PATIENT INTAKE FORM

Today's Date: _____

Last Name:	**First Name:**	**Middle Initial:**
Mailing Address:	**City:**	**State:** **Zip:**
Date of Birth: Age:	Social Security Number: - -	
Height: Weight:	Who Referred You to Our Office:	
Occupation:	Marital Status (Circle): Single, Married, Divorced, Widowed	
Cell Phone: ( ) -	Employer's Name:	
Home Phone: ( ) -	Work Phone: ( ) -	
E-mail Address:	Primary Care Physician:	

As a courtesy, we send Appointment Reminders to patients 24 hours before any future appointments. Please let us know whether you would prefer to receive these reminders via text message or email.	☐ Text Message. Cell Phone Carrier: _____(required) ☐ E-mail (please be sure to provide your email address above) ☐ I would prefer not to receive appointment reminders.

Emergency Contact: _____ Phone: _____

THIS VISIT IS RELATED TO:

☐ Work Related Injury/Symptoms	☐ Motorcycle-Bicycle Injury	☐ Non-Injury Pain/Symptoms
☐ Sport or Recreational Injury	☐ Home Injury Symptoms	☐ Check-up Only
☐ Motor Vehicle Collision Injury	☐ School/Employment Physical	☐ Other (Describe):

HEALTH INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	☐ Yes, ☐ No ☐ Unsure If Yes or Unsure, please allow us to copy your insurance card so that we can verify your insurance benefits.

HIPPA STATEMENT:

As a patient of Center for Chiropractic and Pain Rehabilitation (CCPR), you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the ways in which we secure your information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Notes taken during appointments are kept in your chart and secured in out clinic at all times. If patient charts are in public areas, the names are covered. Access to the clinic is limited to practitioners and employees. Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health in the clinic setting to protect your privacy and ensure that important information is kept in your chart. Your healthcare information is private and cannot be copied or shared with anyone else without your written signed consent. In some cases, verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax and are accompanied with a confidential patient information cover sheet is faxed. Our office needs to leave messages, return telephone calls, and send office mail to your mailing address as part of our normal practice. Federal/State HIPAA patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means.

MISSED APPOINTMENT POLICY:

A 24-hour notice is required for all cancellations. A **$40 fee will be charged for all missed appointments.** This fee will not be covered by your group, auto, or personal insurance. If we are closed, please leave a detailed message.

INFORMED CONSENT FOR CHIROPRACTIC CARE:

As a patient at CCPR, I give the doctor of chiropractic (DC) permission and authority to care for me in accordance with the chiropractic tests, diagnosis and analysis s/he performs. The chiropractic adjustments and other clinic procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The DC will not provide treatment if s/he is aware of any contraindications. It is the responsibility of you the patient to make it known to the DC if you have any latent pathological defects, illnesses or deformities that would not be obvious to the DC. I understand that if I am accepted as a patient by a DC at CCPR, I am authorizing him/her to proceed with any treatment deemed to be necessary. The procedures, alternatives and risks involving the treatment will be explained to me prior to the treatment.

_____ **Patient Signature** _____ **Date**	I am the responsible party. I have read and understand my right to privacy, as per the above **HIPPA STATEMENT** and agree to have the practitioners and employees of CCPR maintain my records confidentially in accordance with the law. I agree to the above **MISSED APPOINTMENT** and **INFORMED CONSENT FOR CHIROPRACTIC CARE** policies. I agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my insurance carrier. CCPR expects payment at the conclusion of each treatment for cash paying patients and the co-payment, co-insurance and/or deductible payments for health insurance patients.

GENERAL HEALTH HISTORY (Page 1)

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

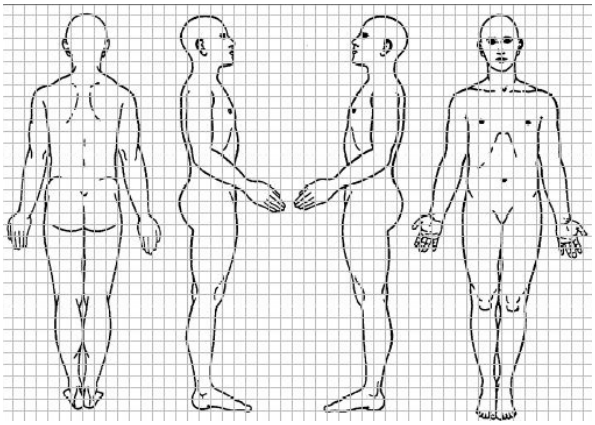
CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
☐ Headaches/Migraines		☐ Upper Back Pain, Soreness, or Stiffness	
☐ Neck Pain, Soreness, or Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, Stiffness		☐ Leg or Foot Pain, Numbness, or Tingling	
☐ Arm/Hand Pain, Numbness, or Tingling		☐ Knee/Ankle Pain	
☐ Shoulder/Elbow/Wrist Pain		☐ Dizziness/Vertigo	
☐ Jaw Pain		☐ Swelling/Stiffness of Joint(s)	
☐ Excessive Fatigue		☐ Other:	

Did your current symptoms come on? ☐ Suddenly, ☐ Gradually

How severe is your pain? 0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

SYMPTOM/PAIN DESCRIPTION (Please circle any words/areas below that describe your current symptoms.)

Pain	Pinching	Spreading	Stiff or tight	Unbearable
Shooting	Soreness	Pulling	Sickening	Falls asleep
Ache	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Pressing	Radiating
Heavy	Nagging	Stinging	Deep pain	Weakness
Irritating	Burning-Hot	Dreadful	Superficial pain	Throbbing
Exhausting	Numbness	Torturing	Sharp	Tender



Please circle or mark with an **X** the areas where you have pain, numbness, tingling or other symptoms.

ARE YOU TAKING ANY MEDICATIONS?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

☐ Muscle Relaxants	☐ Blood pressure/Stroke prevention medications	☐ Cortisone injections
☐ Pain/Anti-inflammatory meds	☐ Osteoporosis (bone strengthening) medications	☐ Other:

WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

☐ Morning is when pain is worse	☐ Bending your back increases pain	☐ Walking increases pain
☐ Afternoon/evening pain worse	☐ Lying down flat increases pain	☐ Standing increases pain
☐ During sleep hours pain worse	☐ Sitting increases pain	☐ Exercise/Stretching increases pain
☐ Standing up from sitting	☐ Poor posture increases pain	☐ Other:

WHAT ACTIVITIES LESSEN YOUR PAIN?

☐ Walking	☐ Being flat on your back	☐ Exercise/Stretching
☐ Sitting	☐ Standing	☐ Other:

DO YOU EXERCISE?

☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting at gym/home	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I am not willing to do exercises	☐ I do regular sports activities

GENERAL HEALTH HISTORY (Page 2)

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	Heal slowly or Bruise easily	☐	☐
☐	Smoke cigarettes or use tobacco products	☐	☐
☐	History of drug or alcohol abuse	☐	☐
☐	Diabetes, hypoglycemia, thyroid disorder, kidney or liver disease, or tuberculosis	☐	☐
☐	Heart attack or have a heart pacemaker or neck or chest shunt?	☐	☐
☐	Currently or recently had any infectious disease such as AIDS, Tuberculosis, etc	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Do you have problems with dizziness, blacking out, balance, fainting, or tripping	☐	☐
☐	Epilepsy-Seizure-Convulsion history or other neurological disease	☐	☐
☐	History of multiple sclerosis, lupus, psoriasis, temporary paralysis, or meningitis	☐	☐
☐	Cancer history or cancer treatment of any type	☐	☐
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae	☐	☐
☐	Told that you have a bulging/herniated disc or disc degeneration in the spine	☐	☐
☐	Have you ever been hospitalized? Why:	☐	☐
☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm	☐	☐
☐	Hypertension (high blood pressure)	☐	☐
☐	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis	☐	☐
☐	Told you have osteoarthritis, rheumatoid arthritis, or gout of your spine or joints	☐	☐
☐	**Do you have any type of chest or breast implants presently (males & females)?**	N/A	☐
☐	**Women only**: Check box to left if there any chance that you are currently pregnant		

☐ No, ☐ Yes Do you have any problems laying face down on an examination table? If yes, why:_____

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN

(☐ I have no history of previous painful injury or pain) If you have had prior injuries or pain, please check below:

☐ Work Injury	☐ Fall	☐ Sports Injury	☐ Lifting Injury	☐ Car Accident
☐ Motorcycle Injury	☐ Head Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches/Migraines	☐ Neck Pain	☐ Middle Back Pain	☐ Low Back Pain	☐ Shoulder Pain
☐ Arm numb-tingling	☐ Arm Pain	☐ Leg pain-numb-tingling	☐ Other Pain:	

FRACTURES/BROKEN BONES HISTORY

(☐ I have never had any broken bones). If you have broken any bones, indicate where and when below:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib bone	
☐ Arm or hand bones		☐ Leg or foot bones	
☐ Pelvis or hip bones		☐ Other: List	

PREVIOUS SURGERIES

(☐ I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck, back, or pelvis)		☐ Appendix or stomach	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Head/Brain		☐ Hernia (inguinal or hiatal)	
☐ Shoulder/Arm/Hip/Leg		☐ Other	

Have you ever been to a Chiropractor before for any condition?

☐ No, ☐ Yes If yes, Chiropractor's Name : _____ Year:_____

Problem(s) seen by Chiropractor for: _____

NOTICE OF PRIVACY PRACTICES

We are required by federal and state laws, to maintain the privacy of your health information. We are required to follow the privacy practices as described below. We reserve the right to change this accordance with applicable law. We support your right to the privacy of your health information. You may request a copy of this Notice at any time.

- We may share your health information with a physician or other healthcare provider treating you.
- We may use your health information to obtain payment for services from your insurance company.
- You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Without your written authorization, we cannot use or disclose your health information for any reason except hose permitted by this Notice.
- In the event of your incapacity or in emergency circumstances, we will disclose heath information to a family member, friend, or other person as necessary only if authorized to do so.
- We will not use your health or personal information (i.e. address & phone number) for marketing purposes.
- We may use or disclose your health information to authorities when we are required to do so by law, including for public health reasons (e.g. disease reporting) if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim or other crimes.
- You have the right to review or receive copies of your health information, with limited exceptions.
- You have the right to request that we amend your health information. Such request must be made in writing, and must explain why the information should be amended. We reserve the right to deny your request.

Please know that there is a fee when your records are specifically ordered by an insurance company, lawyer, or court subpoena. This fee is paid by the requesting party. There is no fee to you for this service or if you request that we send your records to another healthcare provider. Refusal to sign that you have received this information will not affect your treatment, eligibility for benefits or payment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I (or my legal guardian or parent) acknowledge(s) that I have received and read the Notice of Privacy Practices. The Notice describes the policies and procedures regarding the use and disclosure of my health information that is created, received or maintained by Center for Chiropractic & Pain Rehabilitation.

Name of Patient: _____
Please Print

Name of Guardian/Parent: _____ Relationship: _____
(If patient is a minor in or under guardianship) Please Print Please Print

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

FOR OFFICE USE ONLY

Patient was unable or unwilling to sign this document**.**
Reason:_____

Signed: _____ Date: _____