Chiro One Wellness Centers New Patient Intake Paperwork

1 Patient Information

First Name: _____ Last Name: _____ Middle Name: _____

Email:_____ Primary Phone:_____ Legal Sex:_____ Birthdate:_____ Age:_____

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

2 Reason for coming in

Primary Reason for coming in:_____

How long have you experienced this?_____ Most recent occurrence date:_____

Describe the symptoms: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting** ☐ **Burning**

☐ **Tingling** ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other:_____

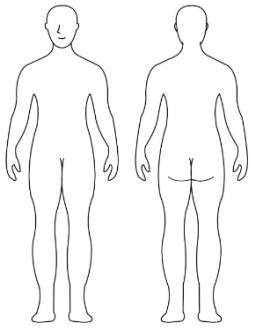
Does the pain/symptoms travel from one location to another? ☐ Yes ☐ No

Where does it start, where does it travel?_____

How often does the pain occur?_____ Does it seem to be getting progressively worse?: ☐ Yes ☐ No

What do you think caused the problem?_____

Indicate where on the figure



What activities make it worse?:_____ Worse in the morning or evening? _____

Which activities are affected by this? ☐ Sitting ☐ Standing ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Walking ☐ Lying Down

☐ Bending/Squatting to lift object ☐ Up/Down Stairs ☐ Running/Jogging ☐ In/Out Bed ☐ On/ OffChair ☐ Food Prep/Eating

☐ Reaching Over Head/ Across Body ☐ None ☐ Other:_____

Rate the severity of your pain at its worst (1- Least to 10-Severe): _____ Least severe (when you feel it):_____ Present moment:_____

Have you sought treatment? ☐ Oral medication ☐ Injections ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other: _____

Are there any activities that improve your condition? ☐ Stretching ☐ Exercise ☐ Rest ☐ Other:_____

What has helped/provided most relief?_____

3 Additional Concerns

Additional Concern 1:_____How long have you experienced this?_____

Describe the symptoms: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting** ☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness

☐ Swelling ☐ Other:_____ Does the pain/symptoms travel from one location to another? ☐ Yes ☐ No

Where does it start, where does it travel?_____ How often does the pain occur?_____

What activities make it worse?:_____ Worse in the morning or evening? _____

Which activities are affected by this? ☐ Sitting ☐ Standing ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Walking ☐ Lying Down

☐ Bending/Squatting to lift object ☐ Up/Down Stairs ☐ Running/Jogging ☐ In/Out Bed ☐ On/Off Chair ☐ Food Prep/Eating

☐ Reaching Over Head/ Across Body ☐ None ☐ Other:_____

Rate the severity of your pain at its worst (1- Least to 10-Severe): _____ Least severe (when you feel it):_____ Present moment:_____

Have you sought treatment? ☐ Oral medication ☐ Injections ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other: _____

Are there any activities that improve your condition? ☐ Stretching ☐ Exercise ☐ Rest ☐ Other:_____

What has helped/ provided most relief?_____

Additional Concern 2 :_____ How long have you experienced this?_____

Describe the symptoms: ☐ **Sharp** ☐ Dull ☐ **Throbbing** ☐ **Numbness** ☐ Aching ☐ **Shooting** ☐ **Burning** ☐ **Tingling** ☐ Cramps ☐ Stiffness

☐ Swelling ☐ Other:_____ Does the pain/symptoms travel from one location to another? ☐ Yes ☐ No

Where does it start, where does it travel?_____ How often does the pain occur?_____

What activities make it worse?:_____ Worse in the morning or evening? _____

Which activities are affected by this? ☐ Sitting ☐ Standing ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Walking ☐ Lying Down

☐ Bending/Squatting to lift object ☐ Up/Down Stairs ☐ Running/Jogging ☐ In/Out Bed ☐ On/Off Chair ☐ Food Prep/Eating

☐ Reaching Over Head/ Across Body ☐ None ☐ Other:_____

Rate the severity of your pain at its worst (1- Least to 10-Severe): _____Least severe (when you feel it):_____ Present moment:_____

Have you sought treatment? ☐ Oral medication ☐ Injections ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other: _____

Are there any activities that improve your condition? ☐ Stretching ☐ Exercise ☐ Rest ☐ Other:_____

What has helped/ provided most relief?_____

4 Family History

Please indicate if siblings, parents, or grandparents have a history of any of the following:

☐ Autoimmune Disease	☐ Cancer	☐ High Blood Pressure	☐ Osteoporosis
☐ Bleeding Disorder	☐ Diabetes	☐ Kidney Disease	☐ Stroke
☐ Clotting Disorder	☐ Heart Disease	☐ Migraines	☐ Thyroid Disease

☐ Family has no history of these conditions

5 Personal History

Please indicate if you have a history of the following:

☐ AIDS/HIV	☐ Diabetes	☐ MS
☐ Allergies	☐ Eating Disorder	☐ Osteoporosis
☐ Anemia	☐ Emphysema	☐ Pacemaker
☐ Anxiety/Depression	☐ Epilepsy/Seizure Disorder	☐ Parkinson's
☐ Appendicitis	☐ Headaches	☐ Pinched Nerve
☐ Arthritis (Osteo, Rheumatoid, etc.)	☐ Heart Disease	☐ Pneumonia
☐ Asthma	☐ Hepatitis	☐ Prostate Problem
☐ Autoimmune Disorder	☐ Hernia	☐ Psychiatric Care
☐ Bleeding Disorder	☐ Herniated Disk	☐ STD
☐ Bronchitis	☐ Hypertension	☐ Stroke
☐ Cancer	☐ Kidney Disease	☐ Thyroid Disease
☐ Chemical Dependence/Alcoholism	☐ Liver Disease	☐ Tuberculosis
☐ Chicken Pox	☐ Migraines	☐ Tumors/Growths
☐ Clotting Disorder	☐ Mononucleosis	☐ Ulcers

☐ Patient has no history of these conditions

Are you Pregnant? ☐ Yes ☐ No ☐ Does Not Apply How Many Weeks?_____

You certify that you are NOT pregnant, and that Chiro One's staff has your permission to perform an X-ray evaluation, if medically necessary. You have been advised that X-ray can be hazardous to an unborn child. Date of last Period: _____

Patient Signature:_____ **Date:**_____

General PCP Name:_____ Phone Number:_____

Please enter the last known date and any notable findings:

Physical Exam:_____ Spinal X-Ray: _____ Spinal Exam: _____ Chest X-ray: _____

MRI: _____ CT-Scan: _____ Bone Scan: _____ Blood Test: _____ Urine Test: _____

Notable Findings:_____

Are you taking any Medications? ☐Yes ☐No List/Frequency:_____

_____

Do you take any vitamins or supplements? ☐Yes ☐No List/Frequency:_____

_____

Previous Chiropractic Experience? ☐Yes ☐No Last seen date/describe: _____

6 Life Activities

Occupation:_____ Employer/School:_____

Primary Work Activities: ☐Sitting ☐Standing ☐Light labor/lifting ☐Heavy labor/lifting ☐Repetitive motions

Previous Work Injuries (Date/Description): _____

Marital Status ☐Married/Partnered ☐Single ☐Widowed

Emergency Contact Name:_____ Phone:_____ Relationship to Patient: _____

Children Name/Age:_____ Did you give birth? ☐Yes ☐No

Please describe any complications during pregnancy:_____

Home Physical Activities:_____

Home Injuries (Date/Description):_____

Exercise: ☐None ☐Light ☐Moderate ☐Heavy Sport Activities (Prior/Current):_____

Sport Injuries (Prior/Current): _____

Habits: ☐Nicotine ☐Alcohol ☐Coffee/Caffeine Drinks ☐High Stress Level ☐None How Often:_____

Sleep Hours/Night: _____

Please rank how your time is spent/ Personal Values (1- Most/ 6- Least)

____Family/Home ____Career/Financial ____Social/Friends _____Mental Health/Spiritual _____Fitness/Nutrition ____Sleep/Rest

7 Prior Traumas

Have you ever been in a Motor Vehicle Accident? ☐Yes ☐No

Date of Accident:_____ Symptoms/Pain:_____ Treatment Received: ☐Medical ☐Chiropractic ☐None

Details including speed of vehicle:_____

_____

Date of Accident:_____ Symptoms/Pain:_____ Treatment Received: ☐Medical ☐Chiropractic ☐None

Details including speed of vehicle:_____

_____

Falls (Date/Describe):_____

Head Injuries (Date/Describe):_____

Dislocations (Date/Describe):_____

Broken Bones (Date/Describe):_____

Surgeries (Date/Describe):_____

8 Payment/Insurance Info

Who is financially responsible for this account? ☐Self ☐Other Name:_____ Relationship to patient:_____

Is the patient covered by insurance? ☐Yes ☐No Name of Insurance Company:_____

Who is the main/subscriber or policy holder? ☐Self ☐Other

Subscriber Name:_____ Relationship to Patient:_____ Subscriber Birth Date:_____

Is the policy associated with: ☐HSA ☐FSA ☐HRA ☐None

Is the patient covered by additional/secondary insurance? ☐Yes ☐No Name of Insurance Company:_____

Who is the main/subscriber or policy holder? ☐Self ☐Other

Subscriber Name:_____ Relationship to Patient:_____ Subscriber Birth Date:_____

9 Additional Clinical Comments

Clinical Comments: _____

Examiner's Name: _____ Examiner's Signature: _____ Date: _____

Physician/Provider Name: _____ Physician/Provider Signature: _____ Date: _____

Patient Informed Consent Form

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both the patient and chiropractor to be working towards the same objective. Chiropractic has only one goal: to alleviate vertebral subluxation, thus minimizing interference to the nervous system and restoring optimal health. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

***Vertebral Subluxation*:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

***Adjustment*:** The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Chiropractic care, like all forms of healthcare, offers considerable benefits and may also carry some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications reported secondary to chiropractic care include sprain/strain injuries, muscle spasms for short periods of time, aggravation temporary increase in symptoms, lack of improvement in symptoms, dislocations, disc injuries, and rarely, and/or fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. You cannot expect the doctor to be able to anticipate and explain all risks and complications, and you agree 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 your best interests.

Prior to your receiving chiropractic care from Chiro One, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another healthcare provider. All relevant findings will be reported to you, along with any recommended future chiropractic care, in a document known as your Care Plan Agreement.

We do not offer to diagnose or treat any disease regardless of what the disease is called, nor do we offer advice regarding treatment prescribed by others. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body maintain the adjustments.

If during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider. You understand and have been informed that you have the right to a second opinion and secure other opinions if you have concerns as to the nature of your symptoms and treatment options. You also understand that there are treatment options available for your condition other than chiropractic procedures. These treatment options include, but are not limited to; 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.

You hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies for yourself (or for the patient for whom you are the parent or legal guardian) by the Chiro One doctor of chiropractic and supporting healthcare staff. You acknowledge that you have had an opportunity to discuss with the Chiro One doctor of chiropractic the nature and purpose of chiropractic adjustments and procedures and that you understand and are informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure.

You hereby authorize the Chiro One Wellness Center providing chiropractic treatment to disclose, consult and/or discuss my diagnostic imaging with a third-party consultant, Medulla Diagnostic Services, a Chiro One

affiliate, for purposes of professional interpretation that the doctor may deem necessary to ensure accurate diagnosis and proper treatment. These external professional consultative services may be billed separately by Medulla Diagnostic Services as appropriate.

NO REVISIONS OR CHANGES TO THIS FORM, BY YOU, WILL BE ACCEPTED BY CHIRO ONE.

Once this form has been reviewed and accepted through our electronic check-in or signed in person, you acknowledge you have read, or have had read to you, the above Patient Informed Consent Form, and understand and agree to the provisions contained within. You have also had an opportunity to ask questions about its content, and by reviewing and accepting, you agree to the above-named procedures, and acknowledge that you are the patient (or the parent or legal guardian of the patient) seeking healthcare from Chiro One. You intend this consent to cover the entire course of treatment for your present condition and for any future condition(s) for which you seek treatment.

_____

Signature of Patient or Responsible Party; parent, guardian or other representative Time/Date

_____

Signature of Witness Time/Date

Payment Agreements & Authorizations

Payment and Assignment of Benefits

In consideration of any services provided by Chiro One in addition to those included in any pre-paid offer, you agree to: 1) certify that the payor information you have provided is accurate and up-to-date, 2) be primarily responsible for all charges owed to Chiro One, including attorney fees, court costs, and other expenses of collection, 3) irrevocably assign and transfer to Chiro One, all right, title, and interest to health insurance or reimbursement benefits to which you are entitled for the purpose of payment of the charges owed to Chiro One, and 4) authorize payment of such benefits directly to Chiro One, and authorize the use of your signature for this limited purpose.

If you have health insurance, you acknowledge that our verification of your health insurance benefits is only an estimate of benefits payable to you, if any, and that health insurance benefits may vary due to the coverage the plan sponsor offered or the coverage you purchased, you or the plan sponsor's failure to pay premiums, termination of the plan by the sponsor, your failure to otherwise remain eligible (e.g., not maintaining full-time employment status), error, and other causes. You further acknowledge that you are primarily responsible for all charges for services rendered, whether or not covered by health insurance.

If you have a health savings account (HSA), flexible spending account (FSA), or a health reimbursement account (HRA), you must inform us so that we can make appropriate arrangements for payment.

You acknowledge that our verification of health reimbursement benefits is only an estimate of benefits payable to you, if any, and that health reimbursement benefits may also vary. We do not directly bill to any HSA, FSA, or HRA plan, but, depending upon your plan provisions, automatic withdrawals may occur when we submit charges to any primary health insurer. Any refund or reimbursement to an HSA, FSA, or HRA account cannot exceed your out-of-pocket contribution toward any treatment. You further acknowledge that you are primarily responsible for all charges owed to Chiro One, whether or not eligible for health reimbursement benefits.

If you are a Medicare, Medicaid, or other government healthcare program participant, you assign, and request that payment of, all benefits be made on your behalf for healthcare services rendered, directly to us. You also authorize any holder of medical or other information about you to release to the Centers of Medicare and Medicaid Services or other applicable government program office and its agents, any information needed for payment of benefits.

Medicare Release

You certify that any information given by you as the Patient or Patient Representative in applying for payment under Title XVIII(18) of the Social Security Act is correct. You authorize any holder of medical or other information about you to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. You authorize payment or benefits to us on your behalf.

Medical Records Privacy and Consent to Release Information

Chiro One respects your privacy. We comply with the Health Insurance Portability and Accountability Act ("HIPAA"), and we may release your "protected health information," as defined by HIPAA, only as allowed by law, such as:

- For your treatment and care coordination;
- To obtain payment for your healthcare;
- To your family, friends, or others you identify who are involved with your healthcare or your healthcare bills, unless you object; or
- In response to a subpoena, court order, or otherwise in connection with a claim, lawsuit, or proceeding in which you are involved.

Payment Agreements & Authorizations

We do not sell any of your “protected health information” for marketing or any other purpose. Accordingly, you consent to us releasing your “protected health information” only as allowed by law. You also acknowledge receipt of Chiro One’s Notice of Privacy Practices, available on our website at https://www.chiroone.com/privacy-policy-page/ .

General Conditions

You are responsible for your personal property while on our premises. The only time we are responsible for any personal property on our premises is when we accept it from you for safekeeping and acknowledge it in writing.

As the healthcare you are seeking is non-emergency care, you acknowledge that we have the right to decline treatment in our sole discretion.

We do not discriminate on the basis of any legally protected classification.

You acknowledge that all references in this document to “Chiro One” shall include its third-party consultant, Medulla Diagnostic Services, a Chiro One affiliate, which you authorized under the Patient Informed Consent may be consulted for professional services, if medically necessary.

NO REVISIONS OR CHANGES TO THIS FORM, BY YOU, WILL BE ACCEPTED BY CHIRO ONE.

Once this form has been reviewed and accepted through our electronic check-in or signed in person, you acknowledge you have read, or have had read to you, the Patient Informed Consent Form, and understand and agree to the provisions contained within. You have also had an opportunity to ask questions about its content, and by reviewing and accepting, you agree to the above-named procedures, and acknowledge that you are the patient (or the parent or legal guardian of the patient) seeking healthcare from Chiro One. You intend this consent to cover the entire course of treatment for your present condition and for any future condition(s) for which you seek treatment.

_____

Signature of Patient or Responsible Party; parent, guardian or other representative Time/Date

_____

Signature of Witness Time/Date