# PATIENT DATA SHEET

## General Information

First Name _____

Middle Initial _____

Last Name _____

Called Name _____

Address _____

City _____

State _____

Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email Address _____

Sex Male Female

Race American Indian, Alaska Native, Asian
Black or African American, Native Hawaiian,
Other Pacific Islander, White, Declined to State

Ethnicity Declined to State, Hispanic or Latino
Not Hispanic or Latino

Language _____

Marital Single, Legally Separated, Married, Widowed, Divorced

Birthdate _____

Social Security _____

Referred By _____

Work Status Employed Full-Time Student Part-Time Student

Appt Reminder _____

CHIROPRACTIC HEALTH & WELLNESS CLINIC

## Informed Consent

Dr. Giddings will use his hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

By_____

Patient's Signature

## Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

If patient is a minor or under a guardianship order as defined by State law:

By_____ _____

Patient's Signature Date Signature of Parent/Guardian (circle one) Date

## Consent to Treatment of Minor Child

## Consent to Treatment of Adult with Medical Power of Attorney

I hereby authorize Dr. Giddings and whomever he/may designate as his assistants to administer treatment as he so deems necessary to _____ (Name of Patient).

_____ _____ _____

Printed Name of Person Authorizing Treatment Signature Date

Relationship to Patient _____

IF YOU ARE CONSENTING ON BEHALF OF AN ADULT, DO YOU HAVE MEDICAL POWER OF ATTORNEY? _____

(Please provide our office with a copy of the medical Power of Attorney). Witnessed: _____

# OFFICE FINANCIAL POLICY

## CASH

All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.

This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

## INSURANCE

If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.

We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.

We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

Whenever you receive any worksheets form your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check-it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.

Any services not covered or coverage reductions by your insurance will be the patient's responsibility.

This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

If the patient is referred to another specialist or discontinues care for any reason other than discharged by the doctor, the bill is due and payment in full expected immediately; regardless of any claims submitted.

If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing Dr. Giddings.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms

_____ _____

Patient's Signature Date

# PATIENT INTAKE FORM

| For Office Use Only |
|---|
| Date: _____ |
| Acct #:_____ |
| Patient Height _____ |
| Patient Weight _____ |
| Patient BMI _____ |
| Patient Blood Pressure _____ |

Name: _____

Are your present problems due to an injury? □Yes □No Enter the date of the injury: _____

Was the injury? □ Job Related □Auto Accident □Personal Injury □Other: _____

Has the accident been reported? □Yes □No If so, to whom? □To Employer □Auto Carrier □Other: _____

Briefly describe the accident, injury or illness:_____

_____

_____

_____

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom

_____ □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe

_____ □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe

_____ □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe

_____ □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe

_____ □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe

List any tests, studies or medications received for this condition:

□Tests/Studies: _____

□Medications: _____

Where you admitted to the hospital due to this condition: □Yes □No

If yes, what hospital? _____Transported by? □Ambulance □Police □Other: _____

Date Admitted: _____ Date Released: _____ Length of Stay: _____

List the hospital procedures received: _____

List symptoms you are experiencing today: Choose the severity level associated with each symptom

_____ □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe

_____ □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe

_____ □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe

_____ □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe

_____ □(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe

Do you have any current work restrictions due to this condition?

Off work: □Yes □No □Previously From: _____ To: _____

Light duty: □Yes □No □Previously (If yes, what are/were your restrictions?) _____

What type of work do you do?_____

_____

---

Do you suffer from any condition other than that for which you are now consulting us? □Yes □No _____

_____

List any past conditions you may have had: _____

**HABITS**

□Current Every Day Smoker □Current Some Day Smoker

□Former Smoker □Never Smoker

□Drinking Alcohol: (Cups/day): _____ □Coffee Cups/Day: _____

□Soft Drink Bottles or Cans/Day: _____ □Water Cups/Day: _____

**EXERCISE**

□None

□Moderate

□Daily

**FAMILY HISTORY**

| | Diabetes | Cancer | Back Pain | Other |
|---|---|---|---|---|
| Mother | □ | □ | □ | □ |
| Father | □ | □ | □ | □ |
| Sibling(s) | □ | □ | □ | □ |

Are you taking any medication (prescription or over-the-counter)? □Yes □No

If Yes, please indicate the following:

Medication: _____ Medication: _____

Route: Oral Route: Oral

Intravenous Intravenous

Other: _____ Other: _____

Frequency: _____ Frequency: _____

Began Use: _____ Began Use: _____

Discontinued Use: _____ Discontinued Use: _____

Medication: _____ Medication: _____

Route: Oral Route: Oral

Intravenous Intravenous

Other: _____ Other: _____

Frequency: _____ Frequency: _____

Began Use: _____ Began Use: _____

Discontinued Use: _____ Discontinued Use: _____

Have you taken any medications in the past? □Yes □No If yes, which ones?: _____

Do you have allergies to medication? ☐Yes ☐No

If Yes, please indicate the following:

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Have you ever had any surgeries? ☐Yes ☐No (If yes, please enter the approximate date of surgery.)

| DATE | | DATE | | DATE | |
|---|---|---|---|---|---|
| _____ | Back Operation | _____ | Hernia | _____ | Gall Bladder |
| _____ | Female Organs | _____ | Thyroid | _____ | Stomach |

Other _____

Have you ever had X-rays taken? ☐Yes ☐No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

## OPERATIONS AND PROCEDURES

**Please check the box for each current or past symptom listed.**

| GENERAL SYMPTOMS | GASTRO-INTESTINAL | EYE/EAR NOSE/THROAT | RESPIRATORY |
|---|---|---|---|
| ☐ Allergy(What) ____ | ☐ Belching or Gas | ☐ Asthma | ☐ Chest Pain |
| _____ | ☐ Colon Trouble | ☐ Deafness | ☐ Chronic Cough |
| ☐ Bronchitis | ☐ Constipation | ☐ Earache | ☐ Difficulty Breathing |
| ☐ Chills (Constant) | ☐ Diarrhea | ☐ Ear Discharge | ☐ Spitting Blood |
| ☐ Convulsions | ☐ Gall Bladder Trouble | ☐ Ear Noises | ☐ Spitting Phlegm |
| ☐ Dizziness | ☐ Hemorrhoids (piles) | ☐ Thyroid Problems | |
| ☐ Fainting | ☐ Jaundice | ☐ Frequent Colds | **GENITO-URINARY** |
| ☐ Fatigue | ☐ Liver Trouble | ☐ Hay Fever | ☐ Bed Wetting |
| ☐ Headache | ☐ Nausea | ☐ Nasal Obstruction | ☐ Blood in Urine |
| ☐ Loss of Sleep | ☐ Stomach Pain | ☐ Nose Bleeds | ☐ Frequent Urination |
| ☐ Loss of Weight | ☐ Vomiting | ☐ Pain in Eyes | ☐ Inability to Control |
| ☐ Nervousness | ☐ Vomiting Blood | ☐ Poor Vision | ☐☐Urine |
| ☐ Night Sweats | ☐ Heart Burn | ☐ Blurred Vision | ☐ Kidney Infection |
| ☐ Numbness or Pain | ☐ Bloody Stools | ☐ Sinusitis | ☐ Kidney Stones |
| in arms/legs/hands | ☐ Acid Reflux | ☐ Sore Throats | ☐ Painful Urination |

☐ Wheezing ☐ Irritable Bowel ☐ Tonsillitis ☐ Prostate Trouble

**MUSCLES & JOINTS**

☐ Backache
☐ Foot Trouble
☐ Hernia
☐ Pain Between Shoulders
☐ Painful Tail Bone
☐ Stiff Neck
☐ Spinal Curvature
☐ Swollen Joints
☐ Tremors

**CARDIO-VASCULAR**

☐ High Blood Pressure
☐ Low Blood Pressure
☐ Chest Pain
☐ Heart Trouble
☐ Poor Circulation
☐ Rapid Heart
☐ Slow Heart
☐ Strokes
☐ Swelling Ankles
☐ Varicose Veins

**SKIN OR ALLERGIES**

☐ Bruising Easily
☐ Dryness
☐ Eczema
☐ Hives or Allergy
☐ Itching
☐ Sensitive Skin
☐ Skin Eruptions

**FOR FEMALES ONLY**

☐ Cramps
☐ Hot Flashes
☐ Irregular Cycle
☐ Painful Periods
☐ Vaginal Discharge
☐ Pregnant Now?
_____ Last Pap Date
_____ Last Menstrual Cycle

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?**

| | | | | | |
|---|---|---|---|---|---|
| ☐Appendicitis | ☐Anemia | ☐Heart Disease | ☐Arthritis | ☐Pneumonia | ☐Measles |
| ☐Goiter | ☐Epilepsy | ☐Rheumatic Fever | ☐Mumps | ☐Influenza | ☐Mental Disorder |
| ☐Polio | ☐Chicken Pox | ☐Pleurisy | ☐Lumbago | ☐Tuberculosis | ☐Diabetes |
| ☐Alcoholism | ☐Eczema | ☐Whooping Cough | ☐Cancer | ☐Venereal Disease | ☐HIV Positive |

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

**Patient's/Guardian's Signature: _____ Date: _____**