MARCO CHIROPRACTIC

Patient Intake Form (PIF)

Date: _____ /_____ /_____

PATIENT INFORMATION

Name: _____
(First Name Middle Initial Last Name)

Address:_____

City:_____ State:____ Zip:_____

SS#:_____-_____-_____ Sex □ Male □Female

Date of Birth:_____/_____/_____ Age: _____

If minor, Parent's Name:_____
If minor, Parent's SS #:_____

Marital Status:

□ Married □ Single □ Widowed
□ Separated □ Divorced □ Minor

Number of children:_____

Military Status: □ Active □ Retired □ None

Race: **(Note:** Various insurance companies require healthcare providers to report both race and ethnicity)

□ White □ African American □ Asian
□ American Indian or Alaska Native □ Other
□ Native Hawaiian or Pacific Islander
□ I decline to answer

Ethnicity: □ Non-Hispanic or Latino
□ Hispanic or Latino □ I decline to answer

Employment Information:

Occupation:_____
Employer:_____
Employer Address:_____

Whom may we thank for referring you to us?

_____

IN CASE OF EMERGENCY, PLEASE CONTACT

Name: _____ Relationship:_____
Home Phone: (_____) _____-_____
Mobile Phone: (_____) _____-_____

INSURANCE INFORMATION

Policy Holder's Name:_____
Relationship to Patient: _____
Insurance Company:_____
Person responsible for account, if other than self?
Name: _____ Phone:_____
Address:_____

PHONE NUMBERS/EMAIL

Home: (_____) _____-_____
Work: (_____) _____-_____
Mobile: (_____) _____-_____
Email Address:_____
Contact Preference(s):
□ Mobile □ Home □ Work □ Email □ Any

CHIEF COMPLAINT(S)

Main reason that brought you in to the office:

_____

Symptoms are worse in the:
□Morning □Afternoon □Evening □Night

When did the pain start? _____ /_____ /_____
How did it happen? _____

How would you rate your current pain Level:
Lowest 1 2 3 4 5 6 7 8 9 10 Highest

Were symptoms a result of a (an):

□ Job-related injury □ Auto Accident
□ Gradual onset □ Illness
□ Other accident □ Unknown cause

□ Date of occurrence: _____ /_____ /_____

Treatments that you have received for this condition:_____
_____
_____

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What activities **aggravate** your condition:

_____

_____

What activities **relieve** your condition:

_____

_____

Have you seen a Chiropractor before? □Yes □No

If so, who?_____

Have you experienced a similar pain before?
Y / N. If so, when? _____

GOALS FROM TREATMENT

Describe your goals from receiving treatment:

□ I want to correct the problem.

□ I just want temporary relief from the pain.

Are there any other symptoms or health problems that you are suffering from:

- _____
- _____
- _____
- _____

Are you currently taking any supplements?
□ Yes □ No
What kind:_____

Are you pregnant or trying to get pregnant?
□ Yes □ No

Have you ever used tobacco?
□ Never □ Previously □ Daily □ Occasionally

Describe your alcohol consumption.
□ Never □ Previously □ Daily □ Occasionally

BioMetrics:

Height: ____'_____" Weight: _____lbs

Weight Goals: □ Lose | □ Gain | □ Maintain

MEDICAL HISTORY

Have you been treated by a physician for any health conditions in the last year? □ Yes □ No
Describe condition:

_____

_____

Primary Medical Doctor's Name:

_____

Phone:_____

MEDICATIONS

MEDICATION NAME	DOSE & FREQUENCY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any medication allergies? □ Yes □ No

MEDICATION NAME	REACTION/ONSET DATE
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any FOOD allergies? □ Yes □ No

FOOD NAME	REACTION/ONSET DATE
_____	_____
_____	_____

Are you Gluten Intolerant? □ Yes □ No □ ?

SURGICAL HISTORY

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

4:_____Date:_____

PLEASE INDICATE WHERE YOU ARE EXPERIENCING YOUR SYMPTOMS

Please place the following indicators where you are experiencing the below symptom:

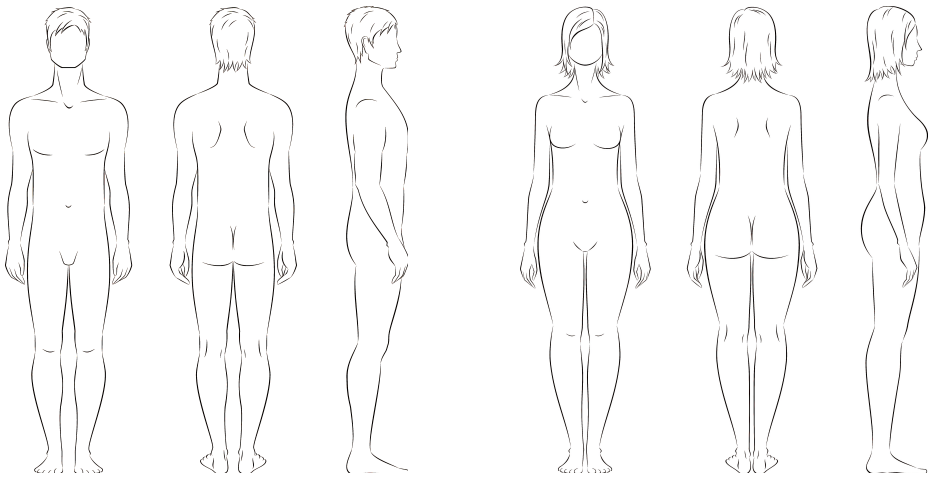
X = Pain

N = Numbness

T = Tingling

B = Burning

S = Shooting pain
(Please draw a line to indicate the direction that the pain travels.)



MEDICAL & FAMILY HISTORY

S=SELF M=MOTHER F=FATHER

Please indicate which **conditions** you have been experiencing (using key above) by checking the appropriate boxes.

S	M	F		S	M	F		S	M	F	
□	□	□	AIDS	□	□	□	Epilepsy	□	□	□	Stroke
□	□	□	Anemia	□	□	□	Fatigue	□	□	□	Thyroid Problem
□	□	□	Ankle Swelling	□	□	□	Headaches	□	□	□	Weakness
□	□	□	Arthritis	□	□	□	Heart Trouble	□	□	□	Weight Gain/Loss
□	□	□	Asthma	□	□	□	High Blood Pressure	□	□	□	Problems Swallowing
□	□	□	Back Pain	□	□	□	HIV	□	□	□	Problems Speaking
□	□	□	Bladder Trouble	□	□	□	Indigestion	□	□	□	Double/Blurred Vision
□	□	□	Bone Fracture	□	□	□	Kidney Disorders	□	□	□	Nausea
□	□	□	Bowel Control Loss	□	□	□	Loss of Smell	□	□	□	Reproductive Trouble
□	□	□	Cancer	□	□	□	Loss of Taste	□	□	□	Sinus Trouble
□	□	□	Concentration Loss	□	□	□	Menstrual Cramps	□	□	□	Dizziness/Loss of Balance
□	□	□	Concussion	□	□	□	Multiple Sclerosis	□	□	□	Double Vision/Blurred
□	□	□	Constipation	□	□	□	Neck Pain	□	□	□	Earache
□	□	□	Convulsions	□	□	□	Nervousness	□	□	□	Other_____
□	□	□	Depression	□	□	□	Numbness/Pins & Needles	□	□	□	Other_____
□	□	□	Diabetes	□	□	□	Poor Circulation	□	□	□	Other_____

Please indicate which **symptoms** you have been experiencing by checking the appropriate boxes.

□ Chronic Indigestion	□ Eye sensitive to light	□ Night Sweats	□ Easy Bruising
□ Heart burn	□ Trouble falling to sleep	□ Trouble staying asleep	□ Bleeding Gums
□ Bloating	□ Dizziness / Fainting	□ Feel tired all the time	□ Irritability
□ Muscle cramps	□ Tired after eating	□ Hormonal Imbalances	□ Skin Rashes

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ACTIVITIES OF DAILY LIVING

Rate your current <u>difficulties</u> of performing daily living activities by placing the appropriate number in the box.

NOTE: If an activity does not cause your pain or if pain does not affect an activity, leave the box blank.

[1] This activity cause some pain, but it is only a minor annoyance.
[2] This activity causes a significant amount of pain, but I can do it.
[3] I cannot perform this activity due to pain and disability.

<u>Physical Activities</u>

[ ] standing	[ ] walking	[ ] reaching	[ ] bending right	[ ] twisting right
[ ] sitting	[ ] squatting	[ ] bending forward	[ ] bending left	[ ] twisting left
[ ] reclining	[ ] kneeling	[ ] bending back	[ ] looking left	[ ] looking right

<u>Functional Activities</u>

[ ] carrying small objects	[ ] lifting object off floor	[ ] pushing/pulling while seated	
[ ] carrying large objects	[ ] lifting weights off table	[ ] pushing/pulling while standing	
[ ] carrying briefcase/purse	[ ] climbing stairs/incline	[ ] exercising upper body	[ ] exercising lower body

<u>Difficulties With Traveling</u>

[ ] driving a car [ ] riding as passenger [ ] Sitting in a car for long periods of time

<u>Please place a CHECK MARK next to any of the following social/recreational activities that you participate in.</u>

[ ] walking [ ] running/jogging [ ] weight Lifting [ ] swimming [ ] biking [ ] yoga
[ ] golfing [ ] horseback riding [ ] gardening [ ] pilates [ ] playing a musical instrument
[ ] competitive sports: _____ [ ] other:_____
[ ] other:_____ [ ] other:_____

_____

<u>List any activities that the pain/symptoms are preventing you from participating in that you would like to enjoy again.</u>

_____ _____ _____
_____ _____ _____

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HIPAA Compliance Patient Consent

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- **Marco Chiropractic** reserves the right to change the privacy policy as allowed by law.
- **Marco Chiropractic** has the right to restrict the use of the information but **Marco Chiropractic** does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments? **YES | NO**
May we leave a message on your answering machine at home or on your cell phone? **YES | NO**
May we discuss your medical condition with any member of your family? **YES | NO**
If YES, please name the members allowed:

_____ _____ _____

_____ _____ _____

This consent was signed by: _____
(PRINT NAME PLEASE)

Patient's Signature: (parent, if minor) _____ Date: ____ /____ /____

Informed Consent:

I hereby authorize physicians and staff at **Marco Chiropractic** to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of **Marco Chiropractic** responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. Our goal is to provide you with the very best care possible. If through our care process we feel that results are not progressing as we anticipate, we will do our best to refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and an acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustments x-rays may be taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Cardiovascular injury- Cardiovascular injury, such as a stroke, is extremely rare but is believed to be an associated complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems- There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask the doctor or staff.

Having carefully read this above, I hereby give my informed consent to have chiropractic treatment administered.

Patient's Signature: (parent, if minor)_____ Date:_____

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Assignment of Benefits

Form Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignments of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **Marco Chiropractic** for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Marco Chiropractic** / **Dr. Sarah Chester** to: (1) release any information necessary to insurance carries regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested services from **Marco Chiropractic** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

- Marco Chiropractic

Patient Signature (parent, if a minor) _____ Date: _____