Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: ______________________________ **Date:** __________ (mm/dd/yr)

Insurance: ______________________________

Date of Birth: ______________________________ ☐ male ☐ female

Address: ______________________________

____

Marital status

S	M	W	D	SEP

OK to receive emails? ☐ yes ☐ no

Phone #: Mobile: ______________ **Home:** ______________

E-mail address: ______________________________

Occupation: ______________ **Employer:** ______________

Check ☑ and indicate the age when you had any of the following:

General

- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint

- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Difficulty bending
- ☐ Difficulty lifting
- ☐ Difficulty standing
- ☐ Foot trouble
- ☐ Joint pain
- ☐ Mid back pain
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Neck Stiffness

Eye, Ear, Nose & Throat

- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Nasal obstruction
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal

- ☐ Abdominal pain
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite

Genitourinary

- ☐ Bed-wetting
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Stress incontinence
- ☐ Painful urination
- ☐ Urgency to urinate

Respiratory

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular

- ☐ High blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Women only

- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause

Menstrual flow

☐ Reg. ☐ Irreg. ☐ Pain / cramps

Date - 1st day last period: ______________

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? _____

How many children do you have? _____

Birth control method: ______________

Check any of the conditions you have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ Influenza
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

How did you hear about ARC Chiropractic?

☐ Walk by ☐ Flyer/Newspaper

☐ Website ☐ Google

☐ Referral: ______________________________

☐ Other: ______________________________

Please list any medication you are currently taking and why:

____

____

____

____

Reproduction is permitted for personal use, not for resale or redistribution. www.prohealthsys.com ©2012 by Professional Health Systems Inc. "Dedicated to Clinical Excellence."

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: ______________________________

____

____

____

Have you had previous chiropractic care?____ Other doctors/treatments for this condition? ______________________________

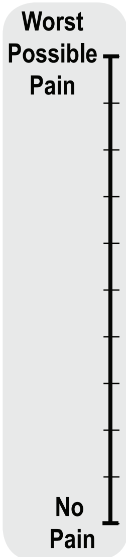
How long have you had this condition? _____________ Is it getting worse? □ yes, □ no ______________________________

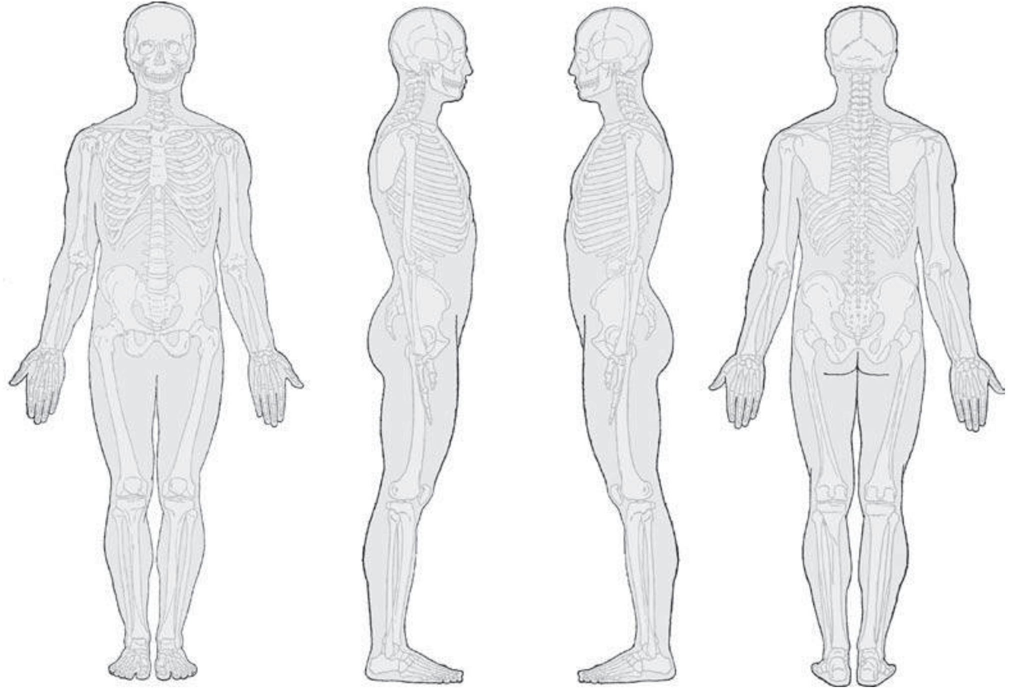
Does it bother you (check appropriate box): □ work, □ sleep, □ walking, □ sitting □ other:______________________________

What seemed to be the initial cause: ______________________________

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	______________________
... had any mental disorders?	□	□	______________________
... had any broken bones?	□	□	______________________
... had any strains or sprains?	□	□	______________________
... ever used orthotics?	□	□	______________________
Do you take minerals, herbs or vitamins?	□	□	______________________

How is most of your day spent? □ standing, □ sitting, □ other: ______________________

My usual health is: □ Excellent, □ Good, □ Fair, □ Poor

When was your last physical exam? _____________ How old is your mattress? ___________

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues/concerns that our staff should be made aware of? ______________________________

______________________________ **Patient's Signature:**______________________________

Reproduction is permitted for personal use, not for resale or redistribution. **www.prohealthsys.com ©2012 by Professional Health Systems Inc. "Dedicated to Clinical Excellence."**

ARC Chiropractic
157 Keveling Drive, Saline MI 48176
Dr. Michael D. Childs
Doctor of Chiropractic
Ph: (734) 429-2410

Consent for Purposes of Treatment, Payment, and Health Care Operations

I acknowledge that ARC Chiropractic's "Notice of Patient Privacy Policy" has been provided to me.

I understand I have a right to review ARC Chiropractic's Notice of Patient Privacy Policy prior to signing this document. ARC Chiropractic's Notice of Patient Privacy Policy has been provided to me. The Notice of Patient Privacy Policy describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of ARC Chiropractic. The Notice of Patient Privacy Policy for ARC Chiropractic is also provided on request at the main administration desk of this practice and on ARC Chiropractic's website at www.ARCchiropractic.com. This Notice of Patient Privacy Policy also describes my rights and ARC Chiropractic's duties with respect to my protected health information.

ARC Chiropractic reserves the right to change the privacy practices that are described in the Notice of Patient Privacy Policy I may obtain a revised practices by accessing ARC Chiropractic's web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____ ______________________________
Signature of Patient or Personal Representative Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

Xray Confirmation:

This is to confirm that I have been advised by ARC Chiropractic that to the best of my knowledge, I am not pregnant, and consent to radiographs.

Signed____ Date ______________________

Assignment:

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic, the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charge for professional services rendered by this clinic. A Photocopy of this assignment shall be considered as effective and valid as the original.

Signed____ Date ______________________

Release of Information:

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster, and attorney involved in this case, and hereby release this clinic of any consequence thereof.

Signed____ Date______________________

Financial Responsibility:

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment, and any services rejected by my insurance company.

Signed____ Date _____________________

Consent to treat a minor:

Minor____

Parent Signature___________________________________ Date _____________________

About your care:

Initial intensive care: Corrects most recent layers of damage, usually gives relief.
Reconstructive care: Begins to correct years of damage before symptoms occurred. Much like braces on teeth.
Wellness care: For **Optimum Health Potential,** and a better quality and quantity of life.

ARC Chiropractic
157 Keveling Drive Saline, MI 48176
Ph: (734) 429-2410

ARC Chiropractic
157 Keveling Drive Saline MI 48176
(734) 429-2410

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

It is possible that you may not have a chiropractic resolution to your primary complaint. This means you may not get help with the problem you presented to us. An informed consent is this statement being presented to you, and your acknowledgement of that statement.

All health providers have some risk. The level of risk is minimal with chiropractic. In rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropracitc care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures.

Prior to receiving chiropractic care at this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. If you have suggestions or complaints that would benefit our care to you, contact our web site at www.ARCchiropractic.com.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I,________________________________have read and fully understand the above statements. All questions
Patient's name
regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

____
Signature

For a Minor:

I,________________________________ being the parent or legal guardian of
Parent's name

________________________________ have read and fully understand the above terms of acceptance and
Child's name
hereby grant permission for my child to receive chiropractic care.

____
Parent's signature

ARC
CHIROPRACTIC
Align • Restore • Connect

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. ‘While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Dr. Michael D. Childs of ARC Chiropractic.

Dated this ___________ day of _____________ 20___

______________________________	_________________________
Patient signature (or Legal Guardian)	Signature of Witness
Print Name:_____________________	Print Name:________________

ARC Chiropractic
157 Keveling Drive
Saline, Michigan 48176

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:__________________________ **Last Name**:__________________________

Email address: _________________@_________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** __________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date:________________

For office use only

Height: _________ Weight:____________ Blood Pressure:______ /______

ARC CHIROPRACTIC
Align • Restore • Connect

Childhood Stress Survey

Child's Name: ___________________________________ Age: _________ Grade: ___________

Parent's Name: ____

Address: ______________________________ City: ______________ State: _______ Zip: __________

Phone Number: _____________________ Parent's Email Address: ______________________________

1. Check off any of the following symptoms your child has complained of:

[ ] Low Back Pain
[ ] Pain between your shoulders
[ ] Neck Pain
[ ] Tension
[ ] Growing Pain
[ ] Ear Infections
[ ] Headaches (Type) _______________
[ ] Allergies

2. Have you noticed your child:

[ ] Sleeping poorly
[ ] Walks only on their tippy toes
[ ] Trips frequently
[ ] Walks with one foot flared in or out
[ ] Head flatness or bald spot on your infant
[ ] Head only turns one way in car seat or bed
[ ] Nurses poorly on one side
[ ] Pants are longer on one leg or clothes twist
[ ] Carries a heavy book bag
[ ] Extra fussy or seems uncomfortable

Childhood Stress Survey

Child's Name: __________________________________ Age: _________ Grade: ___________

Parent's Name: ____

Address: ______________________________ City: ______________ State: _______ Zip: _________

Phone Number: _____________________ Parent's Email Address: ___________________________

1. Check off any of the following symptoms your child has complained of:

[ ] Low Back Pain
[ ] Pain between your shoulders
[ ] Neck Pain
[ ] Tension
[ ] Growing Pains
[ ] Ear Infections
[ ] Headaches (Type) _______________
[ ] Allergies

2. Have you noticed your child:

[ ] Sleeping poorly
[ ] Walks only on their tippy toes
[ ] Trips frequently
[ ] Walks with one foot flared in or out
[ ] Head flatness or bald spot on your infant
[ ] Head only turns one way in car seat or bed
[ ] Nurses poorly on one side
[ ] Pants are longer on one leg or clothes twist
[ ] Carries a heavy book bag
[ ] Extra fussy or seems uncomfortable