

New Patient Health Intake Form

First Name: _____ M.I. _____ Last Name: _____

Address: _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth _____ Age _____ Social Security # _____

If married, Spouse's Name: _____ # of Children _____

Occupation _____ Employer _____

Primary Care Physician Name: _____

Address: _____ Phone _____

I give you permission to share a brief summary of my case and diagnosis with my primary care physician.

Yes No Initial: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

Referred by: _____

1. Reasons for seeking chiropractic care:

Primary reason:

Secondary reason:

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

3. Past Health History:

A. Please indicate if you have a history of any of the following:

- Anticoagulant use Heart problems/high blood pressure/chest pain Bleeding problems
 Lung problems/shortness of breath Cancer Diabetes Psychiatric disorders
 Bipolar disorder Major depression Schizophrenia Stroke/TIA's Other _____
 None of the above

B. Previous Injury or Trauma:

Have you ever broken any bones? Which?

C. Allergies: _____

Name/Initial: _____ Date: _____

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D. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

E. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

F. Prior Imaging (ie., X-rays, MRI, CT, etc):

What Images were performed?	Reason they were done:
_____	_____
_____	_____
_____	_____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Strokes/TIA's | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Cardiac disease | <input type="checkbox"/> Neurological diseases | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Psychiatric disease | <input type="checkbox"/> Adopted/Unknown | <input type="checkbox"/> Cardiac disease below age 40 |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> None of the above |

Deaths in immediate family: _____

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

Social and Occupational History:

A. Job description:

B. Work schedule:

C. Recreational activities:

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

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Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?

- Asthma/difficulty breathing COPD Emphysema Other _____ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

- Heart surgeries Congestive heart failure Murmurs or valvular disease Heart attacks/MIs Heart disease/problems Hypertension Pacemaker Angina/chest pain Irregular heartbeat Other _____
 None of the above

Have you had any of the following **neurological (nerve-related)** issues?

- Visual changes/loss of vision One-sided weakness of face or body History of seizures One-sided decreased feeling in the face or body Headaches Memory loss Tremors Vertigo Loss of sense of smell
 Strokes/TIAs Other _____ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

- Thyroid disease Hormone replacement therapy Injectable steroid replacements Diabetes
 Other _____ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

- Renal calculi/stones Hematuria (blood in the urine) Incontinence (can't control) Bladder Infections
 Difficulty urinating Kidney disease Dialysis Other _____ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

- Nausea Difficulty swallowing Ulcerative disease Frequent abdominal pain Hiatal hernia Constipation
 Pancreatic disease Irritable bowel/colitis Hepatitis or liver disease Bloody or black tarry stools
 Vomiting blood Bowel incontinence Gastroesophageal reflux/heartburn Other _____ None of the above

Have you had any of the following **hematological (blood-related)** issues?

- Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) HIV positive
 Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hemophilia
 Hypercoagulation or deep venous thrombosis/history of blood clots Anticoagulant therapy Regular aspirin use
 Other _____ None of the above

Have you had any of the following **dermatological (skin-related)** issues?

- Significant burns Significant rashes Skin grafts Psoriatic disorders Other _____ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

- Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture Spinal surgery Joint surgery
 Arthritis (unknown type) Scoliosis Metal implants Other _____ None of the above

Have you had any of the following **psychological** issues?

- Psychiatric diagnosis Depression Suicidal ideations Bipolar disorder Homicidal ideations Schizophrenia
 Psychiatric hospitalizations Other _____ None of the above

Is there anything else in your past medical history that you feel is important to your care here?

Name/Initial: _____ Date: _____

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Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What movements/activities make the symptom worse?
 - Please describe: _____
- What makes the symptom better?
 - Please describe: _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What movements/activities make the symptom worse?
 - Please describe: _____
- What makes the symptom better?
 - Please describe: _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Name/Initial: _____ Date: _____

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Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What movements/activities make the symptom worse?
 - Please describe: _____
- What makes the symptom better?
 - Please describe: _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Symptom 4 _____

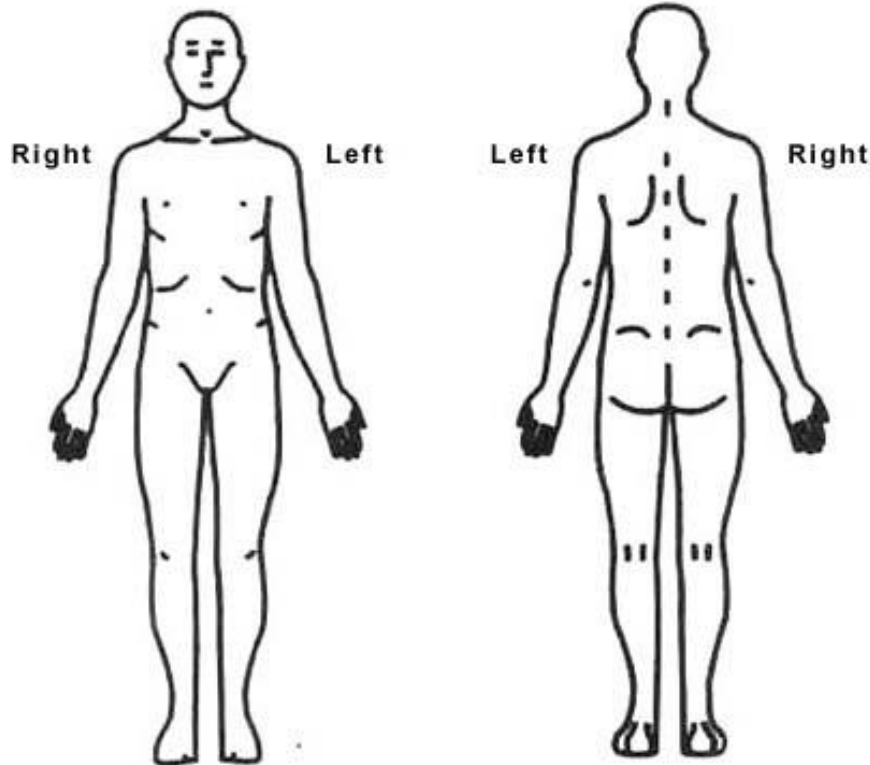
- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What movements/activities make the symptom worse?
 - Please describe: _____
- What makes the symptom better?
 - Please describe: _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Doctor's Notes:

Name/Initial: _____ Date: _____

New Patient Health Intake Form

Please indicate sites of **pain** with an "X". (×××)
Does the **pain radiate (travel)**? If so, mark with an "arrow". (→→→)

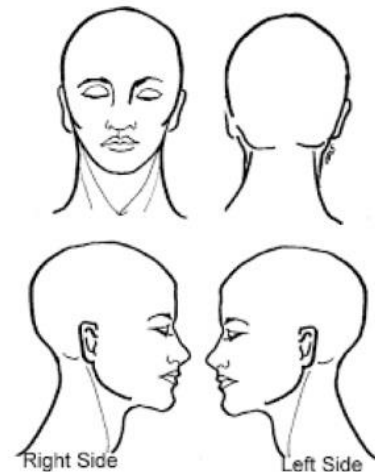


Do you have headaches?

Yes No, skip to next page.

If yes, please answer the following:

- Mark where you get your headache(s) with an "X"
- On a scale from 0-10, with 10 being the worst, indicate the intensity of your headache: 1 2 3 4 5 6 7 8 9 10
- What describes your headaches? (circle all that apply)
Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other: _____
- How often do they occur?
_____ X/week _____ X/month _____ Sporadic
- Are your headaches worse at certain times of the day or night?
Morning Afternoon Evening Night Unaffected time of day
- When did your headaches begin? _____
- What makes your headaches worse? _____
- What makes your headaches better? _____



Name/Initial: _____ Date: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative

Date

Printed Name

Name/Initial: _____

Date: _____

New Patient Health Intake Form

PRIMARY INSURANCE:

INSURANCE COMPANY: _____

INSURED'S NAME: _____ RELATIONSHIP TO INSURED: _____

INSURED'S BIRTHDATE: _____ PHONE NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER NAME: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

INSURED'S NAME: _____ RELATIONSHIP TO INSURED: _____

INSURED'S BIRTHDATE: _____ PHONE NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER NAME: _____

RELEASE OF INFORMATION:

I _____ give permission to the staff at Swickard Chiropractic Clinic of Shawnee, P.A. to share any information related to my care, account and services to the following people:

NAME: (LAST, FIRST, MI): _____

RELATIONSHIP: _____

ADDRESS _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

NAME: (LAST, FIRST, MI): _____

RELATIONSHIP: _____

ADDRESS _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

NAME: (LAST, FIRST, MI): _____

RELATIONSHIP: _____

ADDRESS _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Swickard Chiropractic Clinic of Shawnee, P.A. for services performed.

Patient or Guardian Signature _____ Date _____

Name/Initial: _____ Date: _____

New Patient Health Intake Form

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ **Last Name:** _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

By providing my e-mail address, I understand that authorized personnel from Swickard Chiropractic may communicate with me regarding scheduling, treatment, receipts, statements, appointment reminders, health education, and promotional information. If you do not consent to e-mail communication, please initial here. _____

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Include regularly used over the counter medications)

Medication	Dosage and Frequency (i.e. 5mg once a day, etc.)	Reason for Taking

Do you have any medication allergies?

Medication	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____

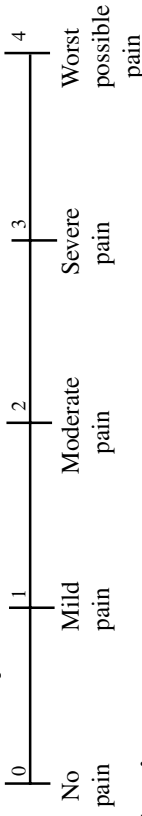
Name/Initial: _____ Date: _____

Functional Rating Index

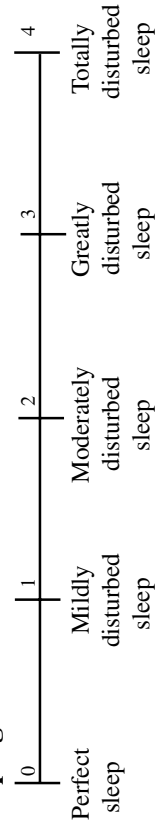
For use with Neck and/or Back Problems only.

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.**

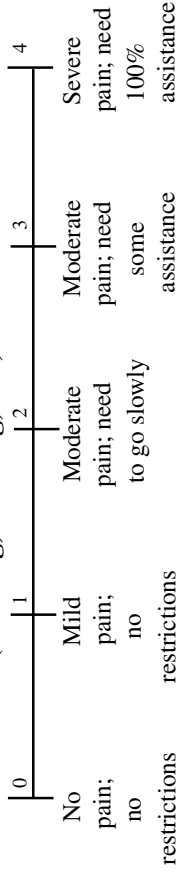
1. Pain Intensity



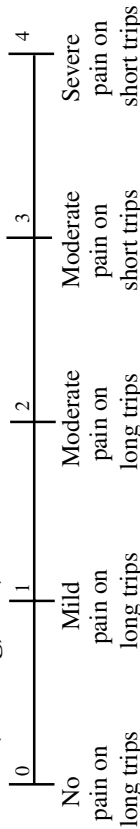
2. Sleeping



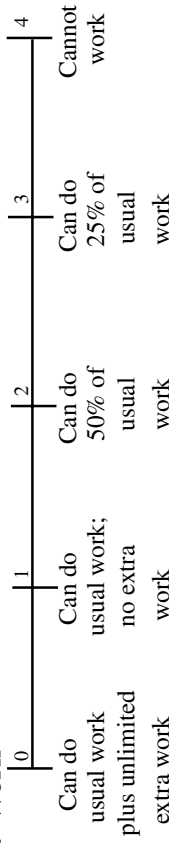
3. Personal Care (washing, dressing, etc.)



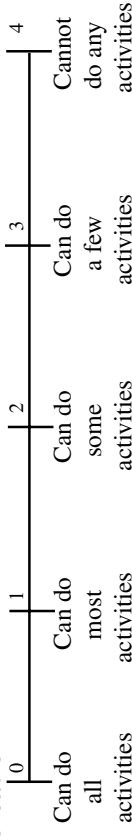
4. Travel (driving, etc.)



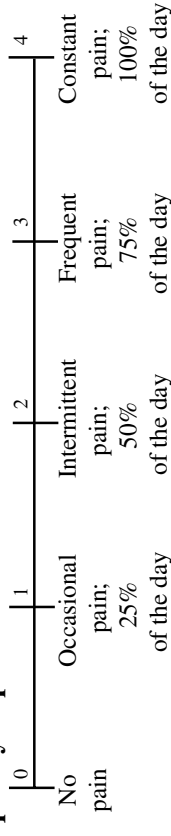
5. Work



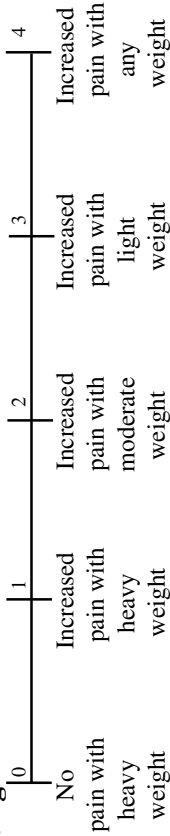
6. Recreation



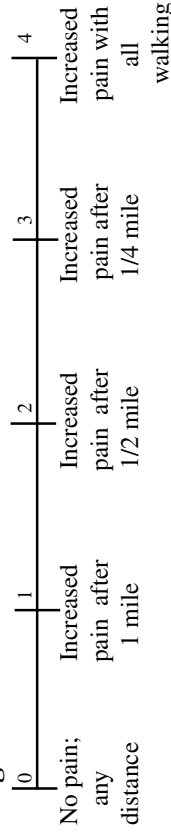
7. Frequency of pain



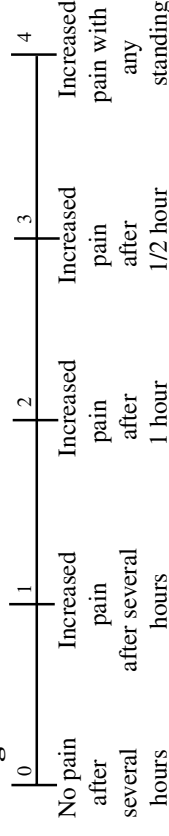
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Total Score _____

Signature _____

Date _____

Office Financial Policy

1. As a service to you we verify how your insurance company supports your care in our office. If we are unable to verify prior to the end of your first visit our policy is to collect \$75. Once benefits are known any credit will be refunded to you or used for future visits if you wish. Any balance will be due at your next visit.
2. We will collect your deductible, co-pay, uncovered services, and/or the percent you are responsible for at the time of each visit.
3. We will submit claims to your insurance and collect according to how they support your care. In the event insurance denies care (examples: services are not a covered benefit, insurance determines care is not medically necessary, etc.) you become responsible for the balance. You will become a "self-pay" patient and will be responsible for the fees. Our self-pay fee for spinal manipulations is \$45. Other treatments and services have additional fees.
4. SELF-PAY Patients: This includes patients with no insurance, patients who have insurance plan with which we do not participate or patients that have exhausted their benefits.
5. All effort is made by our billing office to work closely with the insurance companies. 99% of the time we are quoted the correct benefits, however, benefits are sometimes misquoted. If we are misquoted and a balance is due on your account, it becomes patient responsibility. It is highly recommended that you verify your benefits as well.
6. Personal injury, Workman's Compensation and Auto cases. A signed lien will be required allowing payments to be made directly to us. We file on your behalf. Should benefits be exhausted or denied any unpaid balance becomes patient responsibility.
7. Delinquent accounts over 90 days old will be sent to a collection agency. Any fees incurred will become patient responsibility.

Patient or Guardian

Date

Printed Name