Community Chiropractic
Patient Intake Form

Patient Information

Name ____

Address ____

City ____________________ State ________ Zip ___________

Phone __________________________

Email ____

Date of Birth _______________ Gender M ___ F ___ Height _______ Weight ______

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Employer ____

Occupation ____

In case of emergency, contact __________________________

Phone ___________________________________

Who may we thank for referring you? ____________________________________

Have you ever received Chiropractic care? Yes __ No __ When was your last visit? _______________

How can we help you?

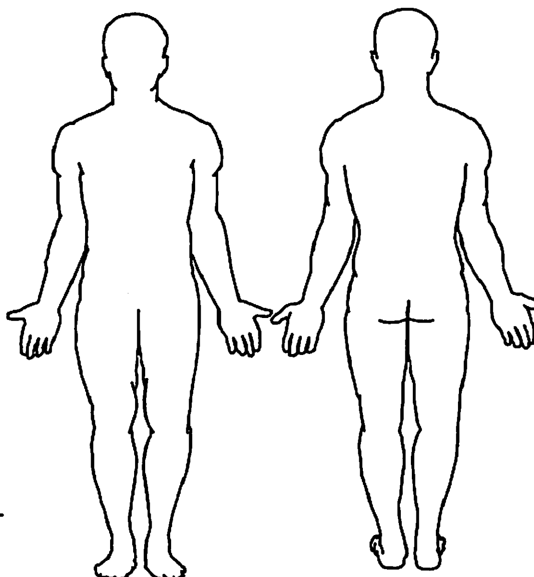
What brings you in today? ____

____

When did your symptoms begin? ____

How severe are your symptoms? (Circle) **0 1 2 3 4 5 6 7 8 9 10**

Please circle areas on the image to the right where you have discomfort:



How does it feel?

___ Sharp ___Dull ___Throbbing ___Numbness

___ Shooting ___Burning ___Stiffness

___ Constant ___Aching ___Tingling

___ Worse in AM ___ Worse in PM

Activities or movements that are painful to perform:

___Sitting ___Standing ___Walking ___Bending

___Transitioning from sit to stand ___Other

Does the pain travel in your body? ___ Yes ___ No

If yes, where? ______________________________

Is there anything that makes this problem worse? ______________________________

Have you recently experienced any trauma? YES NO

Have you experienced any sudden weight changes? YES NO

Have you recently had a fever? YES NO

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HEALTH HISTORY

What treatment have you already received for your condition?

_______ Medications _________ Surgery ______ Physical Therapy

_______ Chiropractic Services ______ None ______ Other ___________________________

Name of doctor(s) who treated you ____

Date of last:

Physical Exam ________________ X-ray ________________

MRI, CT-Scan, Bone Scan _____________________

OBGYN Exam ______________________

Any past surgeries? ____

Significant family health issues: ____

Please circle "yes" or "no" to indicate if you have had any of the following:

Bleeding Disorders	YES	NO	OBGYN Issues	YES	NO
Cancer	YES	NO	Osteporosis	YES	NO
Diabetes	YES	NO	Pace Maker	YES	NO
Emphysema	YES	NO	Parkinson's Disease	YES	NO
Epilepsy	YES	NO	Polio	YES	NO
Goiter	YES	NO	Prostate Issues	YES	NO
Gout	YES	NO	Rheumatoid Arthiritis	YES	NO
Heart Disease	YES	NO	Sexually Transmitted		
Hepatitis	YES	NO	Disease	YES	NO
Herpes	YES	NO	Stroke	YES	NO
High Blood Pressure	YES	NO	Thyroid Problems	YES	NO
High Cholesterol	YES	NO	Tuberculosis	YES	NO
Kidney Disease	YES	NO	Tumor, Growths	YES	NO
Liver Disease	YES	NO			
Migraines	YES	NO			
Multiple Sclerosis	YES	NO			

Are you currently taking any medications? Medication Name Dosage/Frequency

Medication Allergies: ____

Smoking Status (Circle One): Every Day Smoker/Occasional Smoker/Former Smoker/ N/A

Alcohol Status (Circle One): Every Day Drinker/Occasional Drinker/Former Drinker/ N/A

Consent to Examine and Treat

Dr. Curtis Damien – Community Chiropractic

The undersigned consents to any examination (x-ray or otherwise) including, but not limited to, physical, orthopedic and neurological evaluation, visual inspection, palpation and X-rays if needed.

The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, joint mobilization, myofascial release, trigger-point therapy, ultrasound, electrical muscle stimulation, rehabilitative exercise, infrared therapy, low level laser, traction, decompression. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for home care and follow-up care is necessary for the resolution of your complaint.

Because of modern techniques and equipment, examination and therapeutic procedures carry with them a low risk of complication. Even though problems seldom arise during these procedures, risks must be recognized and considered. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. These complications include but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness, or weakness. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedures and each case must be evaluated separately.

If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion.

I have read the above explanation of treatment and diagnostic procedures used in this clinic and have decided that it is in my best interest to submit to these procedures.

Signature:__________________________ Date:______________________

Insurance Information

Insurance Company: ______________________________

Policy Holder Name: ______________________________

Relationship to Patient: ____________________

Member ID: ______________________________

ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s), have insurance coverage with above listed company and assign directly to Dr. Curtis Damien (Community Chiropractic) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above doctor may use my health care information and may disclose \such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____

Signature of Patient, Parent, Guardian or Personal Representative

____________________ ______________________________

Date Relationship to Patient

Financial Agreements /Late Payments

If an insurance company obligated to pay me or Community Chiropractic the charges for services rendered refuses to pay upon demand by the clinic, or if there is no insurance company, then I will pay for services rendered by Community Chiropractic. I will pay my account in full immediately, or I will keep my account current. If I have a liability/ personal injury claim and my attorney refuses to protect the interests of Community Chiropractic, or if I have not engaged the services of an attorney, I hereby promise to pay my bill in full within ten (10) days from the date my liability claim is settled or after the passage of two months from the date of my last treatment, whichever comes first. By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, reasonable attorney fees, court costs, and all other costs related to the collection of this debt.

Signature: ______________________ Date: __________

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by COMMUNITY CHIROPRACTIC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. If you would like a full copy of the Notice of Privacy Policy, please notify staff.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information. This must be received in writing. Any use or disclosure that has already occurred prior to the date which your revocation of consent is received will not be affected.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Our office staff may use your name in open/common treatment areas in your presence when other patients are present and are able to hear your information.

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

All info ____ Diagnosis/Treatment Plan ____ Appointments ____ Billing _______

Persons Authorized to Use or Disclose Information

Information listed above is authorize to be released to:

____

Name of Person Organization

Expiration Date of Authorization

This authorization is effective through ______________________ unless revoked or terminated by the patient or patient's personal representative.

By my signature below I give my permission to use and disclose my health information.

____ _______________

Patient or Legally Authorized Individual Signature Date

NO SHOW, MISSED APPOINTMENT
OFFICE POLICY

When our office books your appointment, we are setting aside a dedicated time slot for you. We only ask that if you must reschedule your appointment, that you please provide us with at least 24 hour notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept. We do understand this may not always be possible and would just ask you to call as soon as possible.

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved and we make arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

There is a charge of $25 per visit for not showing up for scheduled appointments without any notification.

*Repeated cancellations or missed appointments will result in loss of future appointment privileges.

____________________________________ ____________________

Patient Signature Date