:_____

X_____ _____

Patient Signature **Date**