Acct#: ___________

Today's Date: __________ Email:________________________________ Gender: M F
Name:__________________________________ Date of Birth: __________ Age: ________
Your Address: ______________________________________ City: ______________
State:______________________ Zip: ________ SS# ____________ Hm#: ____________
Name of Employer: ____________________________________ Wk#: ____________
Marital Status: S M W D Referred by: ______________________ Cell# ____________
How Many Children Do You Have? ___________ What Are Their Ages? ______________
Emergency Contact: ____________________________ Phone#: ______________
Who is Responsible For Your Bill? ☐Self ☐Spouse ☐Worker's Compensation ☐Medicaid
☐Medicare ☐Auto Insurance ☐Personal Health Insurance ☐Other:______________
Purpose or Reason For Today's Appointment: ______________________________________
How Often Do You Drink Alcoholic Beverages? ______________
Do You Smoke? Yes No How Much? ______________
Do You Exercise? Yes No How Much? ______________ Type? ______________
Do You Have Any Allergies? Yes No Specify: ______________________________________

Have You Ever Suffered From or Been Diagnosed As Having: (check yes or no for each)

Y	N	Condition	Y	N	Condition	Y	N	Condition
		Broken Bone			Diabetes Type I or II*			Osteoarthritis
		Circulation Problems			Epilepsy			HIV Positive
		Rheumatoid Arthritis			Pacemaker			Gall Bladder
		Seizures/Convulsions			Strokes			Head Problems*
		Congenital Disease			Cancer/Tumors*			Depression
		Excessive Bleeding			Ulcers			Headaches
		High/Low Blood Pressure			Coughing Blood			Fatigue
		Stress			Fibromyalgia			Edema
		Blood Clots			Hepatitis			Alcohol/Drug

*Explain:____
____
____

Medication List

Drug	Vitamin/Supplement	Date Started	Date Stopped

Doctor's Notes:

HT: __________ WT: __________ B/P: __________ BPM: __________ RESP: __________

Date: ________ Patient Name: ______________________ Account# ____________

PATIENT HISTORY

Complaint #1: ____________________________ When did it start? ______________

Circle the current **pain level** of your complaint: 0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

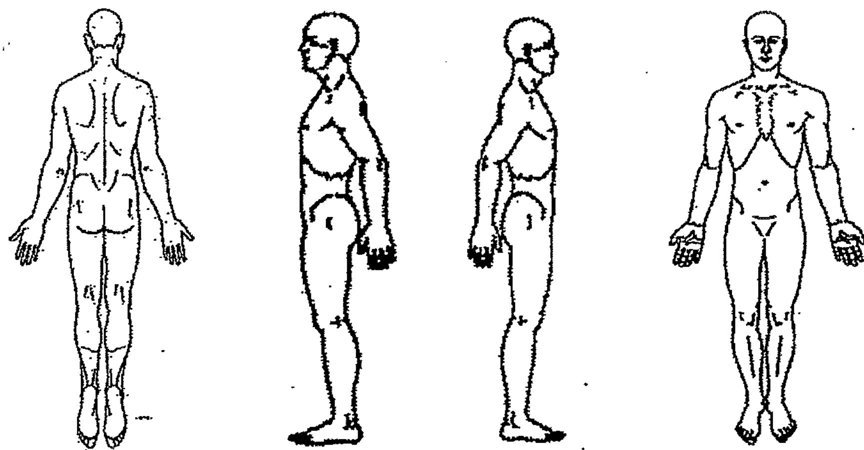
Circle the **percentage** of time you experience the complaint: 0 10 20 30 40 50 60 70 80 90 100 %
Occasional Intermittent Frequent Constant

When do you feel it most? ? AM ? PM When present, how long does the complaint last? _____min _____Hrs

What makes you feel better? ____________________ What make if feel worse? __________________

Using the letters below, please show where you are experiencing all of your complaints on the diagram:

A. Ache
B. Burning
C. Cramping
D. Dull Pain
F. Stiffness
N. Numbness
R. Throbbing
S. Soreness
T. Tingling
X. Sharp Pain



Do you currently have pain and/or difficulty performing any of the following activities? (Circle Y or N)

Activity			Activity		
Walking	? Y	? N	Bending	? Y	? N
Sleeping	? Y	? N	Kneeling	? Y	? N
Sitting	? Y	? N	Lifting Children	? Y	? N
Personal Grooming	? Y	? N	Lifting Objects	? Y	? N
Standing	? Y	? N	Running	? Y	? N
Driving	? Y	? N	Exercising	? Y	? N
Housework	? Y	? N			

1. Have you ever had the condition(s) in the past? ? Yes ? No If yes, please indicate if any treatment was received and what type of treatment: ? Hospitalization ? Chiropractic care ? Medical doctor / specialty provider ? None
2. Have you ever lost time from work due to your condition(s)? ? Yes ? No If Yes, dates? ______________
3. Are you pregnant? ? Yes ? No
4. What was the first day of your last menstrual cycle? ____________________
5. Number of pregnancies? _________ Number of miscarriages? __________

Patient Signature ____________________________ **Date:** ____________ **Physician Initials:** _____

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:________________________ **Last Name:**________________________

Email address: ________________________@________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ______________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date: _____________

For office use only:

Height: ________ Weight:__________ Blood Pressure:_____/_____

Respirations: __________ Pulse: _________

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Medical doctors, chiropractic doctors, osteopath and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I, ________________________, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, exercises, Graston, traction and other therapeutic modalities may also be used.

Although spinal manipulations/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

I have read or have read to me the above explanation of chiropractic treatment. Any questions I had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

______________ ______________________________

Date Patient Signature

______________ ______________________________

Date Witness of Patient Signature

Policies and Authorizations

1. Major Medical Insurance Policy: ____________________ (patient name) authorize Dr. A. Plante and Dr. M. Chen to bill, represent and/or appeal any decision that would dent payment for this office from your ________________________ (insurance company.) If your insurance company denies payment for any service rendered by ChiropracticUSA and does not comply with the information given to us at the time of insurance verification for those services. You will only be responsible for up to a maximum of $70.00/visit. __________
2. Massage Policy: I, ________________________ (patient name) understand due to limited availability of appointments, any cancellations made within **48 hours** will result in **full charge** for the appointment. There will be no exceptions, so please schedule accordingly. ____________
3. Health Care Authorization: ______________________ (patient name) authorizes ChiropracticUSA to use and/or disclose protected health information in accordance with the following:
   a. I give ChiropracticUSA permission to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday cards and information about treatment alternatives or other health related information. ____________
   b. I give ChiropracticUSA permission to share my name on the display screens, white boards and other media in the office. ___________
   c. I give ChiropracticUSA permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations. ___________
   d. You have the right to revoke this authorization in writing at anytime. It can be mailed or hand delivered to the office. It must include your name, SS#, DOB, your intent to revoke this authorization, the date of your request and your signature. __________
4. I acknowledge that I have received and read a copy of the practice HIPAA (Health Insurance Portability and Accountability Act) documents. __________
5. I authorize ChiropracticUSA to share my health information with the following:
   a. ________________________________ (name) _____________________ (ph #)
   b. ________________________________ (name) _____________________ (ph #)
   c. ________________________________ (name) _____________________ (ph #)

______________________________   ______________________________

Patient Name   Patient Signature

ChiropracticUSA™

Amber A. Plante, D.C. Mark H. Chen, D.C. Kaycie Hartley, D.C.

Date:______________

RELEASE OF PATIENT RECORDS AUTHORIZATION

I HEREBY AUTHORIZE__________________________________ (name of practice) to release a copy of my records and/or x-rays containing protected health information to __________________________________. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical records without the expressed written consent of the patient or the patient's legal representatives.

__________________________________ __________________________

Patient's Name (Print) Patient's Date of Birth

__________________________________ __________________________

Patient's or Legal Representative's Signature Patient's Social Security Number

Specific description of information to be disclosed:

____

____

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