PATIENT INTAKE FORM

ALL INFORMATION IS CONFIDENTIAL

BILAN CHIROPRACTIC

Patient Name:_____
(Last) (First) (MI)

Date:_____ **How were you referred to us?**_____

Mailing address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Business Phone:**_____ **Cell Phone:**_____

What type of case is responsible for today's problem? □ Workman's Compensation □ Auto Accident □ Personal Insurance □ Other

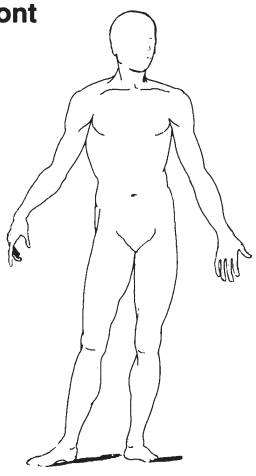
Are you personally insured? □ Yes □ No **Are we going to be billing your personal Insurance?** □ Yes □ No

Insurance Company:_____

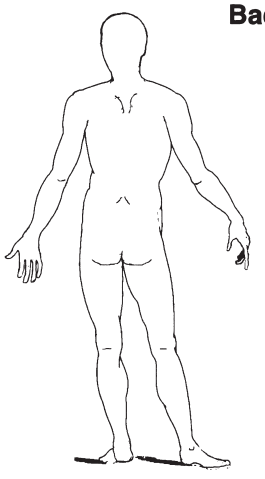
Policy ID:_____ **Group No.:**_____

Indicate on the drawings below where you have pain/symptoms:

Front



Back



You will have to answer questions about <u>each</u> of the different areas indicated on the above figures.

NECK

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Frequently (51-75% of the time) □ Occasionally (26-50% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain?

□ Sharp □ Numb □ Dull □ Tingly □ Diffuse
□ Sharp with motion □ Achy □ Shooting with motion □ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion □ Stiff □ Other:_____

How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist
□ Massage Therapist □ Physical Therapist □ Other:_____ □ No one

How long have you had this problem?_____

How do you think your problem began?_____

Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

What aggravates your problem?

□ Bending □ Sleeping □ While at Work □ Driving a Car □ Climbing Stairs
□ Working at a computer □ Flexing and extending □ Standing Up □ Golfing □ Stress
□ Playing Tennis □ Traveling □ Running □ Walking □ Sitting
□ Other:_____

What alleviates your problem? _____

What concerns you the most about your problem; what does it prevent you from doing? _____

_____

Mid Back

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Frequently (51-75% of the time) □ Occasionally (26-50% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain?

□ Sharp □ Numb □ Dull □ Tingly □ Diffuse
□ Sharp with motion □ Achy □ Shooting with motion □ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion □ Stiff □ Other:_____

How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist
□ Massage Therapist □ Physical Therapist □ Other:_____ □ No one

How long have you had this problem?_____

How do you think your problem began?_____

Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

What aggravates your problem?

□ Bending □ Sleeping □ While at Work □ Driving a Car □ Climbing Stairs
□ Working at a computer □ Flexing and extending □ Standing Up □ Golfing □ Stress
□ Playing Tennis □ Traveling □ Running □ Walking □ Sitting
□ Other:_____

What alleviates your problem? _____

What concerns you the most about your problem; what does it prevent you from doing? _____

_____

Low Back

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Frequently (51-75% of the time) □ Occasionally (26-50% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain?

□ Sharp □ Numb □ Dull □ Tingly □ Diffuse
□ Sharp with motion □ Achy □ Shooting with motion □ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion □ Stiff □ Other:_____

How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist
□ Massage Therapist □ Physical Therapist □ Other:_____ □ No one

How long have you had this problem?_____

How do you think your problem began?_____

Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

What aggravates your problem?

□ Bending □ Sleeping □ While at Work □ Driving a Car □ Climbing Stairs
□ Working at a computer □ Flexing and extending □ Standing Up □ Golfing □ Stress
□ Playing Tennis □ Traveling □ Running □ Walking □ Sitting
□ Other_____

What alleviates your problem? _____

What concerns you the most about your problem; what does it prevent you from doing?_____

What is your: **Age:** _____ **DOB:** _____ **Gender:** **M** **or** **F**

Marital Status: □ S □ M □ W □ D **How many children?**_____ **Name of** □ **Spouse or** □ **Parent**:_____

Email Address: _____**Emergency Contact:**_____

Occupation: _____ **Employer:**_____

How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	
□	□	Headaches
□	□	Neck Pain
□	□	Upper Back Pain
□	□	Mid Back Pain
□	□	Low Back Pain
□	□	Shoulder Pain
□	□	Elbow/Upper Arm Pain
□	□	Wrist Pain
□	□	Hand Pain
□	□	Hip Pain
□	□	Upper Leg Pain
□	□	Knee Pain
□	□	Ankle/Foot Pain
□	□	Jaw Pain
□	□	Joint Pain/Stiffness
□	□	Arthritis
□	□	Rheumatoid Arthritis
□	□	Cancer
□	□	Tumor
□	□	Asthma
□	□	Chronic Sinusitis

Past	Present	
□	□	High Blood Pressure
□	□	Heart Attack
□	□	Chest Pains
□	□	Stroke
□	□	Angina
□	□	Kidney Stones
□	□	Kidney Disorders
□	□	Bladder Infection
□	□	Painful Urination
□	□	Loss of Bladder Control
□	□	Prostate Problems
□	□	Abnormal Weight Gain/Loss
□	□	Loss of Appetite
□	□	Abdominal Pain
□	□	Ulcer
□	□	Hepatitis
□	□	Liver/Gall Bladder Dis.
□	□	General Fatigue
□	□	Muscular Incoordination
□	□	Visual Disturbances
□	□	Dizziness

Past	Present	
□	□	Diabetes
□	□	Excessive Thirst
□	□	Frequent Urination
□	□	Smoking/Tobacco Use
□	□	Drug/Alcohol Depend.
□	□	Allergies
□	□	Depression
□	□	Systemic Lupus
□	□	Epilepsy
□	□	Dermatitis/Eczema/Rash
□	□	HIV/AIDS
□	□	Other:_____
		For Females Only
□	□	Birth Control Pills
□	□	Hormonal Replacement
□	□	Pregnancy

List all prescription medications you are currently taking: _____

List all of the over-the-counter medications or supplements you are currently taking:_____

List all surgical procedures you have had: _____

What activities do you do at work?

□ **Sit:** □ Most of the day □ Half the day □ A little of the day
□ **Stand:** □ Most of the day □ Half the day □ A little of the day
□ **Computer work:** □ Most of the day □ Half the day □ A little of the day
□ **On the phone:** □ Most of the day □ Half the day □ A little of the day
□**Performs Manual Labor** □ **Travels frequently**

What activities do you do outside of work?_____

Have you ever been hospitalized? □ No □ Yes **If yes, why:**_____

Have you seen a Chiropractor before? □ No □ Yes **How long ago?**_____

If yes, what was the result of treatment? □ Great □ Good □ Fair □ Mixed □ Poor

Have you had significant past trauma? □ No □ Yes **Are you current with pap smears/prostate exam?** □ No □ Yes

Anything else pertinent to your visit today? _____

In exchange for Bilan Chiropractic P.C.'s (clinic) forbearance from collecting all amounts owed by me for services rendered at the time of the provision of service, I hereby assign my rights to the clinic as follows: I understand and agree that health and accident insurance policies are an arrangement between an insurance company or carrier and my self. Furthermore, I understand that the clinic will prepare any necessary reports and forms provided by me to assist me, or my legal representative, in making collection from the insurance company or carrier. I hereby specifically authorize the release of any information concerning me to my insurance carriers, insurance carriers of persons or entities responsible for my injuries, my employer, claims adjustors responsible for claims filed by me, administrative agencies, the Alaska Workers' Compensation Board and my attorneys. To the extent of my unpaid bill to the clinic, I hereby irrevocably assign to said clinic on behalf of myself, my heirs and beneficiaries any interest that I might have now or in the future to any cause of action or claim, whether legal or administrative, and direct my legal representative that at the time of final judgment, and final disposition or settlement this assignment shall have priority over all others not entitled by law to superior priority.

I specifically request that any amount authorized to be paid to me by an insurance company, employer or legal representative shall be paid directly to the clinic, and will be credited to my account upon receipt. If the payment is insufficient to pay for all of my indebtedness, I will remain liable to Bilan Chiropractic P.C. for the balance, including finance charges and collection expenses.

I clearly understand and agree that all services rendered to me, whether I have health or accident insurance coverage or not, charged directly to me, and that I am personally responsible for payment and, unless arrangements are otherwise made, said payments are immediately due and payable at time of visit. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In such event, I agree that this assignment will remain effective until all sums I owe Bilan Chiropractic P.C. are fully paid.

Patient Signature or Legal guardian's signature:_____ **Date:**_____

Patient's Social Security No.:_____-_____-_____ (Needed if we are billing an insurance)

PATIENT NO.
DOCTOR NO.

I INSURED
WC WORK COMP
PI PER INJ
PC PROV COUR
M MEDICARE
C PRIVATE
DR DOC COUR
MI MILITARY

PATIENT NAME
LAST
FIRST

On the Job Injury (Worker's Compensation)

Employer Name:_____Employer Address:_____

Contact Person:_____Date Injured:_____ Hour of Injury:_____ a.m./p.m.

Who is your Worker's Compensation carrier? _____ Claim No.:_____

Name of Adjuster:_____ Phone No.:_____Extn:_____

Where are you hurting as a result of your current injury?_____

How did your injury occur? _____

Where were you working when you were injured (Location)?_____

Did you require post-accident hospitalization? □ No □ Yes If yes, name of hospital: _____

Have you lost any days of work? □ No □ Yes Dates:_____ Date last worked:_____

Did you report this injury to your foreman or employer? □ No □ Yes

Do you have an attorney that has advised you in this case? □ No □ Yes

Attorney's name:_____ Address:_____ Phone:_____

Personal Injury (Auto Collision/Other) Essential Information

Date of accident:_____ Hour:_____ a.m./p.m.

Name of insurance company you wish to receive the billing for payment:_____

Adjuster:_____ Claim No.:_____

Address:_____ Phone:_____Extn: _____

Have they authorized payment for medical/chiropractic expenses? □ No □ Yes

Have you been contacted by an insurance adjuster or company representative regarding this claim? □ No □ Yes

Did your injuries occur in the course of employment ("on the job")? □ No □ Yes

Where are you hurting as a result of your current injury?_____

How did your injury occur? _____

Have you lost any days of work? □ No □ Yes Dates:_____ Date last worked:_____

Was a police report filled out? □ No □ Yes

Do you have an attorney that has advised you in this case? □ No □ Yes

Attorney's name:_____ Address:_____ Phone:_____

Auto Collision

Location of accident:_____

Name of insurance company covering the vehicle that you were a passenger/driver in:_____

Name of insurance company covering the other vehicle:_____

To help us better understand the effects of the accident on your body (spine), please complete the following questions:

Were you: □ Driver □ Passenger □ Pedestrian

Were you struck from: □ Behind □ Right side □ Left side □ Front □ Auto was parked

Did your car strike the other (s) involved? □ No □ Yes OR Did the other car strike yours? □ No □ Yes

Was your car stationary at the time of impact? □ No □ Yes

If no, approximately how fast was your car going? □ Under 5 mph □ 10-20 mph □ 25-40 mph □ Over 40 mph

Was the other car stationary at the time of impact? □ No □ Yes

If no, approximately how fast was their car going? □ Under 5 mph □ 10-20 mph □ 25-40 mph □ Over 40 mph

Did you require post-accident hospitalization? □ No □ Yes If yes, name of hospital: _____

Was any other person injured?_____

Anything bizarre happen? (like glasses jerked off face, etc.) _____

Name of the owner of other vehicle (if more than one vehicle was involved)_____