S.P.A.R.C. Chiropractic Patient Intake Form

Patient Information

Full Name:_____ Date:_____

Adress:_____ City:_____

Zip:_____State:_____ Male / Female (circle)

Age:_____ Brith Date:_____Social Security #:_____

Email Address:_____

Primary Contact:_____ Work/ Home/ Cell (circle)

Primary Medical Provider: _____ Telephone: _____

Can we contact Primary regarding your diagnosis and therapy? YES NO

Payment Information

Person Responsible for Payment: Self / Spouse / Parent / Other (circle one)

[Other than self]: Name:_____ D.O.B._____

Payment method: Insurance / Self Pay (circle)

[Copy of insurance card and legal photo ID are required for clinic records]

Consent for Treatment

Assignment & Release: By signing below, I authorize SPARC Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to SPARC Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. **I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient which I am the guarantor**. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

Signed_____ Date_____

Health Questionnaire

Name: _____ D.O.B. _____

Height: _____ Weight:_____

1. Prescription Medications: Yes / No **(List all with dosages and reason for taking)**

2. Over the Counter Medications: Yes / No **(List all with dosages)**

3. Supplements, Vitamins, Herbs: Yes / No **(List all with dosages)**

4. Have you ever been hospitalized or had any surgeries in the past? Yes___ No___
(If yes, list for what and what year)

5. Family Medical History **(List diseases/illnesses and whom in your family)**

Social History

Profession/Job:_____ Marital status:_____

Exercise: Yes / No If yes: Weight lifting / Running / Swimming / Biking / Walking / Other

Do you smoke: Yes / No If yes: amount per day:____ How many years_____

Do you drink alcohol: Yes / No If yes; amount per day: ____ Type:_____

Diet (circle one): Standard American / Paleo-Mediterranean / Vegetarian / Vegan / Other

Past Medical History

[Please circle all that apply previously or currently]

Heart Disease

Heart Attack

Hypertension

Diabetes

Stroke

High Cholesterol

Cancer

Abdominal Pain

Allergies

Depression

Anxiety

Thyroid/Other Hormone

Irritable Bowel Syndrome

Inflammatory Bowel Disease

GERD

Kidney Infection/UTI

Bowel or Bladder Dysfunction

Unexpected weight loss / gain

Excessive thirst/urination

Sciatica

Disc Herniation / Bulge

Stenosis

Osteoarthritis

Rheumatoid Arthritis

Migraine Headache

Other Headache

Visual Disturbances

Vertigo/Dizziness

Previous Fracture

Previous Dislocation

Joint Replacement

Fibromyalgia

General fatigue

Other-specify

Date _____

Acct _____

Patient _____

PATIENT HISTORY

1. What is your **main complaint?** _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

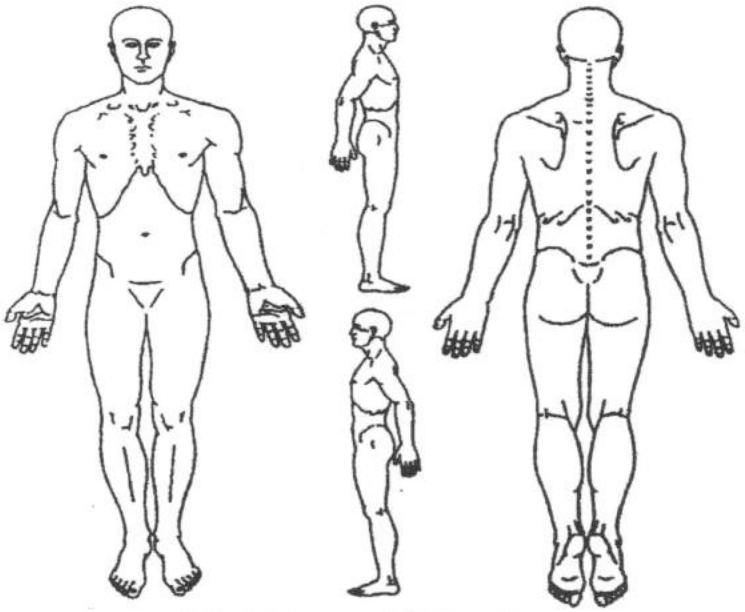
None		***Slight***		***Mild***		***Moderate***			***Severe***
1	2	3	4	5	6	7	8	9	10

3. On the scale below, please **circle** the **percentage of time** you experienced your **main complaint**:

	Occasional			***Intermittent***			***Frequent***			***Constant***
0	10	20	30	40	50	60	70	80	90	10

4. How long have you been experiencing your **main complaint?** _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



6. When do you notice it most? ☐ AM ☐ PM How long does it last?_____ Mins_____Hrs
7. What makes it feel better?_____
8. What makes it feel worst? _____
9. Have you ever had this problem in the past? ☐ Yes ☐ No
10. I have ☐ Be hospitalized ☐ Been treated by another chiropractor ☐ Been treated by another specialty provider ☐ Never received care for this problem.
11. Have you lost time from work because of it? ☐ Yes ☐ No Dates? _____To_____
12. Are you pregnant? ☐ Yes ☐ No
13. What was the first day of your last menstrual cycle?_____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have pain and/or difficulty performing any of the following activities: (Check)

_____ Personal Care_____ Lifting_____ Reading_____ Concentrating_____ Work_____ Driving_____ Sleeping

_____ Recreation _____ Walking_____ Sitting_____ Standing_____ Social Life

Patient Signature _____ **Date** _____

Are you interested in having your blood analyzed for **nutritional** deficiencies that may contribute to many disease processes?

Current research has shown that nutritional (vitamin/mineral/fat) imbalances can be a contributing factor in many patient conditions such as pain, inflammation, chronic fatigue, hypertension, blood sugar problems/diabetes, arthritis, headaches, and many others.

At S.P.A.R.C. Chiropractic we have state of the art computer technology that can analyze your specific blood chemistry for vitamin/mineral/fat imbalances and then identify which nutritional supplements you should take to address the problem.

_____ Yes I am interested in having my blood analyzed for nutritional deficiencies so that I may know which vitamins/minerals I can take as an adjunct to diet changes and traditional care.

_____ I'm not sure and would like more information about having my blood chemistry analyzed for nutritional deficiencies before making a decision.

_____ No I am not interested. Please treat my condition with traditional care only.

S.P.A.R.C. Chiropractic

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. 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 the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

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
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Date Signed ____/____/____

S.P.A.R.C. Chiropractic Financial Policy

Insurance Coverage

Your insurance policy is a contracted agreement between you and your insurer, not between you and this clinic. Coverage of services varies from insurer to insurer, and it is the patients responsibility, not this clinic, to understand their plan's benefits. Most plans have deductibles that need to be met before your insurer will start paying for therapy. Most plans have copays and co-insurance due each visit which is the patients responsibility. This clinic verifies coverage with the patients insurer, and will review these benefits with patients for clarity and understanding, but we are not responsible for your insurer's final payment and benefit determinations.

Payments [Please check one]

A ___ I would like this clinic to bill my insurance and assume all responsibility to pay amounts determined by my insurer.

B ___ I have no insurance or my plan is out of network with the clinic, I agree to assume all responsibility for balances I incur from therapies provided

MISSED APPOINTMENTS

It is the policy of our clinic to assess a $45 missed visit or late cancellation fee for patients who don't show up or fail to notify the clinic within 12 hours of their scheduled appointment. This policy is in place to be respectful to the doctors time and to other patients whom could have scheduled in the missed time spot. This clinic requires a credit card on file for new patients to hold the appointment spot. The card listed below will only be charged if the patient doesn't show up to their scheduled appointment or gives less than 12 hours of cancellation notice.

Credit Card #_____ Expiration date:_____

Security code:_____ Card zip code:_____

_____ My initials indicate I have read the above statement and understand the missed appointment and/or late cancellation policy.

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, 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, 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. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

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:_____