

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:

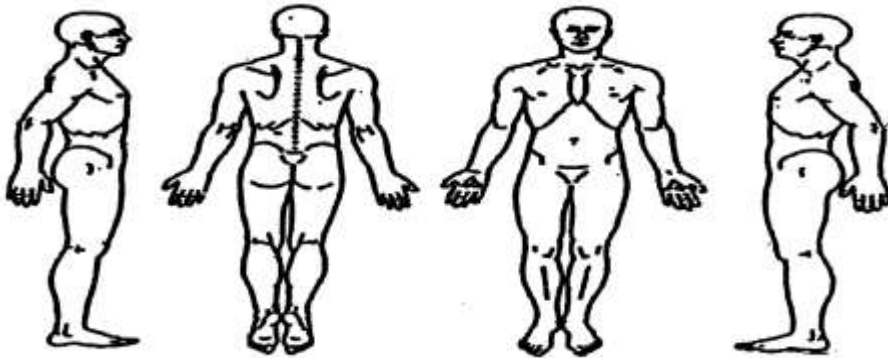
You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering 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: _____

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
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 Shooting Electric like with motion
 Stiff Other: _____

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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

PATIENT INTAKE FORM

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.

<table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Past</th> <th style="text-align: left;">Present</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Headaches</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neck Pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Upper Back Pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Mid Back Pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Low Back Pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Shoulder Pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Elbow/Upper Arm Pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Wrist Pain</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Hand Pain</td> </tr> <tr> <td><input 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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: _____