Patient Intake Form — Waldrop Chiropractic Clinic

1. About You

Print Name: _____ Birth Date: ____/____/_____ Todays Date:____/_____/_____

What do you preferred to be called: _____ □ Male □ Female Age: _____

Mailing Address: _____ City _____ St: _____ Zip _____

Home #_____ Work#_____ Cell#_____ Email: _____

Referred By: _____ Employer: _____ Occupation: _____

Status: □ Minor □ Single □ Married □ Divorced □ Separated □ Widowed

Spouses Name: _____Children: □ Yes □ No How Many: ____

Emergency Contact Information: Who should we contact: _____

Relation: _____ Phone #: _____

Who is your Medical Doctor: _____ M.D.'s Phone #: _____

2. Reason For Your Visit

Reason for Today's Visit: □ Backpain □ Neck pain □ Headache □ Other _____

Describe _____

Did your injury occur during: □ Work □ Sports □ Auto Accident □ Household Activity?

When did you accident occur? ____/_____/_____ Where did your injury occur: _____

Is your condition getting worse? □ Yes □ No □ Constant □ Comes and Goes

Is your condition interfering with your: □ Work □ Sleep □ Daily Routine □ Other

If so, how: _____

Has this or something similar happen in the past: □ Yes □ No

If Yes, Explain: _____

Have You Been Treated For This Condition Previously □ Yes □ No If Yes, Where: _____

Have you ever been treated by a Chiropractor: □ Yes □ No If Yes, Where: _____

What makes the problem better? _____

What makes the problem worse? □ Sitting □ Standing □ Lying □ Movement □ Rest
□ Use □ Walking □ Running □ Working □ Activity
□ Bending □ Lifting □ Twisting □ Other _____

Describe the pain or sensation? □ Achy □ Burning □ Dull □ Numb □ Sharp
□ Shooting □ Sore □ Stabbing □ Stiff □ Tingling

Does the pain radiate to any other area of the body? □ Yes □ No If Yes, Where: _____

How Frequent is the problem? □ Constant □ Frequent □ Intermittent □ Occasional □ On/Off
□ Evening Only □ Morning Only □ Stabbing Worse in the: □ AM □ PM

Activities of Daily Living Affected:

General: □ Arising from seated position □ Bending □ Chewing □ Climbing Stairs □ Exercising
□ Getting in/out of vehicle □ Kneeling □ Lifting Children □Lying in Bed □ Reading
□ Running □ Sitting □ Sleeping □ Standing □ Swimming □ Using Computer
□ Using Phone □ Other _____

House Work: □ Caring for Pets □ Carrying Groceries □ Cleaning House □ Cooking
□ Doing Laundry □ Ironing □ Making Beds □ Washing Dishes

Grooming: □ Brushing Teeth □ Combing Hair □ In/Out Bathtub □ Shaving

Travel: □ Driving □ Riding (passenger) □ Rotating Neck

Yardwork: □ Gardening □ Mowing Lawn □ Raking Leaves

3. Review of Systems and History

Check or Circle the appropriate response, please leave blank if it does not apply.

Past Medical and/or Family History

P= Patient M= Mother
F= Father S= Sibling

□ Heart Disease P M F S
□ Asthma P M F S
□ Cancer P M F S
□ Arthritis P M F S
□ Headaches P M F S
□ Diabetes P M F S
□ MVP P M F S
□ Emphysema P M F S
□ Anemia P M F S
□ Fibromyalgia P M F S
□ Hernia P M F S
□ High BP P M F S
□ Low BP P M F S
□ Alzheimer's P M F S
□ Alcoholism P M F S
□ Colitis P M F S
□ Epilepsy P M F S
□ Goiter P M F S
□ Gout P M F S
□ High Cholesterol P M F S
□ Kidney Disease P M F S
□ Leukemia P M F S
□ Lupus P M F S
□ Mental Condition P M F S
□ Obesity P M F S
□ Rheumatoid Arthritis P M F S
□ Ulcers P M F S
□ Injuries P M F S
□ Trauma Auto/etc. P M F S
□ Other _____ P M F S

Social History

Caffeine □ No □ Light □ Heavy
Tobacco □ No □ Yes
Packs Per Day_____
Alcohol □ No □ Yes
Per Day/ Week_____

Surgical History

□ Appendectomy □ Hemorrhoid
□ Gall Bladder □ Tonsillectomy
□ Thyroidectomy □ Kidney Stone
□ Bladder □ Endoscopy
□ Angioplasty □ Heart Bypass
□ Back Surgery □ Neck Surgery
□ Arthroscopic_____
□ Joint Replacement _____
□ Mastectomy □ Breast Implant
□ Tubalitigation □ C- Section
□ Endometriosis □ Hysterectomy
□ Other _____
□ Other _____

Exercise

□ Frequently □ Occasionally
□ Never Frequency_____

Review of Systems

Please circle if you have had and of the following:
(P = Past, 1 = Mild, 2 = Moderate, 3 = Severe)

General Health

P 1 2 3 Fatigue/ Tiredness
P 1 2 3 Fever/ Night Sweats
P 1 2 3 Trouble Sleeping
P 1 2 3 Skin Irritation / Rash
P 1 2 3 Bleeding Disorder
P 1 2 3 Depression
P 1 2 3 Anxiety/ Tension

EENT

P 1 2 3 Vision/ Eye
P 1 2 3 Hearing/ Ear
P 1 2 3 Throat/ Swallowing
P 1 2 3 Nasal/ Sinus
P 1 2 3 Headaches/ Face Pain

Cardiopulmonary

P 1 2 3 Breathing
P 1 2 3 Swelling/ Edema
P 1 2 3 Chest Pain

Gastrointestinal

P 1 2 3 Stomach/ Abdominal
P 1 2 3 Diarrhea/ Constipation
P 1 2 3 Vomiting

Genitourinary

P 1 2 3 Urinary Frequency
P 1 2 3 Urinary Burning
P 1 2 3 Sexual/ Reproductive

Skeletal

P 1 2 3 Morning Stiffness
P 1 2 3 Night Pain
P 1 2 3 Neck Pain
P 1 2 3 Back Pain
P 1 2 3 Joint Pain_____
□ Fracture _____

Neuromuscular

P 1 2 3 Muscle Pain
P 1 2 3 Weakness
P 1 2 3 Numbness/ Tingling
P 1 2 3 Tremors/ Shakes
P 1 2 3 Loss of Consciousness
P 1 2 3 Passing Out

Females (

Pregnant: □No □ Yes
□ I Don't' Know
Breast Feeding □No □ Yes
Last Menstrual Cycle _____

Males

□ Prostate Problems

Present Medication

□ None □ List_____
_____
_____
_____
_____

Allergies

□ Penicillin □ Codeine
□ Aspirin □ Sulfa
□ Other _____
□ Other _____

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

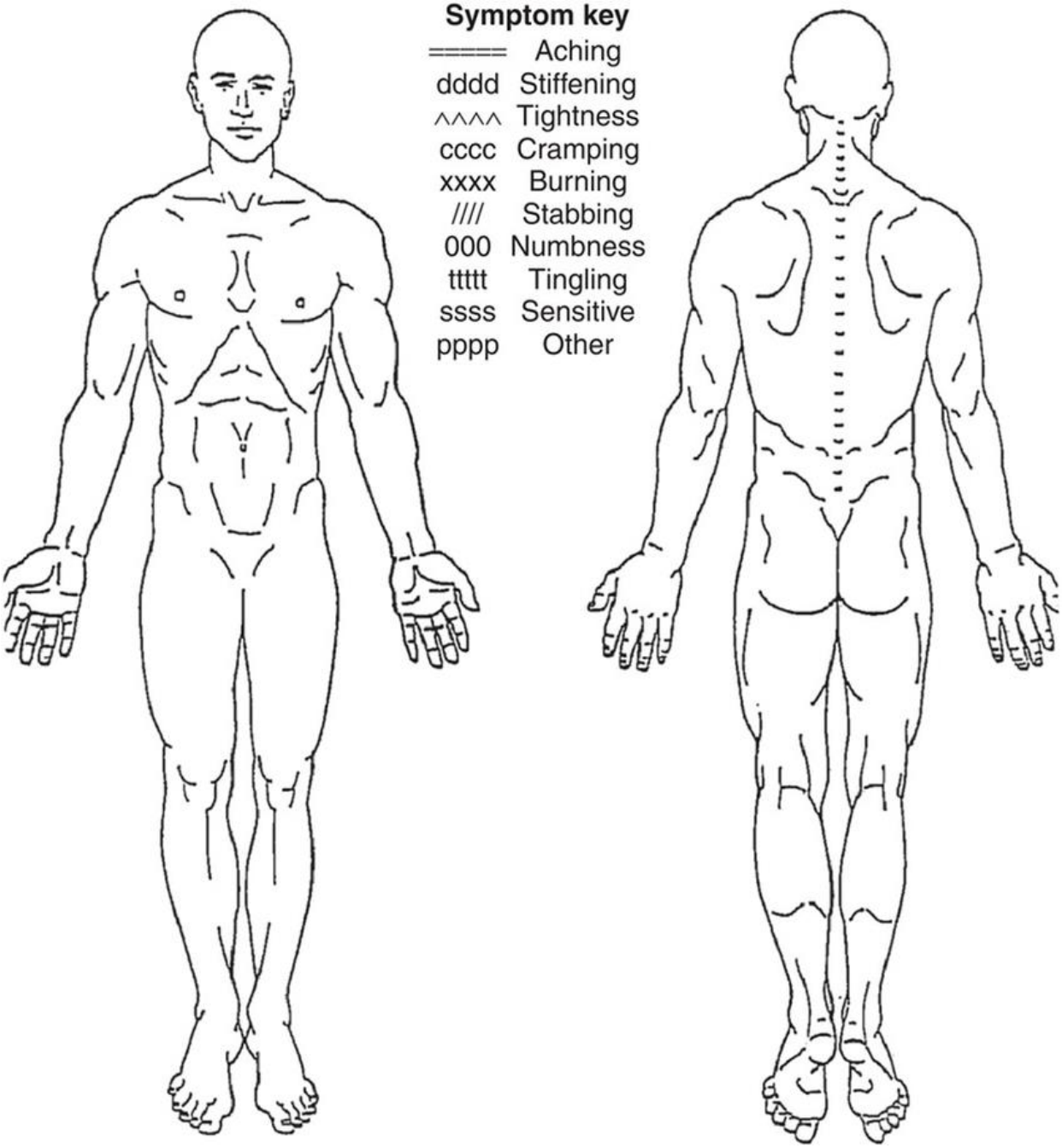
I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ **Date** _____/_____/_____ □ Patient □ Guardian □ Spouse

Symptom Diagram

Name_____ Date _____/_____/_____

Please be sure to fill this form out as accurate as possible. Mark the areas on your body where you feel the described sensation or pain. Use the appropriate symbols where applicable. Mark areas of radiated or traveling pain, include all affected areas.



QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

EXAMPLE:

	Neck				Low Back				Middle Back		
0	1	(2)	3	4	(5)	6	7	(8)	9	10	

1. What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

_____

2. What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

_____

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

0 1 2 3 4 5 6 7 8 9 10

_____

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?

0 1 2 3 4 5 6 7 8 9 10

_____

What percentage of your awake hours is your pain at its worst? _____%

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. Scandinavian Journal of Rehabilitation Medicine 27, 145-151.

FINANCIAL AGREEMENT

In consideration for services rendered or to be rendered at the **Waldrop Chiropractic Clinic**, I agree and fully understand the following:

1.Payment is expected at time of visit unless other arrangements have previously been made with the office staff.

2.I authorize the release of any information acquired in the course of my examination and/or treatment necessary for the process of this claim/assignment.

3.I direct payment of medical benefits otherwise payable to me to the Waldrop Chiropractic Clinic.

4.I will pay any and all charges known not to be covered by insurance at the time services are rendered.

5.I will deliver to Waldrop Chiropractic Clinic, any checks received from an insurance company relative to services rendered within 3 days of receipt of said checks. I also agree that Dr. Greg Waldrop or Dr. Jacob Waldrop be given Power of Attorney to endorse/sign my name on any checks from third party payers for payment of services rendered at this time.

6.I understand that it is the clinic's policy to designate the best plan of care for each of its patients. This plan of care is not based on what an insurance company may or may not pay. I hereby understand and agree that examinations, diagnostic tests, Chiropractic treatments, therapy, rehabilitation, braces, and other supplies filed to my insurance company may or may not be covered by my insurance carrier. Therefore, I agree to pay for all services rendered regardless if they are deemed medically unnecessary or a non-covered service by my insurance carrier. I understand that the clinic staff makes no representation as to coverage of my insurance and I do not rely on any insurance information conveyed to me by the clinic staff.

7.If my plan required a referral prior to evaluation, treatment or for on-going car, I understand it is my responsibility to obtain the referral and/or authorization in these circumstances. Any claims denied due to non-authorization or non-certification will be my responsibility.

8.I understand and agree that the Waldrop Chiropractic Clinic may charge a fee for copying records and/or radiographs and for missed appointments without 24 hours notice. I understand that I am entitled to my records after the appropriate fees (including record search, copy fees ($1.00 for the first 25 pages $.50 for each additional page, plus mailing fees) have been paid.

9.I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. However, I understand that this clinic will prepare any necessary reports and forms to assist me in making any claims with my insurance companies and that any amount authorized to be paid directly to Waldrop Chiropractic Clinic, will be credited to my account on receipt.

10.I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Failure to make payment when requested is bases for legal action and I agree to pay all costs of collections including an attorney's fee if required. I further understand that 18% per annum interest will be charged on all accounts over thirty days and a billing fee of $10.00/mailed statement will be added to your past due balance. I will waive right of exemption under the constitution or laws of Alabama or any other states as to personal property.

Patient: _____ Date:_____

Witness:_____ Date:_____

PRIVACY NOTICE

It is the policy of **WALDROP CHIROPRACTIC CLINIC (WCC)** that all physicians and staff preserve the integrity and confidentiality of PROTECTED HEALTH INFORMATION (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice, its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients.

I, undersigned, herby state that by signing this Consent, I acknowledge and agree as follows:

1. WCC has provided a copy of the PRIVACY NOICE to me. The Privacy Notice includes a complete description of the use and/or disclosure(s) of my protected health information (PHI) necessary for WCC to provide treatment to me, and also necessary for WCC to obtain payment for that treatment and to carry out health care operations. I understand that the PRIVACY NOTICE will be available to me in the future at my request. I understand that it is my right to obtain a copy of the PRIVACY NOTICE carefully prior to signing this Consent, and I have been encouraged to read the PRIVACY NOTICE carefully prior to my signing this CONSEN. WCC will implement reasonable measures to protect the integrity of all PHI maintained about patients.

2. WCC reserves the right to change its privacy policy this s described in this Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders or communications that will be used by WCC.

4. WCC may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for WCC to treat me and obtain payment for that treatment, and as necessary for WCC to conduct its specific health care operations.

5. I understand that I have a right to request that WCC restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, WCC is not required to agree to any restrictions that I have requested. If WCC agrees to a requested restriction, then the restriction is binding on WCC.

6. While WCC owns all medical records, the patient has a right to obtain a copy of their PHI. WCC permits patients to access their medical records when their written requests are approved by our practice. A copy of those records may be obtained within a 30-day time period.

7. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that WC has already taken action in reliance on this consent.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____	_____
Name of Individual (Printed)	Signature of Individual
_____	_____
Signature of Legal Representative	Relationship
_____	_____
Date Signed	Witness