NEW PATIENT INTAKE FORM

Personal Information

FIRST NAME:_____ LAST NAME:_____ DATE:_____

DOB (mm/dd/yyyy):____/____/_____ AGE:_____ SEX AT BIRTH:_____
PRONOUNS:_____ HEIGHT:_____(feet)_____(inches) Weight (lbs):_____

MARITAL STATUS: _Single / Married / Divorced / Widowed_ (circle)

SPOUSES NAME:_____ NUMBER OF CHILDREN:_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

PH #:_(_____)_____

Contact Information

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PH #:_(_____)_____ _Cell / Home / Work_ (circle)

EMAIL ADDRESS:_____

APPOINTMENT REMINDERS TEXT / EMAIL / OR BOTH? _____

Referral Information

REFERRING PHYSICIAN:_____ REFERRED PATIENT:_____

ADVERTISEMENT:_____ (Google / Yelp / Facebook / Internet / Etc.)

REFERRED DIRECTORY:_____

Patient Health Questionnaire

NAME:_____ DATE:____ / ____ / _____

1. **Please describe your major concern:**

_____

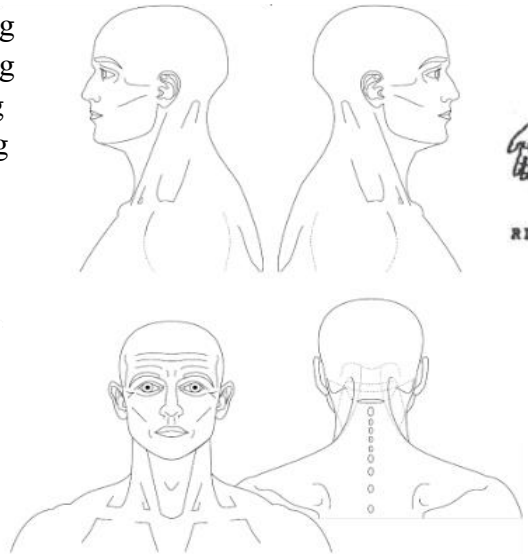
_____

a. Description

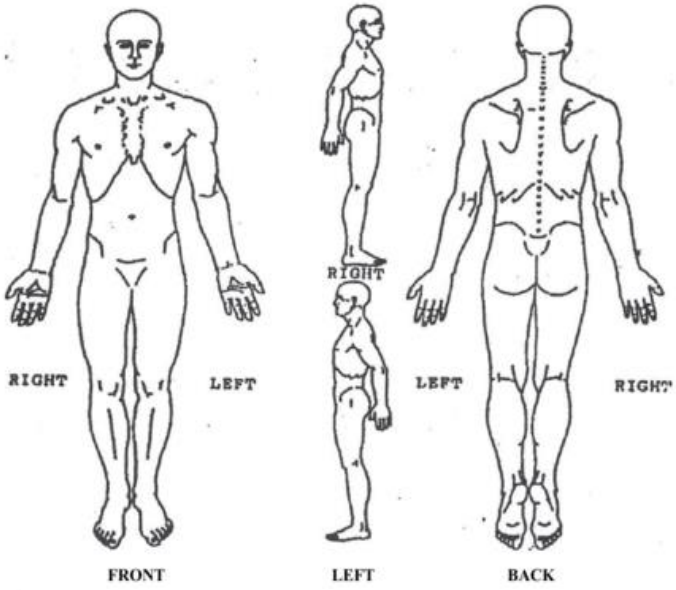
- ○ Sharp Pain
- ○ Dull Pain
- ○ Ache
- ○ Weak
- ○ Throbbing
- ○ Numb
- ○ Shooting
- ○ Gripping
- ○ Burning
- ○ Tingling

b. Frequency

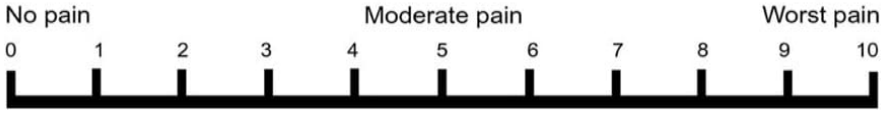
- ○ Constantly (75-100%)
- ○ Frequently (51-75%)
- ○ Occasional (25-50%)
- ○ Intermittent (25% or less)



Please mark the pictures where you have pain or other symptoms↓



c. Indicate the intensity of your pain at its lowest and highest level ↓



d. Your symptoms are:

_____ decreasing
_____ not changing
_____ increasing

e. Symptoms are worse in the:

_____Morning _____Night _____Increases during the day _____Same all day

2. **When did your concern begin? (Specific date if possible)**_____

Describe how your concern began:_____

_____

3. **Have you been treated for *this episode*?** _____ Yes _____ No

If yes, by whom? ____Chiropractor ____MD ____Osteopath ____Physical Therapist ____Occupational Therapist ____Other

Are you Currently being seen? _____ Yes _____ No

If yes, when and what treatment? _____ / _____ / _____

_____

4. **Have you been treated *in the past* for the same or similar problem?** _____ Yes _____ No

If yes, whom did you see for that episode? ____Chiropractor ____MD ____Osteopath ____Physical Therapist ____Occupational Therapist ____Other

When and what treatment did you receive? _____ / _____ / _____

_____

5. **What makes your problem better?** ___Nothing ___Lying Down ___Walking ___Standing ___Movement/Exercise ___Inactivity
6. **What makes your problem worse?** ___Nothing ___Lying Down ___Walking ___Standing ___Movement/Exercise ___Inactivity
7. **How would you rate your general stress level?** ___Little to None ___Minimal ___Moderate ___Great
8. **General Activity Level**: ___No Regular Exercise ___Light Exercise ___Moderate Exercise ___Strenuous Exercise
9. **How are your complaints affecting your ability to be active?**

___No effect
___Some restrictions (able to perform light duty work and household tasks)
___Need limited assistance with common everyday tasks
___Need assistance often
___Have significant inability to function without assistance
___Am totally impaired/disabled (cannot care for myself)

10. **Your physical activity at work is:**

___ Sitting more than 50% of workday ___Light manual labor ___Manual Labor ___Heavy manual labor ___Repeated Motion

11. **Your occupation**:_____ **Has your work status changed due to this complaint?**_____
12. **What is your current work status**?

___Full time, no restrictions ___Part time, with restrictions ___Unemployed ___Other
___Full time, with restrictions ___Off work due to restrictions ___Retired
___Part time, no restrictions ___Full time homemaker ___Full time student

Patient Signature:_____ Date:____ / ____ / _____

To assist your doctor in more thoroughly understanding your state of health, please provide information concerning past and present conditions and diseases. If you have had a listed condition in the past, please check the *PAST* column. If a condition is troubling you presently, check the *PRESENT* column.

Past	Present		Past	Present		Past	Present	
☐	☐	Neck Pain	☐	☐	General Fatigue	☐	☐	Diabetes
☐	☐	Shoulder Pain	☐	☐	Irregular Menstrual Flow	☐	☐	Epilepsy
☐	☐	Pain in Upper Arm or Elbow	☐	☐	Profuse Menstrual Flow	☐	☐	Ulcer
☐	☐	Hand Pain	☐	☐	Breast Soreness/ Lumps	☐	☐	Liver/Gallbladder Problems
☐	☐	Wrist Pain	☐	☐	Endometriosis	☐	☐	Kidney Stones
☐	☐	Upper Back Pain	☐	☐	PMS	☐	☐	Hepatitis
☐	☐	Low Back Pain	☐	☐	Loss of Bladder Control	☐	☐	Bladder Infection
☐	☐	Pain in Upper Leg or Hip	☐	☐	Painful Urination	☐	☐	Colitis
☐	☐	Pain in Lower Leg or Hip	☐	☐	Frequent Urination	☐	☐	Kidney Disorders (by condition)
☐	☐	Pain in Ankle or Foot	☐	☐	Abdominal Pain	☐	☐	Irritable Colon
☐	☐	Jaw Pain	☐	☐	Constipation/ Irregular Bowel Habits	☐	☐	HIV/AIDS
☐	☐	Swelling/Stiffness of Joints	☐	☐	Difficulty in Swallowing	☐	☐	Systemic Lupus
☐	☐	Fainting	☐	☐	Heartburn/ Indigestion	☐	☐	Chronic Cough
☐	☐	Visual Disturbances	☐	☐	Depression	☐	☐	Chronic Sinusitis
☐	☐	Convulsions	☐	☐	Dermatitis/ Eczema/Rash	☐	☐	Other:_____ _____
☐	☐	Dizziness	☐	☐	Aortic Aneurysm			
☐	☐	Headache	☐	☐	High Blood Pressure			
☐	☐	Muscular Incoordination	☐	☐	Angina			
☐	☐	Tinnitus (Ear Noises)	☐	☐	Heart Attack			
☐	☐	Rapid Heart Beat	☐	☐	Stroke			
☐	☐	Chest Pain	☐	☐	Asthma			
☐	☐	Loss of Appetite	☐	☐	Cancer/Tumor			
☐	☐	Loss of Appetite	☐	☐	Prostate Problems			
☐	☐	Anorexia	☐	☐	Blood Disorder			
☐	☐	Abnormal Weight: ___Gain ___Loss	☐	☐	Emphysema (chronic lung disorders)			
☐	☐	Excessive Thirst	☐	☐	Arthritis/ Rheumatoid Arthritis			

Patient Signature:_____ **Date:**_____/_____/_____

To assist your doctor in more thoroughly understanding your state of health, please provide information concerning past and present conditions and diseases. If you have had a listed condition in the past, please check the *PAST* column. If a condition is troubling you presently, check the *PRESENT* column.

Past	Present	
□	□	Pregnancy
□	□	Birth Control Pills
□	□	Hormone/Estrogen replacement
□	□	Medications (list if not listed elsewhere): _____ _____
□	□	Hospitalizations/Surgical Procedures: _____ _____
□	□	Tobacco
□	□	Alcohol
□	□	Drug or Alcohol Dependence
□	□	Coffee/Tea/Caffeinated Soft Drinks – cups/cans per day:_____

Please mark if a family member has had any of these:

□	Cancer	□	Epilepsy
□	Rheumatoid Arthritis	□	Chronic Back Problems
□	Diabetes	□	Chronic Headaches
□	Heart Problems	□	Lupus
□	Lung Problems	□	Other Conditions: _____ _____
□	High Blood Pressure		

____ **Yes** ____ **No** Do you have a permanent disability rating?

Location: _____

Date rating received: _____/_____/_____

Rating Percentage: _____ %

Present: Weight_____ lbs Height _____ft _____in

Doctor's Additional Comments/General Health Concerns:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature:_____ **Date:**_____/_____/_____

Notice of Privacy Practices

We want you to know how your patient health information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA Notice that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this Chiropractic Office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company provided by the patient for the purpose of payment. Be assured that this office will limit the release of all OHI to the minimum needed for what the insurance company requires for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the used if their OHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the used of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient records privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all the precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and healthcare operations, the Chiropractic Physician has the right to refused to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other procedures by Weber Chiropractic LLC. The following points have been explained to me, to my satisfaction, and I have had an opportunity to discuss them with the Dr. and/or other clinic personnel.

-Chiropractic care is the science, philosophy and art of locating and correcting spinal joint dysfunction (misalignments) and as such, is oriented toward improvement of spinal function relative to range-of-motion, muscular and neurologic aspects. There has been no promise implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic.

-I understand that the chiropractor will use his/her hand or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click".

-As with the practice of medicine, the practice of chiropractic is not an exact science, but relies upon information related by the patient, information gathered during the examination, and the doctor's interpretation thereof, as well as the doctor's judgement and expertise in working with similar cases.

-It is not reasonable to expect my chiropractor to be able to anticipate, or explain all possible risks and complications of a given procedure on any particular visit. And I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest.

-An undesirable result, or side effect, does not necessarily indicate error in judgement or an improper treatment.

-As with any health care procedure there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to sprains/strains, dislocations, fractures, disc injuries, or cerebral-vascular accidents. These complications are extremely rare occurrences.

Clinic Account Policy

-Payment is expected at the time of service.

-As a service to you, we will bill your insurance company. We will ask you to pay the amount your insurance company will not pay at the time of each office visit. I.e.; deductible, percentage, co-pay, non-covered service.

-We make every effort to get accurate information from insurance companies. However, insurance companies make mistakes. For example, sometimes they tell us they'll cover certain charges and then not pay them when they receive the billing. For this reason, we periodically review accounts and may have to inform you of a balance due.

-Information received from the insurance company IS NOT A GUARANTEE OF BENEFITS. You are responsible for all charges incurred in this office.

-If you have a personal injury (automobile accident) account, we'll bill your insurance company. The insurance company may not cover 100% of your bill. You are responsible for the difference. We'll keep you updated on the payment activity on your account, and ask that you keep us updated on any new information you may receive regarding your account. We reserve the right to charge 18% interest per year on any outstanding claims over 30 days.

-Weber Chiropractic has a 24-hour cancellation policy, a $60 fee will be charged for missed appointments.

I have read the above consent, or had it read to me and I am comfortable with the information provided and consent to chiropractic treatment and management on that basis.

_____ _____ _____

Patient's Name (printed) Patient's Signature (Parent or Guardian) Date

Weber Chiropractic LLC Notice of Privacy Practices

_____ I have received a copy of Weber Chiropractic's Notice of Privacy Practices.

Initial