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2481 Valleydale Road, Suite A, Birmingham, AL 35244

## PATIENT INTAKE FORM

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex:  Male  Female

Email \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Referred By \_\_\_\_\_

Patient Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Other \_\_\_\_\_

Spouse Name \_\_\_\_\_ Children \_\_\_\_\_

Have you had chiropractic care?  Yes  No Reason for Visit \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Date of onset: \_\_\_\_\_

How did your problem begin? \_\_\_\_\_

How would you describe your pain? (check all that apply)

- Sharp  Soreness  Throbbing  Tingling  Dull  Spasm  
 Stiffness  Burning  Ache  Weakness  Numbness  Shooting

Since your problem began, is the pain:  Getting worse  Getting better  Staying the same

How would you rate the intensity of your pain? (circle number below)

0      1      2      3      4      5      6      7      8      9      10  
(no pain)------(moderate pain)------(terrible/unbearable pain)

How often is the pain present?

- Constant (81-100%)  Frequent (51-80%)  Occasional (28-50%)  Intermittent (25% or less)

Does coughing, sneezing or deep breathing aggravate your problem? \_\_\_\_\_

What aggravates your condition? \_\_\_\_\_

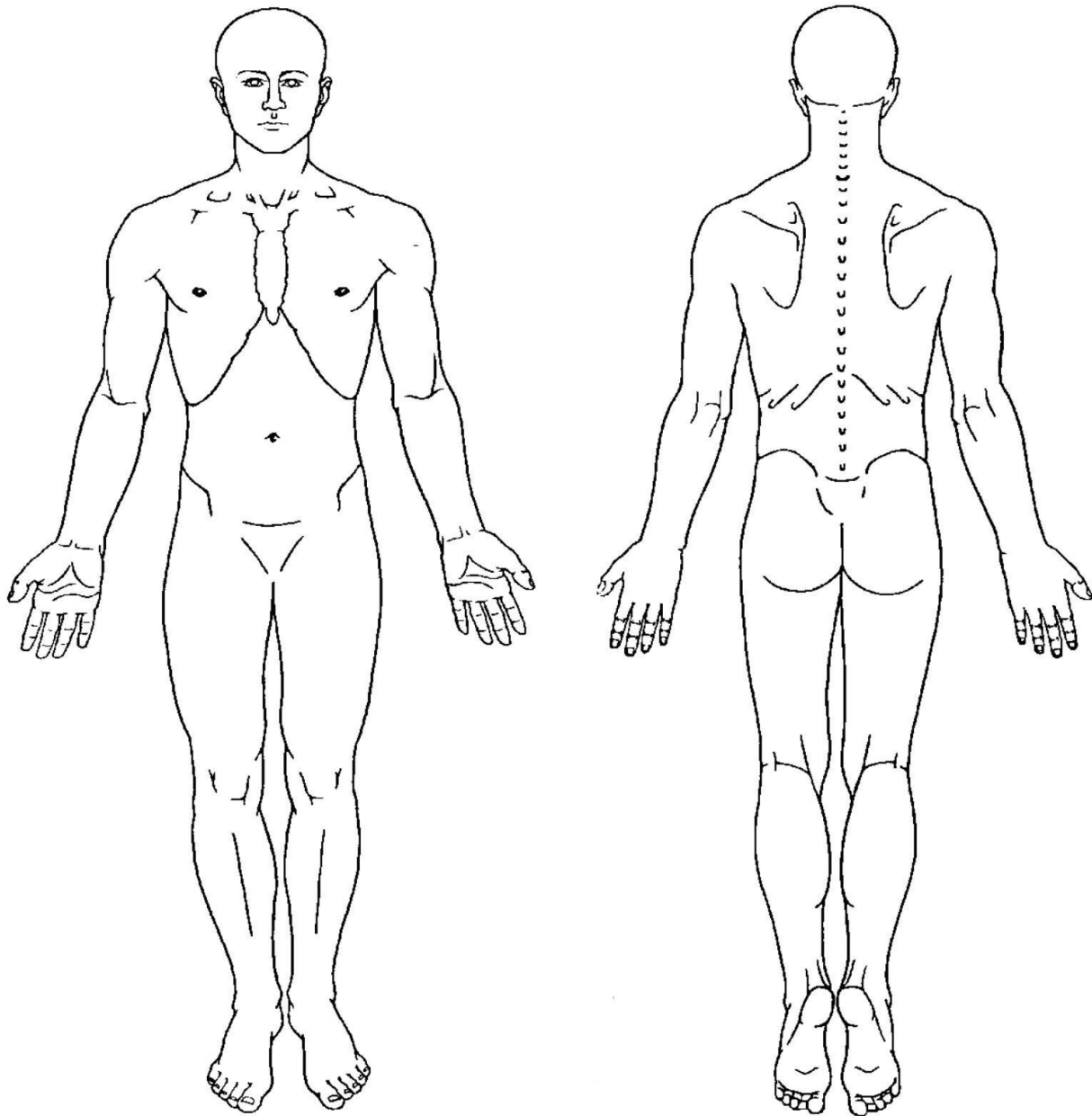
What has the lack of health kept you from doing in your life? \_\_\_\_\_

\_\_\_\_\_

What do you hope to achieve on your first visit with us today? \_\_\_\_\_

\_\_\_\_\_

PLEASE INDICATE ON THE FIGURES BELOW WHAT AREAS BEST REPRESENT YOUR CONDITION:



# CONSENT TO USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS.

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By signing below, you hereby consent for Family Wellness Chiropractic, LLC (the "Practice") to use or disclose information about you (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment and health care operations. You may refuse to sign this consent form. You should read the Notice of Privacy Practices for PHI, available at the front desk, before signing this consent. The terms of the Notice may change from time to time. And you may always get a revised copy of it by asking the front desk for a copy.

You also have the right to request that the Practice restrict how your PHI is used or disclosed in carrying out our treatment, payment or health care operations. Please be aware, however, that the Practice is not required to agree to those requested restrictions. Should the Practice agree to your requested restrictions, though, the restrictions are binding.

Information about you is protected under federal law and you have the right to revoke this consent at any time. This revocation will not apply to action(s) the Practice has already taken in reliance on your consent (as determined by our privacy officer). By signing below, you recognize that the PHI used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Family Wellness Chiropractic, LLC. may communicate information, including payment invoices and appointment reminders to me at the following address and/or phone numbers. I understand that I need not supply either, provided I do not wish to be contacted by the Practice. In such case, I agree to pay for all charges incurred during my visit at the time of service.

The Practice may send correspondence to me at the address listed in my patient information.

The Practice may leave messages at the following numbers:

_____	_____
_____	_____

I authorize the following person(s) to communicate with the practice on my behalf:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse Signature \_\_\_\_\_ Date \_\_\_\_\_

# PATIENT CONSENT TO USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

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I, \_\_\_\_\_, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. Family Wellness Chiropractic, LLC (FWC) Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information (PHI) necessary for FWC to provide treatment to me and also necessary for FWC to obtain payment for that treatment and to carry out health care operations. FWC explained to me that the Privacy Notice will be available to me in the future at my request. FWC has further explained to me 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 my signing this consent. FWC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

2. I understand, that and consent to , the following appointment reminders or communications that will be used by FWC:

- Telephoning my home and/or office and leaving a message on my answering machine or with the individual answering the phone
- Birthday cards, thank you grams, E-mail messages or Sign-in sheets
- Other health related benefits or services that may be of interest to me

3. FWC may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for FWC to treat me an obtain payment for that treatment, and as necessary for FWC to conduct its specific health care operations.

4. I understand that I have the right to request how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, FWC is not required to agree to any restrictions that I have requested. If FWC agrees to a requested restriction, then the restriction is binding on FWC.

5. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that FWC has already taken action in reliance on this consent.

\_\_\_\_\_  
Name of Individual (printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative\*

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness

\*Attorney-in-fact, Guardian, Parent of Minor