Intake Form

Title: (Check one) ☐ Mr. ☐ Mrs. ☐Ms. ☐ Miss ☐ Dr. ☐ Other _______

First Name ___________________ **Middle Initial** ____ **Last Name** __________________________

Address Line 1 ____

Address Line 2 ____

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_____

Spouse Data

First Name ___________________ **Middle Initial** _____ **Last Name** _________________________

Home Phone (_____) _______-__________ **Work Phone** (_____) _________-____________

Employer Data

Name ____

Your Occupation _________________________ **Your Job Description** _____________________

Address ____

City ________________________________ **State** _________________ **Zip Code** ______________

Emergency Contact

Contact Name ____________________________ **Relationship to Patient** ___________________

Contact Home Phone (_____) _______-________ **Cell Phone** (_____) ________-______________

Doctor's Signature ____

Patient Name____**Date**_____________________

How did you hear about our office? ____

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: (Check all that apply to you)

☐ Eggs ☐ Fish and Shellfish ☐ Milk or Lactose ☐ Peanuts
☐ Soy Sulfites ☐ Wheat/Glutens ☐ Other __________

Social History: (Check all that apply to you)

Caffeine use: ☐ occasional ☐ often ☐ never
Drink Alcohol: ☐ occasional ☐ often ☐ never
Exercise: occasional ☐ often ☐ never
Chew Tobacco: ☐ occasional ☐ often ☐ never
Cigarettes: ☐<1 pack/day >1 pack/day ☐ never
Wear Seat Belts: ☐ occasional ☐ always ☐ never
Other __________________

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 ____________________

Occupational Activities: (Check one that best describes your job description)

☐ Administration ☐ Business Owner ☐ Clerical/Secretary ☐ Computer User
☐ Heavy Equipment operator ☐ Daycare/Childcare ☐ Construction ☐ Health Care
☐ Food Service Industry ☐ Medium Manual Labor ☐ Manufacturing ☐ Home Services
☐ Heavy Manual Labor ☐ Light Manual Labor ☐ Executive/Legal ☐ Housekeeper
☐ Other __________________

Doctor's Signature ____

DYNAMINC SPINE
PERFORMANCE CENTER

Patient Name____**Date**________________

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson’s				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken ____
____

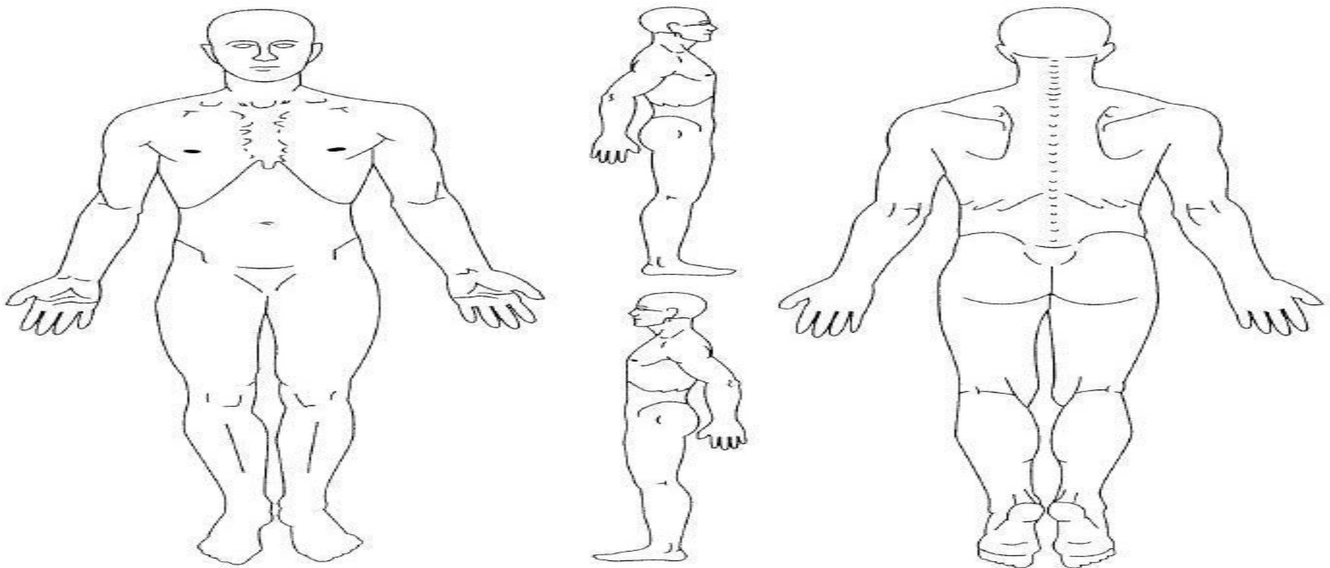
DYNAMINC SPINE
PERFORMANCE CENTER

Symptom Illustrator

Patient Name____ **Date**____________________________

Are you pregnant? Yes_____ No ______N/A______

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



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

____
____

When did your symptoms begin? Month______________ **Day**____________**Year** _______________

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐Work related Accident ☐ Other_____
How did your symptoms begin? ____
____

How often do you experience your symptoms?
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?
☐ Sharp ☐ Dull ache ☐ Numb ☐ Shooting
☐ Burning ☐ Tingling ☐ Stabbing ☐ Other ______

Doctor's Signature ____

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here:
http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _________

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _________

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _________

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _________

Financial Obligation and Appointment Policy

Thank you for choosing Ford Sport and Spine Chiropractic as your chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. RESPONSIBILITY. The patient accepts full financial responsibility for services rendered by this practice. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician.
2. INSURANCE. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
3. MISSED APPOINTMENT. Our policy is to charge $50.00 after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment**.
4. The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

I have read and understood the payment policy and agree to abide by its guidelines.

Initial _________

Signature ______________________________ Date ________________

SIGNATURE OF PHYSICIAN: __________________________________Date: ____________________