Mitchell Chiropractic
2098 Teron Trace, Suite 300
Dacula, GA 30019

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ M.I.___ **Last Name:**_____

Email address: _____@_____

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

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

Current Address: _____ **City:** _____

State: _____ **Zip:** _____ **SS#:** _____ **Home #:** _____

Cell #: _____ **Employer:** _____ **Occupation:** _____

Work #: _____ **Marital Status:** _____ **Spouse's Name:** _____

Spouse Phone #: _____

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

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Low Back, Hip, Neck pain/ muscle pain				

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

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

Are you currently taking any medications?	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Medication	Reaction

☐ **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.)*

Present Health

My present symptoms are: _____

_____

Purpose of this appointment: _____

When did the condition begin: _____

Job Related: _____ Auto Related: _____ Date of Accident: _____

List any recent major traumas: _____

List any recent surgeries: _____

List any medical conditions/ issues: _____

_____

If applicable, are you pregnant: _____ Yes _____ No

Describe your current exercise regimen: _____

_____

MITCHELL CHIROPRACTIC

PRIMARY INSURANCE INFORMATION

Primary Insurance Company:_____ Phone:_____
Address:_____ City:_____ State:____ Zip:_____
Relationship of insured to the patient: ____ Self ___ Spouse ___ Child ___ Other
Name of insured person:_____ Insured date of birth:_____
Address:_____ City:_____ State:____ Zip:_____
Phone # of insured:_____ SS# of insured:_____
Insurance Group Name:_____ Group #:_____ Policy #:_____

SECONDARY INSURANCE INFORMATION

Insurance Company:_____Phone:_____
Address:_____ City:_____ State:___ Zip:_____
Relationship of insured to the patient: ____ Self ___ Spouse ___ Child ___ Other
Name of insured person:_____ Insured date of birth:_____
Phone # of insured:_____ SS# of insured:_____
Insurance Group Name:_____ Group #:_____ Policy #:_____

INSURANCE INFORMATION FOR AUTOMOBILE ACCIDENTS

Insurance Company: _____ Phone:_____
Address:_____ City:_____ State:____ Zip:_____
Name of Claim Adjuster:_____ Claim Number:_____
Is this a Med-pay or Liability Claim?:_____

Attorney:_____ Attorney Phone:_____

ATTENTION: Auto Claims- I hereby authorize the staff at Mitchell Chiropractic to discuss with the attorney above any information pertaining to my auto case. **Initials:**____

I understand that insurance is being filed as a courtesy for me. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered and that any amount authorized to be paid directly to Mitchell Chiropractic will be credited to my account upon receipt. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Co-pays, coinsurance, or any amounts applied to your deductible are due at time of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

PATIENT SIGNATURE:_____ DATE:_____

GUARDIAN SIGNATURE:_____ DATE:_____

Mitchell Chiropractic

2098 Teron Trace, Suite 300
Dacula, Ga. 30019
Phone: (770)614-4060
Fax: (678)482-7788

Informed Consent to Medical or Chiropractic Treatment and Care

I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment or soreness after a massage. If that happens, I will apply ice to the area and rest it. If I am concerned about the discomfort or develop any new symptoms, I can call the number listed above during office hours for an emergency appointment. If any tests were performed outside the office (laboratory or other diagnostic procedures), I understand that if available, the doctor will notify me of the results at my next appointment.

I hereby request and consent to the performance of chiropractic adjustments and other treatment procedures, including various modes of physiological therapies and, if necessary diagnostic x-rays on by my doctor. I have had an opportunity to discuss with the doctor(s), and/or with other office of clinic personnel, the nature and purpose of chiropractic and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, included but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish 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 known, is in my best interest.

I have read the above consent to chiropractic and/or medical treatment as indicated by my signature. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this form to cover the entire course of treatment for my present and for any future conditions for which I seek treatment.

Patient's Signature: _____ Date: _____

Patient's Name: _____ Date: _____

Please Circle the appropriate letter next to each item based on the following:

Y= a condition you have now **N**= never had **P**= a condition you have had in past

Neck Pain	Y	P	N	Emphysema	Y P N
Back Pain	Y	P	N	Difficulty Breathing	Y P N
Lower Back Pain	Y	P	N	Shortness of Breath	Y P N
Extremity Pain	Y	P	N	Heart Disease	Y P N
Chest Pain	Y	P	N	Angina	Y P N
R/L Arm Pain/ Tingling	Y	P	N	High Blood Pressure	Y P N
R/L Leg Pain/Tingling	Y	P	N	Fasciotomy	Y P N
R/L Foot Pain/Tingling	Y	P	N	Edema	Y P N
R/L Hand Pain/Tingling	Y	P	N	Arthroplasty (prosthetic replacement)	
Fingers/Toes Pain/Tingling	Y	P	N		Y P N
Spasms	Y	P	N	Nausea	Y P N
Dizziness	Y	P	N	Vomiting	Y P N
Vision Disturbance	Y	P	N	Constipation	Y P N
Motion Restriction	Y	P	N	Blood in Stool	Y P N
Radiating Symptom	Y	P	N	Gas/Bloating	Y P N
Sleep Disruption	Y	P	N	Liver Disease	Y P N
Anxiety	Y	P	N	Hemorrhoids	Y P N
Night Sweats	Y	P	N	Abdominal Pain	Y P N
Headaches	Y	P	N	Peptic Ulcer	Y P N
Head Injury	Y	P	N	Gall Bladder Disease	Y P N
Impaired Vision	Y	P	N	Pain on Urination	Y P N
Corrected Vision	Y	P	N	Urinary Frequency	Y P N
Depression	Y	P	N	Ligament or Tendon repair, not	
Tearing/Dryness	Y	P	N	arthroscopy, Arthrotomy	Y P N
Double Vision	Y	P	N	Kidney Stones	Y P N
Pallectomy	Y	P	N	Blood in Urine	Y P N
Cataracts	Y	P	N	Joint Pain/Stiffness	Y P N
Impaired Hearing	Y	P	N	Arthritis	Y P N
Ear Ringing	Y	P	N	Broken Bones	Y P N
Earaches	Y	P	N	Muscle Spasms	Y P N
Frequent Colds	Y	P	N	Deep Leg Pain	Y P N
Sinusitis	Y	P	N	Thrombophlebitis	Y P N
Postnasal Drip	Y	P	N	Aspiration of Hematoma	Y P N
Change in Taste	Y	P	N	Fainting	Y P N
Goiter	Y	P	N	Seizures	Y P N
Cough	Y	P	N	Paralysis	Y P N
Sputum	Y	P	N	Muscle Weakness	Y P N
Spit up Blood	Y	P	N	Numbness/Tingling	Y P N
Asthma	Y	P	N	Coordination Difficulties	Y P N
Bronchitis	Y	P	N	Depression	Y P N
Pneumonia	Y	P	N	Anxiety	Y P N

Mood Swings	Y P N
Memory Loss	Y P N
Drug/Alcohol Abuse	Y P N
Difficulty Sleeping	Y P N
Phobia	Y P N
Thyroid Problem	Y P N
Extremity Pain – Numbness	Y P N
Arthrotomy, Meniscectomy, cruciate	Y P N
Excessive Thirst	Y P N
Excessive Hunger	Y P N
Anemia	Y P N
Easy Bleeding	Y P N

Females Only

Age menses began	_____
Age menses ended	_____
Average cycle length	_____
Average bleeding length	_____
Spotting	Y P N
Irregular Cycles	Y P N
Painful Menses	Y P N
Birth Control	Y P N
Sexual Difficulties	Y P N
STD	Y P N
Breast Lumps	Y P N
Breast Pain	Y P N
Nipple Discharge	Y P N
PMS Symptoms	Y P N
Menopausal Symptoms	Y P N
Vaginal Dryness	Y P N
Vaginal Discharge/Sores	Y P N
Number of pregnancies	_____
Number of live births	_____
Number of miscarriages	_____

Males Only

Hernias	Y P N
Testicular Masses	Y P N
Testicular Pain	Y P N
Sexual Difficulties	Y P N
STD	Y P N
Penile Discharge/Sores	Y P N
Prostate Disease	Y P N

Are there any additional health concerns or questions you have?

_____
_____
_____
_____
_____
_____
_____

Please describe a poor experience with a health practitioner you have had in the past.

_____
_____
_____
_____
_____

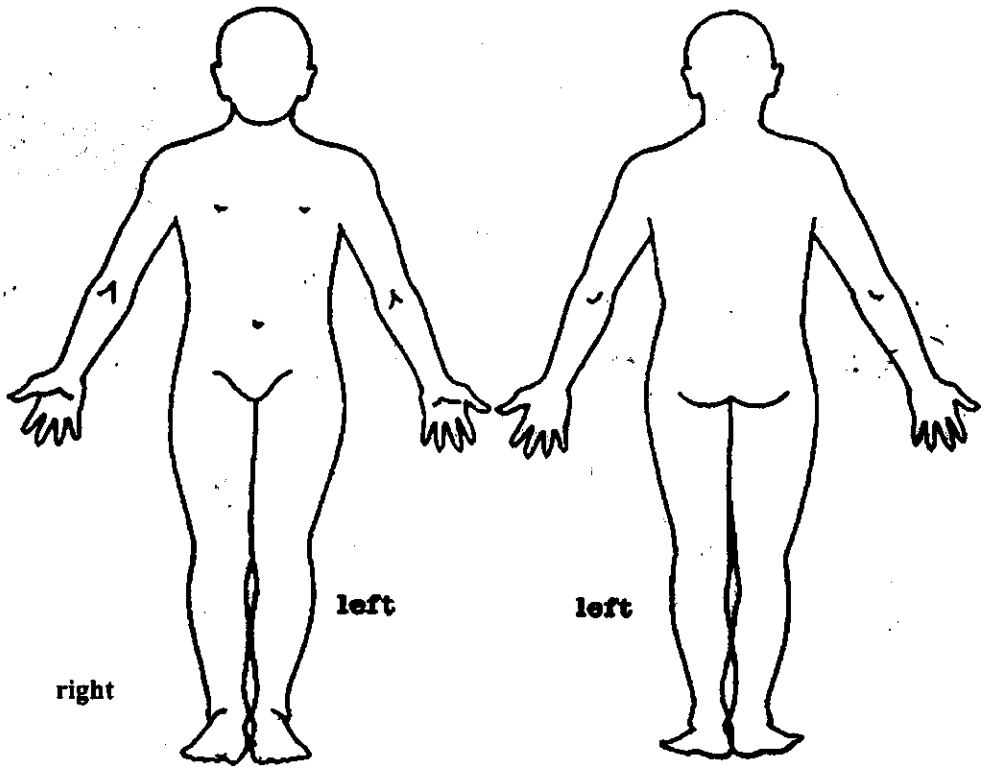
Please describe a good experience with a health practitioner you have had in the past.

_____
_____
_____
_____

Use the pictures below to indicate your problem areas. Use the appropriate symbol to indicate numbness, pins & needles, burning, stiffness, aching, or stabbing pain.

Numbness: □ Stabbing pain: ↑ Pins & Needles .-.

Aching pain: + Burning: # Stiffness: u



Please rate your discomfort on a scale of 1-10.
(1= mild pain, 10=the worse pain you've ever felt).

	Location	Pain rating	Duration
1			
2			
3			
4			
5			
6			
7			
8			

Assignment of Benefits- Redirection of Payments- Waiver of Anit-Assignment Clause

Patient Name: _____

Insurance Company: _____

I hereby authorize the above named insurance company/ companies to assign directly all benefits payable. I make this an irrevocable assignment of benefits. I understand that any insurance checks issued belong to BENJAMIN C MITCHELL, D.C., and or MITCHELL CHIROPRACTIC for services rendered and I agree to endorse them over should I receive them or otherwise repay any amounts paid to me. Failure to do so will result in legal action.

I (we) am (are) aware that if payment is not made within a reasonable amount of time by the insurance carrier(s), that the matter is submitted to a collection agency/attorney, I (we) will be responsible for payment of all costs associated with that collection activity, including but not limited to reasonable attorney's fee's, and court costs.

I fully understand that once the account is past due the practice reserves the right to begin adding interest at 1% per month simple interest, and if sent to collection, I (we) will be responsible for costs for collection agents and/or reasonable attorneys fees and/or costs of litigation.

Patient SIGNATURE: _____ Date: _____

Insured SIGNATURE: _____ Date: _____

ASSIGNMENT OF BENEFITS AND LTD. POWER OF ATTORNEY

I **irrevocably assign** to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, my medical provider.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case in my name including filing an arbitration demand or lawsuit. I specifically authorize that to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due to you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any money due to you for medical services rendered to me.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Dated: _____

_____

Patient Signature

Patient Name: _____ Date: _____/_____/20___

Loss of Enjoyment Summary

Complete the following questionnaire as it relates to the **activities** (work related or otherwise) **you normally would be enjoying** - but are **currently not enjoying** as a result of your injury(s).

Include all activities which you:

- can no longer do or perform, and/or
- cannot do or perform as often as you did before your injury

Job description _____

N/A	**Work**	**Reason for the limitation**		
_____	Lifting	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Bending	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Walking	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Computer duties	□ Increased Pain	□ Restricted movement	□ Fatigue
Other: _____		□ Increased Pain/Anxiety	□ Restricted movement	□ Fatigue

N/A	**Studies/School**	**Reason for the limitation**		
_____	Lifting	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Bending	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Sitting	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Walking	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Computer duties	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Studying	□ Increased Pain	□ Restricted movement	□ Fatigue
Other: _____		□ Increased Pain	□ Restricted movement	□ Fatigue

N/A	**Domestic Duties**	**Reason for the limitation**		
_____	Vacuuming	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Taking care of kids	□ Increased Pain/Anxiety	□ Restricted movement	□ Fatigue
_____	Cleaning	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Preparing Meals	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Other: _____	□ Increased Pain	□ Restricted movement	□ Fatigue

N/A	**Household Duties**	**Reason for the limitation**		
_____	Yardwork	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Transportation	□ Increased Pain/Anxiety	□ Restricted movement	□ Fatigue
_____	Shopping	□ Increased Pain/Anxiety	□ Restricted movement	□ Fatigue
_____	Taking out trash	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Other: _____	□ Increased Pain	□ Restricted movement	□ Weakness

N/A	**Sports**	**Reason for the limitation**		
Name Sport: _____		□ Increased Pain	□ Restricted movement	□ Weakness
Pre-accident level of participation:		□ Social	□ Competitive	□ Professional

Patient Name: _____ Date: ___/_____/20___

Duties Under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day-to-day **living duties, which are painful or difficult for you to perform as a result of the injuries** you sustained in the motor vehicle collision. Then checkmark the appropriate box designating reason for difficulty. Include those duties/responsibilities, which require that you reduce the time you are capable of performing them.

Job description: _____

N/A	**Work**	**Reason for the difficulty**		
_____	Lifting	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Bending	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Sitting	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Walking	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Computer duties	□ Increased Pain	□ Restricted movement	□ Fatigue
Other: _____		□ Increased Pain	□ Restricted movement	□ Weakness

N/A	**Studies/School**	**Reason for the difficulty**		
_____	Lifting	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Bending	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Sitting	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Walking	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Computer duties	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Studying	□ Increased Pain	□ Restricted movement	□ Fatigue
Other: _____		□ Increased Pain	□ Restricted movement	□ Weakness

N/A	**Domestic Duties**	**Reason for the difficulty**		
_____	Vacuuming	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Taking care of kids	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Cleaning	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Preparing Meals	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Other: _____	□ Increased Pain	□ Restricted movement	□ Fatigue

N/A	**Household Duties**	**Reason for the difficulty**		
_____	Yard work	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Transportation	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Shopping	□ Increased Pain	□ Restricted movement	□ Fatigue
_____	Taking out trash	□ Increased Pain	□ Restricted movement	□ Weakness
_____	Other: _____	□ Increased Pain	□ Restricted movement	□ Fatigue