Patient Personal/Confident Intake Form

Today's Date_____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: (best) _____

Email Address: _____

Employer/Occupation: _____

Emergency Contact: _____ Relation:_____ Phone:_____

Whom may we thank for referring you to us? _____

Would you like for us to share information of today's visit with your Primary Care Physician? Y/N

If yes, please provide name of your doctor _____

Health History

Please check all that apply

Present	Past		Present	Past		Present	Past	
		Headaches			High Blood Pressure			Diabetes
		Neck Pain			Heart Attack			Excessive Thirst
		Upper Back Pain			Chest Pains			Frequent Urination
		Mid Back Pain			Stroke			Smoking/Tobacco Use
		Low Back Pain			Angina			Drug/Alcohol Dependence
		Shoulder Pain			Kidney Stones			Allergies
		Elbow/Upper Arm Pain			Kidney Disorder			Depression
		Wrist Pain			Bladder Infection			Systemic Lupus
		Hand Pain			Painful Urination			Epilepsy
		Hip Pain			Loss of Bladder Control			Dermatitis/Eczema/Rash
		Upper Leg Pain			Prostate Problems			HIV/AIDS
		Knee Pain			Abnormal Weight Gain/Loss			Ankle/Foot Pain
		Loss of Appetite			Jaw Pain			Abdominal Pain
		Joint Pain/Stiffness			Ulcer			Arthritis
		Hepatitis			Rheumatoid Arthritis			Liver/GallBladder Disorder
		Cancer			General Fatigue	**For Females Only**		
		Tumor			Muscular Incoordination			Birth Control Pills
		Asthma			Visual Disturbances			Hormonal Replacement
		Chronic Sinusitis			Dizziness			Pregnancy
		Other(s):						

Previous Surgeries and Dates: _____

List ALL Current Medications: _____

How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ Heart Problems ☐ Cancers ☐ ALS

Have you ever been hospitalized? ☐ No ☐ Yes, if yes, Why? _____

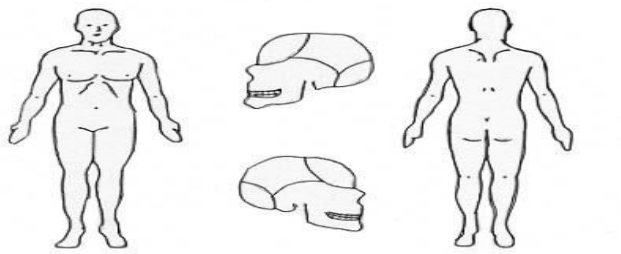
Have you had significant past trauma? ☐ No ☐ Yes, is yes, What? _____

Current Condition

Please answer to the best of your ability

Is Today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation ☐ Other:_____

Indicate on the drawings below your PRIMARY area of pain/symptoms



How often do you experience your symptoms?

☐ Constantly(76-100% of the time) ☐ Frequently(51-75% of the time) ☐ Occasionally(26-50% of the time ☐ Intermittent(1-25% of the time)

How would you describe the type of pain?

☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Achy

☐ Sharp with Motion ☐ Shooting with Motion ☐ Stabbing with Motion ☐ Burning

☐ Shooting ☐ Stiff ☐ Electric like with motion ☐ Other:_____

How are you symptoms changing with time? ☐ Getting worse ☐ Staying the Same ☐ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please Circle)

How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

What concerns you the most about your problem; what does it prevent you from doing?

_____

_____

Is there anything else that you feel we should know?

Insurance Information/Consent for Professional Services and Release of Information

**All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous to my health or others. I authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, or any clinic service he/she deems necessary in my case. I authorize and request my insurance company to distribute funds and any payable benefits directly to this office. I further understand that payment may be less than the actual cost of services and I will be responsible for any outstanding amount owed to this office.*

Patient Signature: _____ Date: _____

Belleview Chiropractic

Consent for Purposes of Treatment & Healthcare Operations

In this document, "I" and "my" refer to the patient

I consent to the use or disclosure of my protected health information by Belleview Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or treatment of me by Belleview Chiropractic may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Belleview Chiropractic is not required to agree to the restrictions that I may request. However, if Belleview Chiropractic agrees to a restriction that I request, the restriction is binding on Belleview Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that Belleview Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may obtain a copy of the Notice of Privacy Practices of Belleview Chiropractic and understand that I have a right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations or Belleview Chiropractic. The Notice of Privacy Practices for Belleview Chiropractic is also in the waiting room at the 5191 S Yosemite. This Notice of Privacy Practices also describes my rights and duties of Belleview Chiropractic with respect to my protected health information.

Belleview Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Belleview Chiropractic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. Our office sends thank you cards for referrals, sends periodic newsletters, posts names on a referral board, and participates in other non-private contact. If you prefer not to participate in this please let Belleview Chiropractic know.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stoke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injection, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about this consent, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature:_____ Date: _____

Parent or Guardian:_____ Signature:_____ Date: _____

Witness name: _____ Signature: _____ Date: _____