PINKUS FAMILY CHIROPRACTIC

ADULT INTAKE FORM

Date: _____

PERSONAL INFORMATION

First Name:_____ M.I.:____ Last Name:_____
Preferred Name:_____ Social Security Number:_____
Address:_____ City:_____

State:_____ Zip:_____ Email:_____

Cell Phone:( )_____ Alternate Phone:( )_____

Date of Birth:_____ Age:_____ Sex: M F Marital Status: S M D

Employer/Occupation:_____

Significant Other/Spouse Name:_____ Cell #: ( )_____

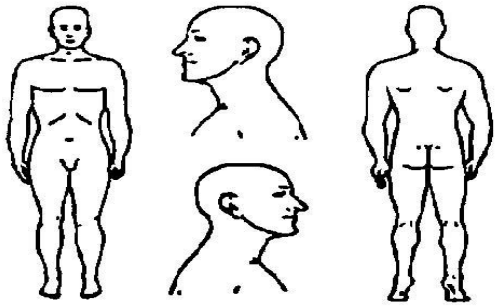
# of Children_____ Children's Name's/Ages_____

_____

How did you hear about us?_____

What is your reason for seeking care at Pinkus Family Chiropractic?_____
_____
When and How did this begin?_____
What Activities of Daily Living is this affecting?(ie:walking, lifting, sitting, standing, sleeping, etc.)_____
_____
How Long is Activity of Daily Living affected? (ie; 5min, 1 hour, all day, waking up, evenings etc.)_____
_____
Frequency of Pain? **Please circle:** (100% of the day) (75-50% of the day) (50 to 25% of the day) (less than 25% of the day)
How long have your symptoms been present?_____
Has the complaint changed since the start? YES/NO If yes, how?_____
What are your treatment goals?_____
Have you seen any other providers for this condition? (List all that apply)_____
_____
Have you seen a chiropractor before? YES/NO
If Yes, How long ago?_____ Clinic/Doctor Name: _____
What is your level of pain/discomfort? 1 2 3 4 5 6 7 8 9 10
Explain Discomfort: **dull, sharp, stabbing, numbness, (other)**_____
Symptoms Relieved By**: heat, cold, rest, stretching, chiropractic, (other)** _____

Indicate symptoms with an "X" on figures below



CIRCLE the SYMPTOMS that apply below

Achy/Dull
Burning
Numb
Pins & Needles
Spasms/Cramping
Sharp
Stiff
Tight/Weak

Other:_____

HEALTH CONCERNS

☐ 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:

_____

_____

Is there anything else regarding your current condition you feel the doctor should know?

_____

_____

MEDICATIONS

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

Explain any boxes checked above: _____

_____

_____

Allergies to any medications? ☐Yes ☐ No
List:_____

EMERGENCY CONTACT

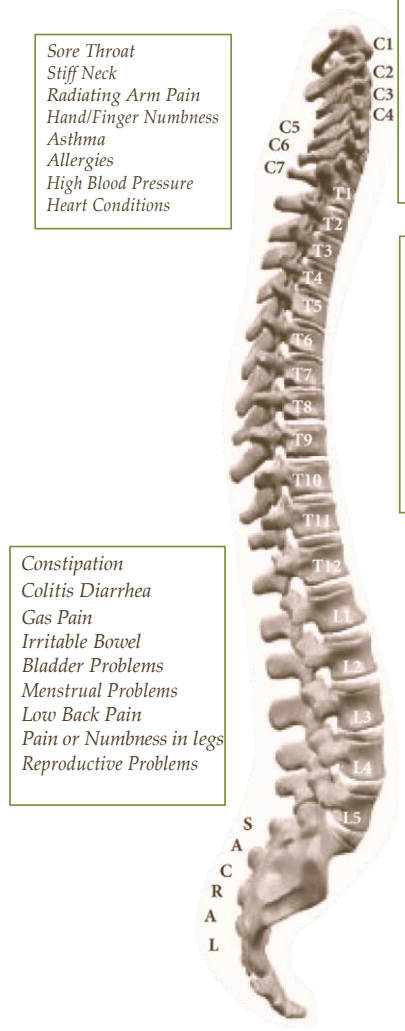
Name:_____

Address:_____

City/State:_____ZIP:_____

Phone: ( )_____Relationship:_____

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**.



VITAMINS/SUPPLEMENTS

☐ Multi-Vitamin
☐ Vitamin D3
☐ Calcium
☐ Fish Oil/Omega 3
☐ Probiotics
☐ Vitamin B Complex
☐ _____

Explain any boxes Checked above: (frequency, how long, amount etc.)_____

_____

Does pain radiate? If so, where does pain radiate?_____
Does pain radiate into arm(s)? Yes/No Explain Where:_____
Does pain radiate into leg(s)? Yes/No Explain Where:_____
If you have a neck injury, does it affect:(circle all that apply) hearing, vision, balance, ringing in your ears, other_____
Do you feel pressure or pain behind your eyes? Y/N Do you have difficulty lifting or turning head? Y/N
Other Comments/Explain:_____

CHECK ACTIVITIES DURING WHICH YOU EXPERIENCE DIFICULTY

□ Lying on back	□ Getting in/out of car	□ Pulling	□ Sitting	□ Standing for long periods
□ Lying on side	□ Dressing Self	□ Reaching	□ Bending forward	□ Sneezing
□ Turning over in bed	□ Sexual Activity	□ Kneeling	□ Bending backward	□ Coughing
□ Lying flat on stomach	□ Pushing	□ Stooping	□ Walking	□ Other:_____

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

Please List Any Prior Surgeries:_____
_____

Please List Any Prior Accidents/Injuries:_____
_____

Stress Questionnaire

Most life stresses can be grouped into 3 main categories: Physical, Chemical, and Emotional Stress. Please check any of the following stresses you experience on a regular basis.

Physical Stress
☐ Physical Pain ☐ Low Energy/Fatigue ☐ Job/Hobbies Cause Discomfort ☐ Tightness/Stiffness
☐ History of Accidents/Injuries ☐ Inability to Exercise/Perform Physical Activities ☐ Other _____
Explain: _____

Chemical Stress
☐ Fast Food/Highly Processed Food ☐ Medications (Prescription or OTC) ☐ Consume Alcohol ☐ Tobacco
☐ Amalgam Fillings ☐ Makeup/Lotion/Other Skin Products ☐ Other
Explain:_____

Emotional Stress
☐ Work/Job ☐ School ☐ Health ☐ Finances ☐ Family ☐ Daily Schedule/Time ☐ Other_____
Explain: _____

PATIENT HIPAA CONSENT FORM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement. **

Release of Protected health information/HIPAA By signing this form, you are granting consent to Drs. Brenton and Kathleen Pinkus and/or Pinkus Family Chiropractic to use and disclose your protected health information for the purpose of treatment, payment and health care operations.

Our notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at 802-362-7512. You have a right to request us to restrict how we use and disclose your protected health information. We are not required by law to grant your request. However, if we do grant your request, we are bound by our agreement. You have a right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your request. Acknowledgement of receipt of notice or privacy practices I have received a copy of the office's Notice of Privacy Practices.

I understand that 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 among the healthcare providers who may be directly and indirectly involved in providing my treatment.
• Obtain payment from third-party payers.
• Conduct normal healthcare operations such as quality assessments and accreditation.

I, _____, have been offered to read and receive a copy of this office's Notice of Privacy Practices and give my consent for this office to use personal health information.

_____ _____ _____

Please Print Name **Signature (Patient/Parent/Guardian)** **Date**

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign;
- Communication barriers prohibited obtaining the acknowledgement,
- An emergency situation prevented us from obtaining acknowledgement, Other (Please Specify)_____

AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at Pinkus Family Chiropractic to treat my condition as deemed appropriate. At Pinkus Family Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/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 the doctors or any staff member of Pinkus Family 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:**(Patient/Parent/Guardian)_____

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 aswell.

- We urge our patients to follow the doctors' 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 Pinkus Family 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 charges incurred by me.
- If using insurance which may include benefits for Chiropractic Care, I understand that my insurance policy may have a co-payment or deductible and I will be responsible for those charges and any services denied or not covered by my insurance company at each visit. I also realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges not approved. The insurance company will review any/all documentation submitted by Pinkus Family Chiropractic for their assessment of medical necessity and base their approval/denial upon this documentation. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for professional services rendered.
- 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 know that some health insurance policies 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 such as massage therapy, examinations and taping. Signing below signifies that you want these items and services but understand that some of these services will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as services were not submitted and/or billed to them.
- I authorize the direct payment to Pinkus Family Chiropractic of any sum I now or hereafter owe by my attorney out of settlement of my case, and by any insurance company obligated to make payment to me or Pinkus Family Chiropractic based in whole or in part upon the charges made for services received. I hereby appoint Pinkus Family Chiropractic authority to endorse and cash checks, drafts, or money orders made payable to the undersigned or as co-payee with this clinic or payments due for services rendered on behalf of the undersigned by
- I understand there are discounted fees, family plans and pre-paid visit discounts available to patients who do not have insurance or choose not to use insurance and will be furnished with these options at my first visit.
- If you have other questions, please ask our staff. Signing below means that you have received and understand this notice

Date:_____ **Signature :**(Patient/Parent/Guardian)_____

Patient Authorization for Chiropractic Care in an "Open Adjusting" Environment.

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is not the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters. In the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an "open adjusting" environment other arrangements will be made for you. Your decision will have no adverse effects on your care from Dr. Katie and Dr. Brenton or your relationship with our staff.

Your signature indicates your authorization of this activity.

Signature (patient/parent/guardian)_____ **Date**_____

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of Pinkus Family Chiropractic, to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the doctor would like to discuss results, or to ask a patient to call Pinkus Family Chiropractic, regarding an issue or concern. At no time will a representative of Pinkus Family Chiropractic discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name:_____

Signature: (Patient/Parent/Guardian)_____ **Date:**_____