ChiropracticWellness

New Patient Intake Form

Adult

Please fill out this form as completely as possible

Date:_____

Personal Information:

Name:_____ Preferred to be called:_____

Address:_____ City, State, Zip Code:_____

Primary Phone Number:_____ Secondary Phone Number:_____

Date of Birth: ___/___/_____ Age:_____ SSN:_____ Gender at birth:_____

E-Mail Address (we will not give out to others):_____

Employer:_____ Work Phone:_____

Work Address:_____ City, State, Zip Code:_____

Emergency Contact 1_____ Relationship:_____ Contact #_____

Emergency Contact 2_____ Relationship:_____ Contact #_____

Are you seeking care for Work Compensation, Automobile Accident, or Personal Injury? YES NO

Who may we thank for referring you to our office?_____

What Conditions are you seeking treatment for? (i.e. low back pain, neck pain, headaches, etc.)

Describe Condition #1:_____

How did this condition develop?_____

_____

Date of Onset:_____ Have you gotten other tests or treatment for this condition: If yes, please explain:

_____

- This condition is...(CIRCLE all that apply):
  Sharp Shooting Aching Throbbing Burning Numbness Weak Tingling
  *Constant Frequent Comes & Goes Getting Worse Other:*_____
- What is your level of discomfort on a scale of 0-10? (0=No Pain, 10=Severe Pain) _____/10
- Is it interfering with...(Circle all that apply) Work Sleep Daily Routine Hobbies Exercise
- What does it keep you from doing?_____
- What makes this condition better?_____
- What makes it worse?_____

Describe Condition #2:_____

How did this condition develop?_____

_____

Date of Onset:_____ Have you gotten other tests or treatment for this condition: If yes, please explain:

_____

- This condition is...(CIRCLE all that apply):
  Sharp Shooting Aching Throbbing Burning Numbness Weak Tingling
  *Constant Frequent Comes & Goes Getting Worse Other:*_____
- What is your level of discomfort on a scale of 0-10? (0=No Pain, 10=Severe Pain) _____/10
- Is it interfering with...(Circle all that apply) Work Sleep Daily Routine Hobbies Exercise
- What does it keep you from doing?_____
- What makes this condition better?_____
- What makes it worse?_____

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New Patient Intake Form

Adult

Health History:

Please circle the correct letter if you, your mother, or your father has had any of the following:

S=Self M=Mother F=Father

Heart Attack (S M F)	Stroke (S M F)	Rheumatoid (S M F)
Heart Defect (S M F)	Cancer (S M F)	Scoliosis (S M F)
Parkinson's (S M F)	Lupus (S M F)	Multiple Sclerosis (S M F)
Diabetes (S M F)	HIV/AIDS (S M F)	Seizure/Epilepsy (S M F)
High Blood Pressure (S M F)	Low Blood Pressure (S M F)	Alzheimer's (S M F)

Other serious medical conditions/diagnosis that you've had: _____

_____

Allergies: _____

Previous accidents and injuries: _____

_____

_____

Surgeries/Hospitalizations: _____

_____

_____

Current medications and supplements: _____

_____

_____

Medical Doctor's Name: _____ Previous Chiropractor: _____

Lifestyle: Do you...

Smoke? Yes / No If yes, how long? _____ Drink Alcohol? Yes / No If so, how often? _____

Exercise? Yes / No If so, what type of exercise and how often? _____

Women: Are you...

Pregnant? Yes / No If yes, how far along? _____ Nursing? Yes /No

Taking birth control? Yes / No If yes, what kind? _____ Regular Periods Yes/No

Have you been pregnant? Yes / No If yes, when and how many live births? _____

Payment Information:

□ I currently have **BCBS or Medicare.** I give full authorization to Chiropractic Wellness Connection and its employees to do and release all that is necessary to have the insurance payments covered. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I know that I am ultimately responsible for any balance on my account. *CWC will need a copy of your insurance card and all of the insured's information in order to bill today.

□ I have **other medical insurance** and would like a receipt that I can send to my insurance company myself for possible reimbursement. I know that I am responsible for any balance on my account.

□ I have a worker's compensation, automobile accident or other personal injury account and claim that has been opened and is current. I am seeking treatment for injuries directly related from this accident. I know that I am responsible for any balance on my account and will need to pay all balances at the time of service. I as the patient will seek reimbursement from party responsible.

□ I do <u>not</u> have insurance coverage and will be paying as a cash patient. I am fully responsible for my account.

Name of Responsible Guardian (if patient is a minor) _____

<u>Consent to Examination and Treatment</u>

I, the undersigned, do hereby authorize Dr. Jennifer C. Daniel-Price, D.C. and/or any other licensed chiropractic physicians and assistants employed by Chiropractic Wellness Connection to perform any examination, diagnostic tests, diagnosis and render necessary treatment as deemed necessary by the doctor to myself or minor child.

Signature: _____ Date: _____

Low Back Pain Disability Questionnaire (Rev. Oswestry)

Name:_____ Date:_____

Please circle the number below that best describes your low back pain in each category.

Section 1: Pain Intensity
0. I can tolerate the pain without having to use pain killers.
1. The pain is bad but I can manage without taking painkillers.
2. Painkillers give complete relief from pain.
3. Painkillers give moderate relief from pain.
4. Painkillers give little relief from pain.
5. Painkillers have no effect on the pain and I do not use them.

Section 2: Personal Care
0. I can look after myself normally without causing extra pain.
1. I can look after myself normally, but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help, but manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, I wash with difficulty and stay in bed.

Section 3: Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives me extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed (ex. On a table)
3. Pain prevents me from lifting heavy objects, but I can manage light to medium weights if they are conveniently positioned.
4. I can only lift light weights.
5. I cannot lift or carry anything.

Section 4: Walking
0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking more than one mile.
2. Pain prevents me from walking more than one-half mile.
3. Pain prevents me from walking more than one-quarter mile.
4. I can only walk using a stick or crutches.
5. I am in bed most of the time and have to crawl to the toilet

Section 5: Sitting
0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. Pain prevents me from sitting at all.

Section 6: Standing
0. I can stand as long as I want without extra pain.
1. I can stand as long as I want but it gives me extra pain.
2. Pain prevents me from standing more than 1 hour.
3. Pain prevents me from standing more than 30 minutes.
4. Pain prevents me from standing more than 10 minutes.
5. Pain prevents me from standing at all.

Section 7: Sleeping
0. Pain does not prevent me from sleeping well.
1. I can sleep well only by using tablets.
2. Even when I take tablets I have less than 6 hours sleep.
3. Even when I take tablets I have less than 4 hours sleep.
4. Even when I take tablets I have less than 2 hours sleep.
5. Pain prevents me from sleeping at all.

Section 8: Social Life
0. My social life is normal and gives me no extra pain.
1. My social life is normal, but increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests.
3. Pain has restricted my social life and I do not go out as often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of pain.

Section 9: Traveling
0. I can travel anywhere without extra pain.
1. I can travel anywhere but it gives me extra pain.
2. Pain is bad but I manage journeys over 2 hours.
3. Pain is bad but I manage journeys less than 1 hour.
4. Pain restricts me to short necessary journeys under 30 minutes.
5. Pain prevents me from travelling except to the doctor or hospital.

Section 10: Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates, but is definitely getting better.
2. My pain seems to be getting better, but improvements is slow at present.
3. My pain is neither getting better nor getting worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Neck Pain Disability Index Questionnaire

Name:_____ Date:_____

Please circle the number below that best describes your neck pain in each category.

Section 1: Pain Intensity
0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain in the worst imaginable at the moment.

Section 2: Personal Care
0. I can look after myself normally without causing extra pain.
1. I can look after myself normally, but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help, but manage most of my personal care.
4. I need help every day in most aspects of self care.
5. *I do not get dressed, I wash with difficulty and stay in bed.*

Section 3: Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it gives me extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed (ex. On a table)
3. Pain prevents me from lifting heavy objects, but I can manage light to medium weights if they are conveniently positioned.
4. I can only lift light weights.
5. I cannot lift or carry anything.

Section 4: Reading
0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want to with slight pain in my neck.
2. I can read as much as I want with moderate pain.
3. I can't read as much as I want because of moderate pain in my neck.
4. I can hardly read at all because of severe pain in my neck.
5. I cannot read at all.

Section 5: Headaches
0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have slight headaches which come frequently.
3. I have moderate headaches which come infrequently
4. I have moderate headaches which come frequently
5. I have headaches almost all the time.

Section 6: Concentration
0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

Section 7: Work
0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I can't do any work at all.

Section 8: Driving
0. I can drive my car without any neck pain
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I like with moderate pain in my neck.
3. I can't drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive my car at all because of severe pain in my neck.
5. I can't drive my car at all.

Section 9: Sleeping
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hr. sleeplessness)
2. My sleep is moderately disturbed (1-2 hrs. sleepless)
3. My sleep is moderately disturbed (2-3 hrs. sleepless)
4. My sleep is greatly disturbed (3-4 hrs. sleepless)
5 My sleep is completely disturbed (5-6 hrs. sleepless)

Section 10: Recreation
0. I am able to engage in all my recreation activities with no neck pain at all.
1. I am able to engage in all my recreation activities with some neck pain.
2. I am able to engage in most, but not all of my usual recreation activities because of neck pain.
3. I am able to engage in a few of my usual recreation activities because of neck pain.
4. I can hardly do any recreation activities because of pain in my neck.
5. I can't do any recreation activities at all.

Review of Systems

Name:_____ Date:_____

At Chiropractic Wellness Connection, we strive to find the CAUSE of your concerns. This questionnaire will help us to identify what is going on specifically for you. Please rate each of the following symptoms based what you have experienced in the **last 60 days.**

Point Scale: **leave blank** = *never* have the symptom, **1** = *occasionally* have symptom, **2** = *regularly* have symptom, **3** = *frequently* have symptom, **4** = *constantly* have symptom

Eyes, Ears, Nose, Throat:
__chronic ear infections
__ringing in the ears
__blurred or tunnel vision
__eye pain
__itchy or watery eyes
__nasal congestion
__nose bleeds
__loss of smell
__sore throat
__sores in mouth
__difficulty swallowing/gagging
__white patches on throat/tongue
__need to repetitively clear throat

Musculoskeletal:
__joint pain
__joint stiffness
__pain in muscles
__abnormal muscle movements
__muscle weakness

General:
__unexplained weight loss
__unexplained weight gain
__severe fatigue
__fever
__excessive thirst
__frequent illnesses
__difficulty sleeping

Urinary:
__difficulty urinating
__blood in urine
__chronic UTIs
__frequent urination

Neurological:
__tremors/tics
__difficulty walking
__difficulty with balance
__headaches
__numbness or tingling
__bruises easily
__ seizures

Digestive:
__nausea or vomiting
__diarrhea
__constipation
__bloated belly
__heart burn
__abdominal pain
__blood in stool

Mental/Emotional:
__memory loss
__depression
__anxiety/social anxiety
__confusion
__inability to focus
__hyperactivity
__loss of interest/motivation
__homicidal/suicidal thoughts

Respiratory:
__short of breath
__wheezing
__asthma
__coughing

Integumentary:
__itchy skin
__rashes
__jaundice
__swollen lymph nodes
__hair loss

Cardiovascular:
__chest pain
__heart palpitations
__irregular heartbeat
__fainting
__swelling in hands/feet
__difficulty with speech
__dizziness
__restless legs
__slurred speech

Female Reproductive Only:
__abnormal periods
__excessive bleeding/clots
__period irregularity
__loss of pregnancy
__slurred speech

Total:_____

Brookside Radiology Consultants, Inc.
P.O. Box 349
Buzzards Bay, MA 02532
Phone: 508-743-5691
Fax: 774-302-4713

X-Ray Assignment Agreement and Consent

I understand that my doctor is submitting my X-Rays for radiological interpretation and report by John R. Henry, DC DACBR, a radiologist certified by the American Chiropractic Board of Radiology.

I give my consent to Brookside Radiology Consultants, Inc. for use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operations of the Practice. I acknowledge that I have received or reviewed and understand the Notice of Privacy Practice of Brookside Radiology Consultants, Inc. which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice. **My signature authorizes the release of medical information.**

_____ _____

Patient Name (Please Print Clearly) Patient Signature

Today's Date: _____

Birth Date: _____ Age: _____ Sex: M F

To be completed by office staff:

Referring Doctor: _____ Clinic Phone: _____ Date of Films: _____

X-Ray Studies Submitted: _____ Clinical Concern: _____

Comments:

_____

Informed Consent to Care

You are the decision maker for your health care. "Informed consent" involves your understanding and agreement regarding the care we recommend,risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

CHIROPRACTIC TREATMENT involves the management of conditions by means of a chiropractic adjustment, a specific type of joint manipulation performed by hand or instrument with person to person contact. The chiropractic adjustment carries a plethora of benefits but also has risks associated with it. Results are not guaranteed.

Serious risks and side effects associated with the chiropractic adjustment are extremely rare but include the following:.

Temporary soreness, muscle spasm, increased pain, dizziness, headache, nausea and increased other symptoms: It is not uncommon for the patients to experience temporary soreness, muscle spasm, headache or increased symptoms or pain after treatments especially with beginning care. It is less likely to experience dizziness and nausea post treatment.

Fractures: When patients have underlying conditions and/or treatments that weaken bones, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening condition and/or medical treatment. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse: Spinal disc conditions like bulges or herniations may worsen with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke: There is an extremely rare association with stroke and certain types of chiropractic care. This is a very debatable topic as any stroke can occur from a multitude of reasons and the timing can be spontaneous and unknown until the event has occurred no matter the cause. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Patients who are experiencing a stroke may or may not have initial symptoms. We do our best to determine the possibility and risk of stroke with every patient at every visit. There may be times when chiropractic treatment is not given and medical testing is advised instead.

Other possible risks: Other possible risks include but are not limited to bruising, disruptions of internal medical devices, dislocations, and/or sprains and strains. If any of these conditions or symptoms occur, notify your chiropractor immediately.

It is important to know that it is not possible to know every potential complication to care. It is important to notify the chiropractor immediately if you experience these symptoms or any adverse symptoms during or after your care. Your chiropractor has the right to refuse treatment in the event that they have concern with your current condition and do not advise treatment accordingly.

ACUPUNCTURE treatment is a form of therapy in which fine needles are inserted into specific points on the body. Acupuncture is generally very safe and serious side effects are very rare. Acupuncture may be contraindicated on certain patients so notify chiropractor before treatment if you have any of the following: are pregnant, have a pacemaker or other electrical implant, bleeding disorder, blood borne pathogens, or are taking anticoagulants or any other medications. It is important to not move during the insertion, retention, or removal of the needles.

The following are known risks with **acupuncture care:**

Drowsiness and dizziness may occur after treatment in a small number of patients, and, if affected, you are advised not to drive.

Minor bleeding, bruising, pain , temporary worsening of symptoms, numbness and tingling, and/or muscle contractions may occur after treatment.

Infection is another possible risk, although the chiropractor uses sterile, single use, disposable needles.

It is important to know that it is not possible to consider every possible complication to any type of care.

It is also important that you understand there are treatment options available for your condition other than chiropractic and acupuncture procedures. These options may include, but are not limited to: self-administered care, over the counter pain relievers, rest, medical treatment, physical therapy, bracing, injections, and surgery. You have the right to a second opinion and trying other options in healthcare as you see fit.

I have read, or had read to me, the above consent. I have discussed any questions or concerns with my chiropractor and/or their staff , have had these answered to my satisfaction prior to my signing this document and acknowledge that no guarantee can be given as to the results or outcome of my care. I have made my decision voluntarily and freely. I hereby give my consent to the performance of diagnostic tests, procedures and chiropractic treatment, acupuncture treatment and physical modalities recommended by my chiropractor and/or management of my conditions.

Patient Name: Signature:

_____ _____ Date:_____

Parent or Guardian: Signature:

_____ _____ Date:_____

Witness Name: Signature:

_____ _____ Date:_____

Jennifer Daniel-Price, D.C.
Chiropractic Wellness Connection
410 E. Elm St. Canton, IL 61520
Phone: 309-647-7490

Communication Regarding Confidential Information

In order for us to keep communication regarding your information confidential, we need the following:

Mark below the means by which you authorize us to contact you. MARK ALL THAT APPLY. Write N/A if you do not want that form of communication.

- ☐ Call Home at this phone number: _____
- ☐ Call Cell at this phone number: _____
- ☐ Text Cell at this phone number: _____
- ☐ Email address: _____

Do you want appointment reminders sent to you? Yes _____ No _____
If yes, how would you like your reminder? Text to Cell phone _____ E-mail _____

May we leave a message and/or talk with another party on your behalf? Yes _____ No _____
Please list authorized person(s) to receive protected health information on your behalf:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Please list any other special requests regarding your health information: _____
_____

I, the undersigned, hereby acknowledge that by signing this Consent:

1. I am aware that the Practice's Privacy Notice is available to me upon request. 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 health care operations. The Privacy Notice is also 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 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 laws.
3. The Practice's "Notice of Privacy Practices" is provided at 410 E. Elm St., Canton, IL 61520. I may also request a copy from this office at any time directly from the office or via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

Patient's Name (please print): _____

Signature: _____ Date: _____

If you are not the patient, please specify your name and relationship to the patient:
_____