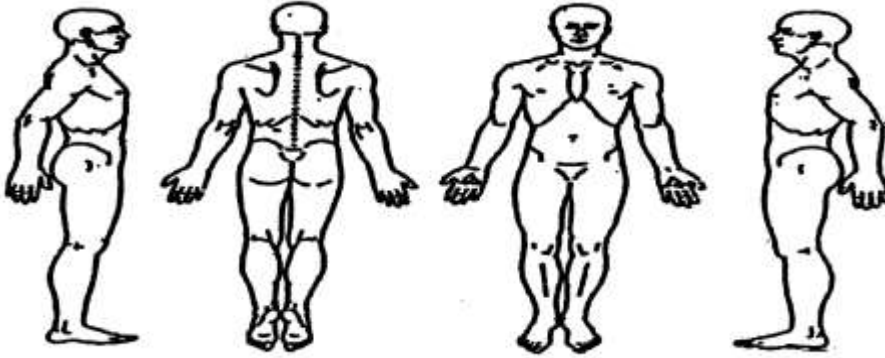


PATIENT INTAKE FORM

Patient Name: _____ Date: _____

Indicate on the drawings below all the areas where you have pain/symptoms:



First Complaint: _____

How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

How are your symptoms changing with time? Getting Worse Staying the same Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)

How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely N/A

How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

Who else have you seen for your problem?

- Chiropractor Massage Therapist Primary Care Physician Neurologist
 Orthopedist ER physician Physical Therapist Other: _____

Provider Name / Date of visit: _____

How long have you had this problem? _____

How do you think your problem began?

- Cause Not Known Auto Accident Work Injury Slip / Fall Sports Injury Other _____

What aggravates your problem?

- Nothing Coughing Reaching Standing
 Sneezing Lifting Sitting Pulling
 Bending Walking Straining at Stool Turning
 Other – Describe: _____

What makes your problem better?

- Nothing Stretching Heat Massage
 Rest Exercise Ice Adjustments
 Sitting Standing Medications Sleeping
 Other – Describe: _____

Do you consider this problem to be severe? Yes Yes, at times No

PATIENT INTAKE FORM

Second Complaint: _____

How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

How are your symptoms changing with time? Getting Worse Staying the same Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)

How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely N/A

How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

Who else have you seen for your problem?

- Chiropractor Massage Therapist Primary Care Physician Neurologist
 Orthopedist ER physician Physical Therapist Other: _____

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- Nothing Coughing Reaching Standing
 Sneezing Lifting Sitting Pulling
 Bending Walking Straining at Stool Turning
 Other – Describe: _____

What makes your problem better?

- Nothing Stretching Heat Massage
 Rest Exercise Ice Adjustments
 Sitting Standing Medications Sleeping
 Other – Describe: _____

Do you consider this problem to be severe? Yes Yes, at times No

What concerns you the most about your problems; what does it prevent you from doing?

What is your: Height _____ Weight _____ Date of Birth _____

Occupation _____

How would you rate your overall Health? Excellent Very Good Good Fair Poor

What type of exercise do you do? Strenuous Moderate Light None

Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<u>For Females Only</u>	
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

List all prescription medications you are currently taking: (feel free to include separate list if needed)

List all of the supplements you are currently taking:

List all surgical procedures you have had:

What activities do you do at work? Do Not Work / Retired

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

What activities do you do outside of work?

Have you ever been hospitalized? No Yes

if yes, when and why _____

Have you had significant past trauma? No Yes If yes, please list all previous traumas

Anything else pertinent to your visit today? _____

Patient Signature _____ Date: _____

OFFICE POLICY

We believe that a clear definition of our office policies will allow both you the patient and our staff to concentrate on the big issue – REGAINING AND MAINTAINING YOUR HEALTH.

APPOINTMENT POLICY

Multiple appointments may be given for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine. Our recommendations are made at intervals appropriate for your condition and are always based upon and modified according to your clinical progress.

Regardless of how many appointments are scheduled for you each week, please note that it is frequency of visits that counts and not the days.

Therefore, we ask that you make every attempt to comply with your professional's advice regarding your treatment schedule. If you are unable to keep an appointment for any reason, we ask that you call immediately to reschedule your visit. **24 hours notice is greatly appreciated.**

When entering the office on any given visit, please go directly to the front desk where staff will present your "sign-in form". We attempt to honor all appointments at the scheduled time. If you are late you may have to wait for the next available appointment. If there are any questions, please ask the receptionist. Walk-in and call-in appointments are always welcome and will be seen at the next available time.

YOU MUST KEEP YOUR SCHEDULED APPOINTMENTS

In order to make the necessary corrections to your injury, it is vital that you keep your appointments as scheduled. This also allows us to serve you better by keeping waiting times to a minimum. We also ask that you show up on time (or 5 minutes early) for each visit. If you are more than ½ hour late for your scheduled appointment, you will have to wait to be treated after the patients that are scheduled at that time.

MISSED APPOINTMENT POLICY

If you miss an appointment, you must make it up within 1 week. Our care is comparable to an exercise program that requires a consistent frequency of sessions that build on the other visits. Without consistency your progress will be much slower.

FINANCIAL POLICY

Alliance Chiropractic Center is happy to verify your health insurance benefits and submit your health insurance claims as a courtesy. Please be aware however that we can only accept assignment on your insurance when coverage has been determined. You will be responsible for all uncovered services as they are rendered.

Our office will gladly verify your insurance benefits with your health care carrier BUT all verifications are NOT a guarantee of payment and subject to all your specific plan provisions and restrictions. The confirmation of benefits does not imply payment and you are ultimately responsible for any uncovered portions of your bill.

Our office policy is to collect any co-payments or co-insurance as or before service is rendered.

1. All deductible payments **MUST** be made prior to insurance submittal.
2. Since we **do not own your policy** and since from time to time we experience difficulty in collecting from your insurance company and since insurance assignment is a privilege it may be terminated at any time. Of course we will give you ample notice and ask that you act in your own behalf with **your** insurance company.
3. This office **does not** promise that an insurance company will pay for the usual and customary charges of this office, **nor will this office enter in any dispute with an insurance company over reimbursement or the amount of reimbursement.**
4. If your carrier has not paid a claim within 60 days of submission you are responsible to take an active part in the recovery of your claim and after 90 days you will be responsible for payment in full of any outstanding balance.
5. By your signature on this document, you agree to be **personally responsible** for any HMO, PPO or third party **"non-covered service,"** regardless of what the negotiated contract with the carrier is.
6. When making a health care decision it is important to remember that you the patient are ultimately financially responsible for any services rendered.
7. Lastly, it is the goal of this office to provide you will the finest quality health care available. If you have any questions with regard to your care or any of our policies, please let us know. We welcome your referrals and look forward to a professional-patient relationship that works for our mutual benefit.

Signed _____ Date _____

I clearly understand the entire policy, and agree to all its terms.

CONFIDENTIAL PATIENT INFORMATION
PLEASE PRINT

Date: ___ / ___ / ___

Full Name _____	Called Name _____
Address _____	City _____ State _____ Zip _____
SSN _____ - _____ - _____	Marital Status _____ Sex _____ Age _____ DOB _____
Phone _____	Work Phone _____ Cell Phone _____
Email _____	Spouse's Name _____
Occupation _____	Employer _____
Emergency Contact _____	Phone _____
How did you hear about our office? _____	

What brought you into our office today (chief complaint):

Is your condition due to: An Auto Accident A Personal Injury A Work Injury Other
Type of Claim: Cash Insurance Personal Injury Worker's Comp Medicare Medicaid

HEALTH CARE AUTHORIZATIONS: | *(Please Cross Out Any Permission You Would Like to Revoke)*

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I give permission to Alliance Chiropractic Center to use my address, phone number, email and clinical records to contact me with birthday cards, holiday related cards, information about treatment alternatives, office seminar dates, patient appreciation dates or other health related information such as newsletters.

C. I give permission to Alliance Chiropractic Center to use my name and clinical records to display my photos or x-rays and use my testimonial and experience in an effort to increase the public's awareness of chiropractic.

D. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

E. I understand that my travel card (Daily Visit Chart) contains protected health information and that I should keep it in my possession and upside down to prevent this information from being seen by another patient.

F. I authorize Alliance Chiropractic Center to take any x-rays the doctor determines will be beneficial to my case during the course of my care. I also recognize that if I am a female it is my responsibility to notify the doctor if I am pregnant or it is possible that I am pregnant.

G. I am giving Alliance Chiropractic Center permission to use and disclose my protected health information in accordance with the directives listed above.

H. I am giving Alliance Chiropractic Center permission to contact other health care providers on my behalf to discuss treatment recommendations and co-management of my health care problems.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges: The right to view the notice prior to signing this consent, the right to object to the use of my health information for directory purposes, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

RIGHT TO REVOKE AUTHORIZATION:
You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to Alliance Chiropractic Center. This AUTHORIZATION is requested by Alliance Chiropractic Center for its own use/disclosure of PHI.

Patient Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____

Informed Consent to Treatment

The nature of chiropractic treatment: The doctor may use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic laser, acupuncture or mechanical traction may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. I am here solely for the purpose of my health, and I represent no other agency, group, organization other than myself.

Patient Printed Name

Patient Signature

Date

Witness Printed Name

Witness Signature

Date