Circle of Life Chiropractic New Patient Intake Forms

Patient Data **Date** _____

Title: (Check one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ **Middle Initial** ___ **Last Name** _____

I prefer to be called by _____

Address Line _____

City _____ **State** _____ **Zip Code** _____

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Cell Phone (____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** Male Female

Occupation _____

Marital Status: Single Married Other

Race: White Asian Black/ African American Indian Native Hawaiian Decline to Answer

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to Answer Unknown

What is your highest level of education _____

Emergency Contact _____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____-_____ **Cell Phone** (____) _____-_____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

Arthritis Cancer Diabetes Heart Disease
Hypertension Psychiatric Illness Skin Disorder Stroke

Other _____

Weight:_____ **Blood Pressure:**_____

Height: _____ **Heart Rate:**_____

Temperature_____

Surgeries: (Check all that apply to you)

Appendectomy Cardiovascular procedure Cervical spine Hysterectomy
Joint Replacement Prostate Lumbar spine Gall Bladder
Brain Shoulder Thoracic spine Knee
Carpal Tunnel Gastro-intestinal Uro-genital Hernia
Other _____

Have you had any lab work done in the past 6 months?:

*Yes No

*If yes, please list below:

Allergies: (List any allergies)

Social History: (Check all that apply to you)

Caffeine use: occasional often never
Drink Alcohol: occasional often never
Exercise: occasional often never
Tobacco Use: occasional often never How long?
Sleep: Hours per night= _____
Stress Level: High Moderate Low None

Health History (Circle all that apply)

AIDS/HIV	Cataracts	Hepatitis	Osteoporosis
Alcoholism	Chemical Dependency	Hernia	Pacemaker
Allergy Shots	Chicken Pox	Herniated Disc	Parkinson's Disease
Anemia	Depression	Herpes	Pinched Nerve
Anorexia	Diabetes	High Cholesterol	Pneumonia
Appendicitis	Emphysema	Kidney Disease	Polio
Arthritis	Epilepsy	Liver Disease	Prostate Problems
Asthma	Fractures	Measles	Prosthesis
Bleeding Disorders	Glaucoma	Migraine Headaches	Rheumatoid Arthritis
Breast Lump	Goiter	Miscarriage	Rheumatic Fever
Bronchitis	Gonorrhea	Mononucleosis	Scarlet Fever
Bulimia	Gout	Multiple Sclerosis	Stroke
Cancer	Heart Disease	Mumps	Tumors, Growths
Suicide Attempt	Thyroid Problems	Tonsillitis	Tuberculosis
Typhoid Fever	Ulcers	Venereal Disease	Whooping Cough
Scoliosis	C-section	Other	

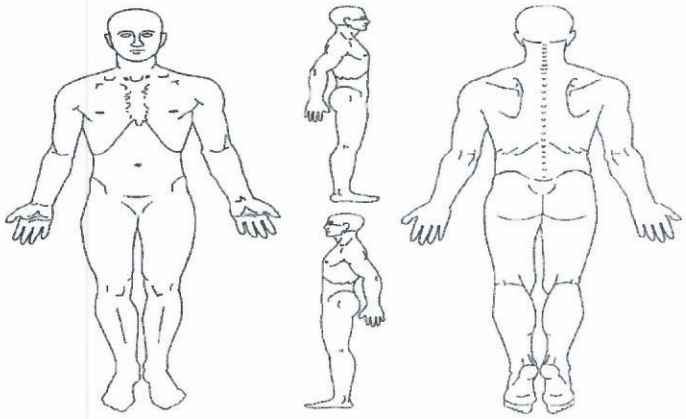
Please list **ALL** current medications and/or supplements being taken:

_____

_____

Are you pregnant? Yes___ No ____N/A____ Nursing? Yes____ No____ Taking Birth Control? Yes____ No____

By using the key below, indicate on the body diagram where you are experiencing pain:



Please Rate your pain for the following:

Neck	1	2	3	4	5	6	7	8	9	10
Mid-Back	1	2	3	4	5	6	7	8	9	10
Low Back	1	2	3	4	5	6	7	8	9	10
Headaches	1	2	3	4	5	6	7	8	9	10

Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

When did you first notice the symptoms?_____

Is the condition getting progressively worse_____

Is the pain constant or does it come and go? _____

What treatment have you received for your condition? Surgery Medication Physical Therapy Other_____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Circle of Life Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, I authorize the use of my signature on all insurance submissions.

Circle of Life Chiropractic may use my health care information and may disclose such information to above- named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below:

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to patient

NEW PATIENT REGISTRATION

DR. DIANE CAPONE

Please print clearly to help avoid billing errors

Patient Last Name **First** **MI**

Mailing Address **Apt or Unit #**

City **State** **Zip code**

Home Telephone **Cell Number** **Work Telephone** **Email**

Date of Birth **Age** **Social Security**

Marital Status: Single Married Divorced Other **Sex: Male Female**

Employment Status: Employed Full Time Employed Part Time Full Time Student Unemployed Retired

GUARANTOR NAME- person to bill if other than patient

Mailing Address **Apt or Unit #**

City **State** **Zip code**

Assignment and Release: *I hereby authorize and direct my insurance benefits to be paid directly to Dr. Diane Capone and I understand I will be held financially responsible for any and all non-covered services provided by Dr. Capone.*

Signature:_____ **Date:**_____

**********Below for Office Use Only**********

New Patient's Initial Visit

DIAGS: (1)_____ (2)_____ (3)_____ (4)_____

NEW EXAM: 9920__	9894__	97110	97112	97140	97124	97012
	Manip.	Thera Ex.	Neuro-Ed	TriggerPt.	Massage	Mech. Trac.

MEDICARE PATIENTS ONLY: Date of current illness:_____

Amount Paid this Visit: $_____ ☐ Check Box to **BLOCK PATIENT STATEMENTS**

Informed Consent to chiropractic treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands to perform an adjustment order to realign your vertebrate. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", you may also feel movement of the joint.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. A minority of patients may notice muscle stiffness or soreness after the first few days of adjustments similar to after a new workout. Rare complications, while extremely unlikely, can include a fracture, ligamentous sprain, or injury to intervertebral discs. These complications are only seen with inherent weakness in the body already present. Our exam process is designed to pick up these red flags.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as very rare, about as often as complications are seen from taking a single aspirin tablet.

Other Treatment Options: No other profession is trained to find and correct your subluxations.

Risks of Remaining Untreated: Delay of treatment allows degenerative changes to continue and these changes can further reduce skeletal mobility and increase nerve irritation. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

No Warranty: I understand that my doctor at Circle of Life Chiropractic, cannot make any promises or guarantees regarding improvement in my condition. I understand that my doctor will share with me his/her opinion regarding potential results from chiropractic care and will discuss treatment options with me. I have read the explanation above of chiropractic care. I have had the opportunity to have questions answered to my satisfaction. I have fully evaluated the risks and benefits of chiropractic care and have freely decided to undergo the recommended care plan. And hereby give my full consent to receive chiropractic care.

Printed Name Signature Date

CONSENT TO TREAT MINOR- For use when applicable: I hereby authorize Circle of Life Chiropractic doctors of chiropractic, to administer chiropractic care, as deemed necessary, to my child.

Printed Name Signature Date

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act of 1996* (HIPPA), we are required to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that i have been offered a copy of Circle of Life Chiropractic's *Notice of Privacy Practices for Protected Health Information.*

Patient Printed Name

Date

Patient Signature

Authorized Provider Representative

Personal Representative Printed

Personal Rep. Signature

Description of Personal Representative's authority to act for the patient