Patient Intake | Chiropractic

THOMPSON
CHIROPRACTIC

Please have this form filled out prior to your first visit. All information is strictly confidential.

CURRENT DATE

LAST NAME | FIRST NAME | INITIAL

AGE | DATE OF BIRTH | SEX | MARITAL STATUS | SSN

ADDRESS

CITY | STATE | ZIP CODE

EMAIL ADDRESS | HOME PHONE | MOBILE PHONE

EMPLOYER | OCCUPATION

WORK ADDRESS

WORK EMAIL ADDRESS | WORK PHONE

EMERGENCY CONTACT | EMERGENCY EMAIL

EMERGENCY HOME PHONE | EMERGENCY MOBILE PHONE | EMERGENCY WORK PHONE

PRIMARY CARE PROVIDER

Health History

PLEASE LIST ANY MEDICATIONS (INCLUDING PAIN KILLERS) YOU ARE TAKING:

LIST DRUG ALLERGIES, IF ANY:

Please list any serious injuries or surgeries you have had in the last 10 years:

FALLS — DATE

HEAD INJURIES — DATE

BROKEN BONES — DATE

DISLOCATIONS — DATE

SURGERIES — DATE

OTHER SERIOUS INJURIES — DATE

Are you pregnant? Y N If so, how far along? _____ Nursing? Y N

Medical Conditions

Check the if you have had or currently have any of the following medical conditions:

- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ Fainting/Seizures/Epilepsy
- ☐ Shingles
- ☐ Psychiatric Problems
- ☐ Difficulty Breathing
- ☐ Hepatitis
- ☐ Anemia
- ☐ Food Allergies
- ☐ Material Allergies (latex, wool, metal, chemicals) Other: _____
- ☐ Arthritis
- ☐ Frequent Neck Pain
- ☐ Jaw Pain
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Lower Back Problems
- ☐ Severe/Frequent Earaches
- ☐ Ringing in Ears
- ☐ Severe/Frequent Headaches
- ☐ Diabetes/Tuberculosis
- ☐ Dizziness
- ☐ Emphysema/Glaucoma
- ☐ Kidney Problems
- ☐ Artificial Bones/Joints
- ☐ Cancer
- ☐ HIV Positive/AIDS
- ☐ Ulcer/Colitis
- ☐ Gout
- ☐ Numbness, where? _____
- ☐ Tingling, where? _____
- ☐ Muscle Spasms, where? _____

Personal Habits

	HEAVY	MODERATE	LIGHT	NONE
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Reason for Visit

HAVE YOU EVER SEEN A CHIROPRACTOR? ☐ Y ☐ N | IF YES, WHEN AND WHY?

YOUR REASON FOR THIS VISIT

PLEASE DESCRIBE YOUR PAIN AND ITS LOCATION

WHEN DID SYMPTOMS BEGIN (DATE)? | HAVE YOU HAD SIMILAR CONDITIONS IN THE PAST?

IS PAIN GETTING: ☐ WORSE ☐ BETTER ☐ SAME ☐ COMES AND GOES | HOW OFTEN DO YOU HAVE THIS PAIN?

HAVE YOU BEEN TREATED BY A MEDICAL PHYSICIAN FOR THIS CONDITION?

IF SO, WHEN AND WHERE?

ACTIVITIES OR MOVEMENTS THAT ARE DIFFICULT/PAINFUL TO PERFORM: ☐ SITTING ☐ WALKING ☐ BENDING ☐ LYING DOWN ☐ LIFTING

TYPE OF PAIN: ☐ SHARP ☐ DULL ☐ THROBBING ☐ ACHING ☐ BURNING ☐ TINGLING ☐ NUMBNESS ☐ CRAMPING ☐ STIFFNESS ☐ SWELLING ☐ OTHER

IS PAIN INTERFERING WITH: ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ RECREATION

Primary Insurance

PERSON RESPONSIBLE FOR ACCOUNT | LAST NAME | FIRST NAME | INITIAL

RELATION TO PATIENT | DATE OF BIRTH | SSN

ADDRESS (IF DIFFERENT FROM PATIENT)

CITY | STATE | ZIP CODE

EMAIL ADDRESS | HOME PHONE | MOBILE PHONE

PERSON RESPONSIBLE EMPLOYED BY | OCCUPATION

EMPLOYER ADDRESS

WORK EMAIL ADDRESS | WORK PHONE

INSURANCE COMPANY | INSURANCE PHONE

INSURANCE EMAIL

CONTRACT # | GROUP # | SUBSCRIBE #

NAME OF OTHER DEPENDENTS UNDER THIS PLAN

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN | DATE

Patient consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Thompson Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by Thompson Chiropractic describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Thompson Chiropractic reserves the right to revisit its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Tim Thompson, DC.

With this consent, Thompson Chiropractic may call my home or other alternative location and leave a message on voice mail, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Thompson Chiropractic may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they're marked "Personal and Confidential."

With this consent, Thompson Chiropractic may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Thompson Chiropractic restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Thompson Chiropractic to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or late revoke it, Thompson Chiropractic my decline to provide treatment to me.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE

PRINT PATIENT'S NAME

PRINT NAME OF LEGAL GUARDIAN (IF APPLICABLE)

Informed Consent

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health, the recommended care, and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic care is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease of infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method or correlation is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by hand-held instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

PRINT NAME _____ PATIENT SIGNATURE _____ DATE _____

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Non-Covered Services Member Consent Form

I, _____ understand that the services and/or supplies listed below may not be considered eligible for benefits (e.g., services and/or supplies may be determined to be not medically necessary, non-covered or investigatory) by _____ (health insurer). I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies. Since I have chosen to obtain the services and/or supplies listed below, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

PATIENT SIGNATURE _____ DATE _____