BODY ELEMENTS CHIROPRACTIC
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NEW PATIENT INTAKE FORMS

Patient Data **Date** _____

Title: (check one) _____ **Mr.** _____ **Ms.** _____ **Miss** _____ **Dr.** _____ **Other**

First Name _____ **Middle Initial** _____ **Last Name** _____

I prefer to be called by _____

Address Line _____

City _____ **State** _____ **Zip Code** _____

Home Phone (___) _____ _____ **Work Phone** (_____) _____ _____

Cell Phone (_____) _____ _____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** _____ **Male** _____ **Female**

Social Security Number: _____- _____ - _____ **Marital Status:** ____**Single** _____ **Married** ___ **Other**

Employment Status: _____ **Employed** _____ **Unemployed** _____ **FT Student**

_____ **PT Student** _____ **Other**

Emergency Contact _____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____ _____ **Cell Phone** (____) _____ _____

How did you hear about our office? _____

Patient Name _____ **Date** _____

Medical Conditions: (Check all that apply to you)

□ Arthritis □ Cancer □ Diabetes □ Heart Disease
□ Hypertension □ Psychiatric Illness □ Skin Disorder □ Stroke
□ Other _____

Surgeries: (Check all that apply to you)

□ Appendectomy □ Cardiovascular procedure □ Cervical spine □ Hysterectomy
□ Joint Replacement □ Prostate □ Lumbar spine □ Gall Bladder
□ Brain □ Shoulder □ Thoracic spine □ Knee
□ Carpal Tunnel □ Gastro-intestinal □ Uro-genital □ Hernia
□ Other _____

Allergies: (List any allergies)

Social History: (Check all that apply to you)

Caffeine use: □ occasional □ often □ never
Drink Alcohol: □ occasional □ often □ never
Exercise: □ occasional □ often □ never
Tobacco Use: □ occasional □ often □ never
Sleep: Hours per night _____
Stress Level: High Moderate Low None

Family History: (Check all that apply)

Arthritis:	□ Parent	□ Sibling
Cancer:	□ Parent	□ Sibling
Diabetes:	□ Parent	□ Sibling
Heart Disease:	□ Parent	□ Sibling
Hypertension:	□ Parent	□ Sibling
Stroke:	□ Parent	□ Sibling
Thyroid:	□ Parent	□ Sibling

Other _____

Patient Name _____ **Date** _____

Review of Systems – (Check if you have had trouble with any of the following within the last 3 months)

General:
___ Weight change
___ Fever
___ Chills
___ Night Sweats
___ Weakness
___ Fatigue

Eyes:
___ Vision
___ Pain
___ Discharge

Ears:
___ Hearing
___ Ringing
___ Pain
___ Discharge

Nose:
___ Pain
___ Bleeding
___ Taste

Mouth/Throat:
___ Sores
___ Bleeding
___ Taste

Skin:
___ Rash
___ Itching
___ Hair Changes
___ Nail Changes

Neurologic:
___ Headache
___ Dizziness
___ Fainting
___ Convulsions

G-I:
___ Appetite
___ Abdominal Pain
___ Vomiting
___ Diarrhea
___ Constipation

G-U:
___ Frequent Urination
___ Painful Urination
___ Incontinence

Cardio:
___ Murmur
___ Chest Pain
___ Palpitations
___ Difficulty Breathing
___ Cough
___ Wheezing
___ Blue Extremities
___ Swollen Extremities

Breasts:
___ Mass
___ Pain
___ Discharge
___ Self-exam

Psychologic:
___ Anxiety
___ Depression
___ Moods
___ Memory

Musculoskeletal
___ Neck
___ Upper Extremities
___ Upper Back
___ Lower Extremities
___ Lower Back

Additional Info:

Please list **ALL** current medications and/or supplements being taken:

_____

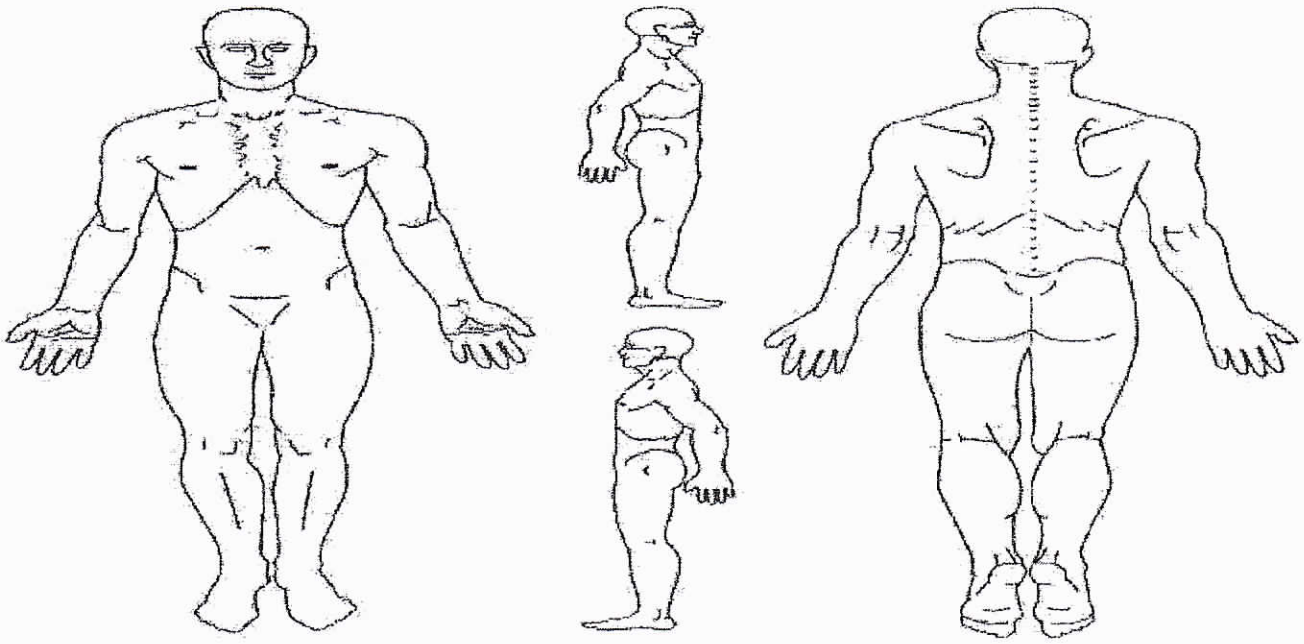
_____

_____

Patient Name _____ **Date** _____

Are you pregnant? Yes_____ No _____N/A_____

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10 = the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐ Work related Accident ☐ Other_____

How are your symptoms changing?

☐ Getting better ☐ Not changing ☐ Getting worse

Patient Name _____ **Date** _____

Activities of Daily Living

Please circle if you have pain or difficulty performing the following:

Bending Carrying Groceries Change Posn–Sit-Stand Climb Stairs
Driving
Extended Computer Use Feeding Household Chores Kneeling
Lift Children
Lifting Pet Care Reading (Concentration) Self Care–Bathing
Self Care–Dressing
Sexual Activities Sleep Static Sitting Static Standing
Walking
Yard Work Other_____

What type of treatment are you looking for?

___ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem

___ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem

___ I am looking to take care of my problem and then go on to "achieve optimal health and wellness"

Cancellation Policy

We are very pleased to participate in your healthcare, and have set aside time for your appointment. We understand that sometimes it is necessary to cancel or change an appointment. In consideration of the others who need care, we ask that if you are unable to keep an appointment with our office, that you please observe our cancellation policy which follows:

Our office requires at least 24 hour notice for all appointment cancelations. If you are unable to provide 24 hour notice, you will be billed a $25.00 charge to your credit card on file for scheduled chiropractic appointments.

Please circle one: Visa Discover MasterCard
Card Number: _____
Expiration Date: _____
Cardholder: _____
Signature: _____
Your credit card will not be charged without notification. It is kept on file only to enforce the cancellation policy.

Please sign stating you agree to the terms and conditions.

Signature _____ Date: _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.
I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.
I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____
Signature of Patient:_____
Name Printed of Guardian/Parental and Relationship to Patient:_____
Guardian/Parental Signature:_____
Date:_____
Doctor of Chiropractic Name:_____
Signature of Doctor of Chiropractic:_____
Date:_____

Health Insurance Portability and Accountability Act of 1996

Body Elements Chiropractic is required by applicable federal and state law to maintain the privacy of your personal health information ("PHI") . We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect, which will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time and make the new notice available upon request.We reserve the right to make the changes in our privacy practices and the new terms of our notice, effective for all health information that we maintain, including health information we created or received before we made the changes.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. Some instances, but not limited to:

Payment: We may use or disclose your PHI to obtain payment for services we provide to you.

Treatment: We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, location, general condition, or death. In the event of your incapacity or emergency circumstances, we will disclose health, information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Required by Law: We may use or disclose your PHI to provide you with appointment reminders (such as, but not limited to voicemail messages, postcards, or letters).

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Marketing Health – Related Services: We will not use your PHI for marketing communications without your written authorization.

Patient Rights:

Access: You have the right to get copies of your PHI, with limited exceptions. You must complete a Medical Records Release Request to obtain access to your information. Your copies can be mailed to you, you may pick them up at our office, or we will mail them to a specified location.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your PHI.Your request must be in writing and explain why the information should be amended. We may deny your request under certain circumstances.

Breach Notification: We are required to notify you in the event your PHI has been, or is reasonably believed to have been accessed, acquired, or disclosed due to a breach.

Patient Responsibilities

You should arrive on time for appointments and cancel, when necessary, by telephone or in person.
You should provide timely payment for any services requested and delivered.
You should notify this office of any changes in your health status.
You should notify this office of any changes in your insurance, employment, or demographic information.
You should accept responsibility if you decide to refuse treatment.
You should ask questions if you do not understand.

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date_____