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CHIROPRACTIC

New Patient Adult Intake Form

Today's Date: _____

Name: _____ Birth Date: _____ Age: _____ ☐ Male ☐ Female

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D

Spouse/Partner: _____ Spouse Phone: _____

Names and ages of children: _____

Occupation: _____ Employer: _____ Years on Job: _____

Emergency Contact: _____ Phone Number: _____

Would you like to receive e-mail or text message reminders? (circle one) E-mail Text Phone carrier: _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

What is your main complaint:_____

When did this condition begin? _____/____/_____ Did it begin: Gradual Sudden Progressive over time

On a scale of 1 to 10 with 10 being the worst, please rate your pain/discomfort: _____

What activities aggravate your symptoms? _____

What has relieved your symptoms? _____

Type of Pain: □ Sharp □ Dull □ Ache □ Burn □ Throb □ Spasm □ Numb □ Tingling □ Shooting

Does the Pain Radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? Yes No

How often do you experience these symptoms?: 100% 75% 50% 25% 10% Only with Activity

Does complaint(s) interfere with: □ Work □ Sleep □ Hobbies □ Daily Routine Explain: _____

Have you experienced this condition before? □ Yes □ No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

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HEALTH CONDITIONS

□ Neck Pain	□ Sinus Issues	□ Shortness of Breath	□ Pain in hips/legs	□ Menstrual Problems
□ Pain Into Arms	□ Allergies	□ Asthma	□ Sciatica	□ Sexual Dysfunction
□ Numbness/Tingling	□ Recurrent colds/flu	□ Mid Back Pain	□ Low Back Pain	□ Cancer
□ Headaches/Migraine	□ Low Energy	□ Heart Burn / Reflux	□ Muscle Cramps in leg	□ MS
□ Dizziness/Vertigo	□ Heart Palpitations	□ Nausea	□ Constipation/Diarrhea	□ Sleep Apnea
□ Vision Problems	□ Heart Murmurs	□ Ulcers	□ Bladder Infections	□ Trouble Sleeping
□ Thyroid Issues	□ High Blood Pressure	□ Diabetes	□ Difficulty Urinating	□ Anxiety/Depression

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Have you received chiropractic care before? □ No □ Yes When/Where? _____

Please list any medications you are currently taking (prescription AND over the counter):

_____

Are you interested in reducing or eliminating the use of your medications? □ No □ Yes □ N/A

Females Only: Are you pregnant? □ No □ Yes

If pregnant, Due Date: _____ Name of OB/GYN or Midwife: _____

Where will you be birthing your baby? □ Hospital □ Home □ Birthing Center

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What are your goals for care? (Check all that apply) □ Relief of symptom(s) □ Relief and prevention of symptom(s) □ Healthier spine and nervous system □ Optimal nervous system function

□ Other _____

How would you best describe yourself (please check all that apply)?

□ Happy □ Sad □ Spiritual □ Angry □ Depressed □ High energy □ Low energy □ Stubborn

□ Open-minded □ Close-minded □ Faith based □ Analytical □ Vibrant □ Optimistic

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Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebrae in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and/or laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

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I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH.
I UNDERSTAND THE INFORMATION PROVIDED.
ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION.
HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE *Dr. Allison J. Parisi* TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT DATED THIS ___ DAY OF _____, 2018.

_____ _____
Patient Signature Doctor's Signature

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for
Parent/Guardian: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for
Parent/Guardian: _____
Signature: _____
Relationship to Patient: _____

Remarks:

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HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Live Free Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Live Free Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.

- If Live Free Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.

- I give permission to Live Free Chiropractic to use my name on a welcome board, referral board, and birthday board.

- I give permission to Live Free Chiropractic to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.

- I give permission to Live Free Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

- I give Live Free Chiropractic permission to treat me in an open room where other patients are also being treated. 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 doctor at any time in private, the doctor will provide a room for these conversations.

- By signing this form you are giving Live Free Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Live Free Chiropractic plus 7 years or until revoked by me.

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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 the Privacy Official of Live Free Chiropractic. The written notice must contain the following information:

Your name, Social Security number and date of birth;

A clear statement of your intent to revoke this AUTHORIZATION;

The date of your request; and

Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Live Free Chiropractic for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Live Free Chiropractic will not refuse to provide treatment however, it will not be possible for Live Free Chiropractic to file third party billing on my behalf and I will be responsible for 1)payment in full at the time services are provided to me 2) scheduling my own appointments since Live Free Chiropractic will be unable to contact me 3) all contact with Live Free Chiropractic regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient's name (please print): _____ Patient's DOB:_____

Patient's Signature: _____ Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print): _____

Signature: _____

Description of Representative's Authority to Act on Patient's Behalf: _____

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Office Policies

1. We value your time and will always do our best to see you at your scheduled appointment time. We hope that you will extend the same courtesy to us. If you are unable to keep a scheduled appointment, kindly give 24 hours notification.

2. We understand that unexpected events occur that will cause you to miss an appointment without notification. After the 2nd occurrence you will be charged $25 for any missed appointment.

3. Payments are due at the time the service(s) is rendered. This office may make financial arrangements on an individual basis and will remain confidential. Any such plan or arrangement will be discussed in private.

4. This office does not participate with any insurance companies. If you wish to submit insurance claims, ask the front desk to print a super bill. The patient is responsible for submitting claims to insurance companies for reimbursement. This office is not liable for any unpaid claims by the insurance company.

5. This office accepts all major credit cards, cash, and personal checks.

6. I hereby give permission to Live Free Chiropractic to use my name and photographic likeness. Photos may be used for print, web or digital reproduction and for commercial and/or editorial use, including (but not limited to) advertising/promotion via social media, newsletters, and/or printer material relevant to Live Free Chiropractic. I seek no compensation for the use of these photographs.

I have read and understand the Office Policies and agree to abide by these terms.

_____ _____

Patient/Guardian Signature ***Date***