PROHEALTH CHIROPRACTIC CENTER

ADULT INTAKE FORM

Date: _____

PERSONAL INFORMATION

First Name:_____M.I.:_____Last Name: _____

Preferred Name:_____ Social Security Number:_____

Address:_____

City / State / Zip: _____

Home Phone: ( ) _____Work Phone: ( ) _____

Cell Phone: ( ) _____Email: _____

Birth Date: _____Age:_____ Sex: M F

Occupation:_____ Employer's Name: _____

Marital Status: S M D W Other Spouse's Name: _____

# of Children: _____

Children's Names & Ages: _____

_____

Who can we thank for referring you or how did you hear about ProHealth?_____

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at ProHealth Chiropractic? _____

_____

When did this begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your life? (List all that apply)

_____

Have you seen any other providers for this condition? (List all that apply)

_____

Have you seen a chiropractor before? Yes No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

For Office Use Only

ID#: _____ Films: _____ ROF: _____ Dx: 1. _____

Visits: _____ PE: _____ X-Rays: Yes / No 2. _____

3. _____

Other: _____ Code:_____ 4. _____

HEALTH CHALLENGES

❒ Anxiety/Depression
❒ Digestive Troubles
❒ Nausea/Vomiting
❒ Diabetes
❒ Hypertension
❒ Arthritis
❒ Loss of Balance
❒ Neck/Back Pain
❒ Pain in Arms/Legs
❒ Irritability
❒ Fatigue/Sleep Issues
❒ Dizziness
❒ Ringing in Ears
❒ Sensitivity to Light
❒ Loss of Concentration
❒ Memory Problems
❒ Headaches
❒ Stiffness/Flexibility
❒ Sinus Troubles/Allergies
❒ Cold Hands/Feet
❒ Other _____

Explain any boxes checked above or add additional concerns:

_____

_____

_____

_____

_____

MEDICATIONS

❒ Anxiety/Depression
❒ Blood Pressure
❒ Pain Narcotics
❒ Muscle Relaxers
❒ Migraine/Headache
❒ Cholesterol
❒ ADD/ADHD
❒ Diabetes
❒ Other _____
❒ Other _____
❒ Other _____

Explain any boxes checked above: _____

_____

_____

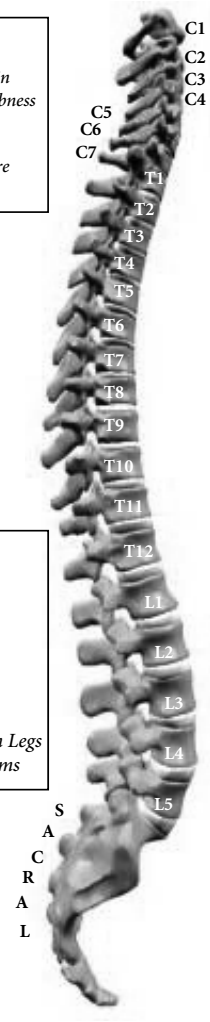
_____

Did You Know...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue / Sleep Problems
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems



Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems
Indigestion

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in Legs
Reproductive Problems

VITAMINS / SUPPLEMENTS

❒ Multi-Vitamin
❒ Vitamin D3
❒ _____
❒ _____
❒ Fish Oil/Omega-3
❒ Probiotics
❒ _____
❒ _____

Explain any boxes checked above:

_____

_____

_____

HEALTH STATUS QUESTIONNAIRE

What are the **facts** regarding your current state of health? Please be **real.** (Ex: I'm taking medications, I don't sleep at night and my energy suffers as a result, I'm not at my ideal weight)

What are the **feelings** surrounding the facts of your current state of health? Be **raw**. (Ex: Frustrated, Discouraged, Angry, Overwhelmed, Let down)

In regards to your health, what **target** will we be focusing on that will make the greatest impact in your life? Be **specific**. (Ex. Sleeping a full 7 hours, Being able to work out, Being able to shop for my own groceries, Playing in the park with my kids, Picking up my child out of the crib, Increased energy to tackle the day)

On a 1–10 scale, how committed are you to hitting this **target**?

What obstacles are there that may potentially keep you from hitting your **target**?

What else about your health or life do you feel is important for the doctor to know?

PATIENT HIPAA CONSENT FORM

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Date: _____ Print Patient Name: _____

Signature:_____ Relationship to Patient : _____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

- We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.
- I authorize ProHealth Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.
- If you have any questions about our financial policies, please ask to speak to our financial officer. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN)*. Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions, please ask our front desk. Signing below means that you have received and understand this notice.

Date: _____ Signature : _____

AUTHORIZATION FOR CARE

Patient Consent to X-Ray

I authorize the performance of x-ray examination, which ProHealth Chiropractic may consider necessary or advisable in the course of my examination and treatment.

Date: _____ Signature : _____

X-Ray Consent for Women of Childbearing Age

This is to certify that, to the best of my knowledge, I am not pregnant, and ProHealth Chiropractic has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis can be hazard s to an unborn child.

Date: _____ Signature : _____

AUTHORIZATION FOR CARE

I hereby authorize doctors and staff at ProHealth Chiropractic to treat my condition as deemed appropriate. At ProHealth Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of ProHealth Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Date: _____ Signature: _____