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|  | Patient Intake Form |

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| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Male / Female (Circle) |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_ |
| City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age: \_\_\_\_\_\_\_\_ |
| State \_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_ | Birth Date: \_\_\_\_\_\_ |
| Mobile #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Marital Status: (Circle) |
| In case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ Name Phone # | M S W D |
| Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | #Children \_\_\_\_\_\_\_ |
| Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Patient Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| How did you find out about us? |  |
| Web Site | Social Media | **Person:** | (name) |

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| HEALTH INFORMATION |  |
| Present complaint – Area(s) of Pain / Discomfort / Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Is the condition accident related?Y / N |
| Have you had similar conditions in the past?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | How long have you had this condition?(in months / years)? |
| Other Complaints/ and or accident related? If so, when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Have you had surgery related to this condition?Y / N |
| What aggravates this condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Does this condition affect your work? Y / N |
| Other Doctors seen for this condition: | Does this condition affect your family or social life?Y / N |
| What treatment have you already received for your condition? 1) None 2) Physical Therapy 3) Chiropractic Care  |  |

Please **circle the following** if it pertains to you:

Pregnant Headaches Neck Pain Arm or Shoulder Pain Back Pain Hip or Leg Pain Chest Pain Abdominal Pain Thyroid Problem Heart Trouble Angina Circulatory, Phlebitis High or Low Blood Pressure Tuberculosis Prostate Disorder Kidney Problems Rheumatic Fever Lung/Bronchial Disorder Digestive Disorder Constipation Bleeding Disorder Diabetes Swollen Joints Asthma Dizziness Numbness Ulcer Depression General Fatigue Stroke Seizure Disorder Anemia Glaucoma Cancer Recent Weight Loss

Please list all current medication(s) your taking, how much you take and for how long you have been taking the medication.

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| Medication | Dosage | How Long? |
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| Are you allergic to any medications?  | If Yes – please list: |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What helps relieve your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any other health issues? Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you currently consume alcohol?Circle One:NeverOccasionallyOften | Do you currently smoke tobacco of any kind? Circle One:YesFormer SmokerNever Smoked | If yes, what is your level of interest in quitting smoking? Circle one:No InterestVery Interested |
| Family History of Diseases/Death |
| Father:­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sister(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Brother(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grandparents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| INSURANCE INFORMATION: |  |
| (Please include ALL information for INSURED): |
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| Insurance Company Name: |
| Insurance Address: |
| Member ID: | Group number: |
| Member date of birth: \_\_\_\_\_\_\_\_\_\_  | Patient relation to INSURED:Circle One:Self Spouse Child Other |
| Insured’s EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insured’s EMPLOYER ADDRESS: |

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that I authorize payment directly to this office which will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I authorize the release of any medical or other information pertinent to my treatment and necessary to process any insurance claims.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian / Parent Permission to treat minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIPPA-Patient Rights:

Healthy Spine Chiropractic will identify and evaluate the likelihood and consequences of threats to the security of Protected Health Information and implement reasonable and appropriate measures to safeguard the confidentiality, availability, and integrity of that information. Healthy Spine Chiropractic will adopt and implement HIPAA security practices outlined in the approved HIPAA Security Procedures.

This policy applies to all members of the Healthy Spine Chiropractic workforce, along with all independent contractors who provide services that require access to the clinic building or computer network. They will be required to adhere to the policies and procedures in the HIPAA Security Procedures, as well as any procedures established to support this policy.

Healthy Spine Chiropractic will safeguard information in a manner consistent with applicable requirements of federal, state and local law and regulations, including the final rule governing the security of health information systems enacted by the Department of Health and Human Services as required by HIPAA.

**Your rights as a patient:**

* To be treated with respect and consideration without regard to race, creed, national origin, disability, gender or age.
* To obtain complete and current information concerning all aspects of your care.
* To know the name and professional status of all people who provide your care.
* To refuse care and to be informed of the clinical consequences of this action.
* To expect that communications and records are treated confidentially according to current regulations and/or as required by law.
* To understand why tests and procedures are required.
* To understand and receive an explanation of your bill, regardless of source of payment, and options for available payment plans.
* To review your personal healthcare record and to receive an explanation of information contained therein within a reasonable timeframe, in accordance with clinic policy.
* To request an amendment of your personal healthcare record.
* To be free from all forms of abuse or harassment.
* To receive care in a safe and smoke-free environment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, , \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Healthy Spine Chiropractic , which describes the Practice’s policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT TO TREATMENT Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment. There are some risks that may be associated with treatment, in particular you should note: ‘While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment; There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote; Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms. I acknowledge I have discussed the following with my healthcare provider: The condition that the treatment is to address; The nature of the treatment; The risks and benefits of that treatment; and Any alternatives to that treatment. I have had the opportunity to ask questions and receive answers regarding the treatment. I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Dr. Kronowitz:

Dated this \_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_

Patient signature (or Legal Guardian) Permission to treat a minor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As of January 1st, 2017 patients that do not give a 24 hour notice to cancellations will be **charged a 25.00 fee**.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank You | Healthy Spine Chiropractic P.C.