# PATIENT INTAKE FORM

Last Name _____ First Name _____ Middle Initial ___ Preferred First Name_____

Address: _____ City_____ State_____ Zip_____

Cell Phone _____Home Phone _____ Work Phone_____

Email_____*Email will not be shared and will only be used for occasional office announcements and appointment reminders*

Sex ◻ M ◻ F Date of Birth _____ Age _____Social Security # _____

Marital Status _____ # Children ____ Occupation _____ Employer _____

Spouse's Name _____ Spouse's Date of Birth_____ Spouse's Employer_____

In Case of An Emergency Contact _____ Phone #_____

How did you hear about our office? _____ Name of person who referred you: _____

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**Current Complaints**

Nature of Injury: ◻ Automobile ◻ Work ◻ Other

Please describe your Complaints.

_____

_____

What caused the problem? _____

Date of Injury _____ Date symptoms appeared _____

Did your pain come on: ◻ Suddenly ◻ Gradually Is the pain: ◻ Mild ◻ Moderate ◻ Severe

Do you experience pain every day? ◻ Yes ◻ No Do changes in the weather affect your symptoms? ◻ Yes ◻ No

Do your symptoms affect your daily life? ◻ Yes ◻ No Do You wear Orthotics? ◻ Yes ◻ No

Does your pain wake you up at night? ◻ Yes ◻ No Do you take vitamins or supplements? ◻ Yes ◻ No

Are your symptoms worse at certain times of the day? ◻Yes ◻ No If so, when? _____

What activities aggravate your symptoms? _____

Have you had this same condition before? ◻ Yes ◻ No If yes, how long ago? _____

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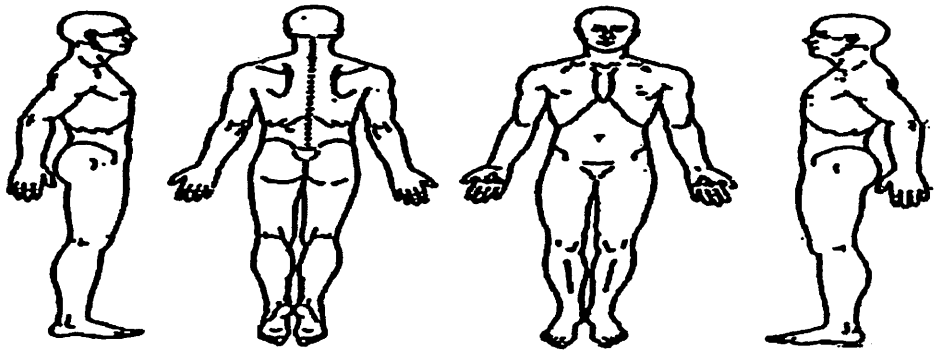
**Indicate on the drawings below where you have pain/symptoms**



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?

- ◻ Burning
- ◻ Dull Ache
- ◻ Radiating
- ◻ Sharp
- ◻ Stabbing
- ◻ Tightness
- ◻ Tingly
- ◻ Numbness
- ◻ Throbbing
- ◻ Shooting
- ◻ Other: _____

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)

Who else have you seen for your problem?

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

What is your current: Height: _____ Weight: _____ Occupation: _____

List all prescription medications you are currently taking: _____

_____

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

_____

List all surgical procedures you have had: _____

_____

List any allergies you may have _____

_____

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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 ***CURENTLY*** have a condition listed below, place a check in the "**CURRENT**" column.

| PAST | CURRENT | | PAST | CURRENT | | PAST | CURRENT | |
|---|---|---|---|---|---|---|---|---|
| ◻ | ◻ | Neck | ◻ | ◻ | Diabetes | ◻ | ◻ | High Cholesterol |
| ◻ | ◻ | Upper Back | ◻ | ◻ | Pre-Diabetes | ◻ | ◻ | Congestive Heart Failure |
| ◻ | ◻ | Middle Back | ◻ | ◻ | High Blood Pressure | ◻ | ◻ | Lupus |
| ◻ | ◻ | Low Back | ◻ | ◻ | Cancer | ◻ | ◻ | Parkinson's |
| ◻ | ◻ | Shoulder | ◻ | ◻ | Arthritis | ◻ | ◻ | Neuropathy |
| ◻ | ◻ | Arm | ◻ | ◻ | Fibromyalgia | ◻ | ◻ | Liver/Gallbladder |
| ◻ | ◻ | Elbow | ◻ | ◻ | Epilepsy | ◻ | ◻ | Multiple Sclerosis |
| ◻ | ◻ | Wrist | ◻ | ◻ | Depression/Anxiety | ◻ | ◻ | Stomach Problems |
| ◻ | ◻ | Hand | ◻ | ◻ | ADD/ADHD | ◻ | ◻ | Ulcers |
| ◻ | ◻ | Fingers | ◻ | ◻ | PTSD | ◻ | ◻ | Kidney Stones |
| ◻ | ◻ | Hip | ◻ | ◻ | Neurological Disorder | ◻ | ◻ | Hepatitis |
| ◻ | ◻ | Leg | ◻ | ◻ | AIDS/HIV | ◻ | ◻ | Endometriosis |
| ◻ | ◻ | Knee | ◻ | ◻ | Neuropathy | ◻ | ◻ | Menstrual Issues |
| ◻ | ◻ | Ankle | ◻ | ◻ | Scoliosis | ◻ | ◻ | Pacemaker/Defibrillator |
| ◻ | ◻ | Foot | ◻ | ◻ | Epidural Steroid Injections | ◻ | ◻ | Prosthetics |
| ◻ | ◻ | Toes | ◻ | ◻ | Pregnancy/Infertility | ◻ | ◻ | Incontinence/Freq. |
| ◻ | ◻ | Headaches | ◻ | ◻ | Smoking/Tobacco | ◻ | ◻ | Allergies |
| ◻ | ◻ | Migraines | ◻ | ◻ | Drug Dependence | ◻ | ◻ | Birth Control |
| ◻ | ◻ | Ribs | ◻ | ◻ | Hormone Replacement | | | |
| ◻ | ◻ | Chest | | | | | | |
| ◻ | ◻ | Jaw | Other_____ | | | | | |

**REVIEW OF SYSTEMS (Check those which you currently have)**

***Constitutional:***
□ None □ Fever □ Night Sweats □ Chills □ Fatigue □ Weight Loss/Gain
□ Changes in Appetite

***SLEEP:***
□ None □ Snoring □ Gasping □ Insomnia □ Restless Legs □ Difficulty Sleeping

***Ears:***
□ None □ Difficulty Hearing □ Hearing Loss □ Hearing Aides □ Vertigo

***Eyes:***
□ None □ Change in Vision □ Loss of Vision □ Blurred Vision □ Double Vision
□ Glass/Contacts □ Eye Pain

***NOSE, MOUTH AND THROAT***
□ None □ Change in Smell □ Runny Nose □ Nose Bleeds □ Sores in Mouth
□ Sore Throat □ Problem Swallowing

***CARDIOVASCULAR***
□ None □ Chest Pain □ Palpitations □ Swollen Legs □ Fainting □ Shortness of Breath

***RESPIRATORY***
□ None□ Cough □ Coughing up Blood □ Coughing up Phlegm □ Wheezing

***GASTROINTESTINAL***
□ None □ Abdominal Pain □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Heartburn

***MUSCULOSKELETAL***
□ None □ Muscle Pain □ Bone Pain □ Joint Pain □ Swollen or Red Joints □ Broken Bones

***GENITOURINARY***
□ None □ Difficulty urinating □ Vaginal or Penile Discharge □ Kidney Stones

***SKIN***
□ None □ Rash □ Ulcers that will not heal □ Moles that are changing

***ENDOCRINE***
□ None □ Heat or Cold Intolerance □ Frequent Urination □ Unusually thirsty
□ High Blood Sugar □ Low Blood Sugar

***NEUROLOGICAL***
□ None □ Headaches □ Weakness □ Seizures □ Dizziness □ Tremors □ TIA □ Stroke

***LYMPH AND BLOOD***
□ None □ Easy Bleeding □ Swollen Lymph Nodes

***PSYCHIATRIC***
□ None □ Depression □ Anxiety □ Hallucinations

What activities do you do outside of work?

_____

Have you ever been hospitalized? □ No □ Yes
If yes, when, and why?

_____

Have you ever been to a chiropractor before? □ No □ Yes How long ago?

_____

Have you had significant past trauma? □ No □ Yes

Anything else pertinent to your visit today?

_____

**Patient Signature**_____ **Date:** _____

Nicole Halkovic, DC
Zachary Chiropractic Clinic
1121-B Church Street
Zachary, La 70791
225-654-0048

## Informed Consent Form

# Consent to Treatment

The following points have been explained to me to my satisfaction and I have had the opportunity to discuss them with the doctor and or other clinic personnel.

1. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, and there may be an audible "pop" or "click" as a result of joint movement.
2. The practice of health care is not an exact science, but relies upon information related by the patient, information gathered during the examination (and the doctor's interpretation thereof), as well as the doctor's judgment and expertise. Chiropractic health care is no different.
3. It is not reasonable to expect my doctor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedures which he/she feels at the time to be in my best interest.
4. Though infrequent, as with any health procedure, there are certain complications which may arise during chiropractic health care. These complications include soreness, sprains/strains, dislocations, fractures, disc injuries, cerebral-vascular accidents, physiotherapy burns, or soft tissue injuries. These complications are extremely rare occurrences.
5. Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will give you our best care.
6. I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.
7. **I understand the NOTICE OF PRIVARY PRACTICES, and I have been provided an opportunity to review it.**

I have read the above consent, or it has been read to me. I have had the opportunity to ask questions and receive answers, am comfortable with the information provided, and consent to chiropractic treatment and management on that basis. In signing this document, I in no way compromise my protection against negligence.

Patient Signature: _____

**(If patient is a minor please print child's name and sign your name beside it)**

Witness' Signature: _____

# AUTHORIZATION AND RELEASES

# PERSONAL INJURY

NAME_____ DATE_____

**CONSENT FOR TREATMENT**

I, undersigned, hereby authorize Nicole Halkovic, D.C. and whomever she may designate as her assistants to perform diagnostic test but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that the amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES ARE RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's
Signature_____ Date_____

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize the release of any medical information necessary to process my insurance claims and certify that all insurance information to this clinic is correct and complete.

Patient's
Signature_____ Date_____

**REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE**

A. I hereby **AUTHORIZE** the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Zachary Chiropractic Clinic the expense benefits allowable and otherwise payable to me under my current policy, as payment the total charges for professional service rendered. I have agreed to pay, in a current manner, any balance of said professional charges. I agree that this office be given power of attorney to endorse/sign my name on all drafts for payment of my bill. By filing my medical insurance, I will be responsible for any Co Pay and/or deductible allowed amounts per the contract with my medical insurance at each visit in which this amount will be reimbursed by my attorney or auto insurance upon settling you claim.

Patient's
Signature_____ Date_____

B. I, the undersigned patient understands that Zachary Chiropractic has a contact with Medical Insurance companies to file my medical insurance during my treatment here. I have been told the difference between filing my insurance and choosing not to file. By signing below, I hereby **DO NOT AUTHORIZE** Zachary Chiropractic Clinic to file my medical insurance during this treatment.

Patient's
Signature_____ Date_____

**ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE**

I, the undersigned patient am directing my attorney, _____to pay any out-standing bills out of my settlement and, in effect, protecting any such balance. I hereby understand that I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am personally responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

Patient's
Signature_____ Date_____

**X-RAY/MEDICAL RECORDS RELEASE**

I have requested the release of records of (patient's name) _____._____ , which are a part of the records at (clinic) _____.

I hereby request and authorize you, your employees and agents to furnish to the persons listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photo static copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward this to:

(Name)_____**Dr.NicoleHalkovic,DC**_____(Address)_____**1121-B Church Street Zachary, La 70791**_____

Patient's
Signature_____ Date_____

**CONSENT FOR TREATMENT OF MINOR**

I hereby authorize Nicole Halkovic, D.C., and whomever she may designate as his/her assistants to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as she deems necessary to my (indicate relationship of child: _____).

Childs Name: _____
Guardian
Signature_____ Date_____

## ACCIDENT INFORMATION

Patient Name: _____ Date of Accident: _____

Location/Road/Intersection _____

1. Where were you seated in the vehicle? _____
2. Where were your hands at the time of the accident? _____
3. What direction were you facing at the time of the accident? _____
4. What area of your vehicle was impacted? _____
5. Was Damage Considered ☐ Mild ☐ Moderate ☐ Totaled?
6. What position was your headrest in at time of accident? (Check Answer)

   ☐ High ☐ Middle ☐ Low ☐ Unknown

7. What were the Lighting Conditions? ☐ Dawn ☐ Dusk ☐ Full Daylight ☐ Night
8. What were the Road Conditions? ☐ Damp ☐ Dry ☐ Icy ☐ Snow ☐ Wet
9. What was the Visibility? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
10. What Type of Vehicle were you in? _____
11. Was your vehicle moving at the time of the Accident? ☐ Yes ☐ No
12. What was your speed at time of Accident? _____
13. What Type of Vehicle impacted yours? _____
14. What was the speed of the other vehicle? _____
15. Did Airbags Deploy? ☐ Yes ☐ No If yes, which ones? _____
16. Describe the accident to the best your ability. _____

    _____

    _____

17. How were you injured in your vehicle? (Check all that Apply)

    ☐ By being thrown from the Vehicle ☐ By the Seatbelt

    ☐ Hitting another Passenger ☐ Hitting the Back of the Front Seat

    ☐ Hit the Console ☐ Hit the Dashboard

    ☐ Hit Door ☐ Hit the Roof of the Vehicle

    ☐ Hit Steering Wheel ☐ Hit Side Window ☐ Hit Windshield

18. Did you lose consciousness following the accident? ☐ Yes ☐ No

    If Yes, for how long? _____

19. Were you aware of the Accident was going to happen? ☐ Yes ☐ No
20. Did you brace for impact? ☐ Yes ☐ No ☐ Don't Remember
21. Did you go to the hospital after the accident? ☐ Yes ☐ No
22. Did you go to an Urgent care after the accident? ☐ Yes ☐ No
23. What was the name of the facility? _____

☐ Did you go immediately after the accident?

☐ Later that day?

☐ Another date?

How did you get there? _____

24. Were X-rays taken? ☐ Yes ☐ No If so, what areas_____

25. Were any other Imaging tests performed? ☐ Yes ☐ No

26. Did you receive any medication or injections, if so, what were they? _____

_____

27. Did you receive any prescriptions for medications? ☐ Yes ☐ No

If yes, what were the names of the medications_____

_____

28. Did you fill your prescriptions? ☐ Yes ☐ No

29. Are you still taking your medications? ☐ Yes ☐ No

30. What areas of your body were injured in the accident? (Check all that apply)

☐ Back of Head Back of Neck ☐ Chest ☐ Fingers on Left Hand

☐ Fingers on Right Hand ☐ Forehead ☐ Front of Face ☐ Front of Head

☐ Front of Neck ☐ Left Arm ☐ Left Elbow ☐ Left Hand ☐ Left Hip

☐ Left Knee ☐ Left Leg ☐ Left Shin ☐ Left Shoulder ☐ Left Wrist ☐ Low Back

☐ Mid Back ☐ Nose ☐ Right Arm ☐ Right Elbow ☐ Right Hand ☐ Right Hip

☐ Right Knee ☐ Right Shin ☐ Right Shoulder ☐ Right Wrist ☐ Side of Face

☐ Side of Head ☐ Side of Neck ☐ Upper Back

31. What were your feelings following the accident? Check all that apply

☐ Anger ☐ Disoriented ☐ Dizzy ☐ Nauseous ☐ Scared ☐ Unconscious ☐ Upset ☐ Weak

32. Who have you seen since the accident for your symptoms?

☐ ER Doctor ☐ Urgent Care Doctor ☐ Primary Care Doctor ☐ Orthopedist

☐ Neurologist ☐ Pain Management Doctor ☐ Massage Therapist ☐ Acupuncturist

33. Have you lost any work due to the accident? If so, what dates?_____

Other_____

SIGNATURE: _____ DATE_____

# Post-Concussion Symptom Checklist

**Name:**_____

**Date:**_____

**Please indicate how much each symptom has bothered you over the past 2 days.**

| | Symptoms | None | Mild | | Moderate | | Severe | |
|---|---|---|---|---|---|---|---|---|
| PHYSICAL | Headache | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Nausea | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Vomiting | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Balance Problem | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Dizziness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Blurry or double vision | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Sensitivity to Light | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Sensitivity to Noise | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Balance Problems | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Pain other than headache | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| THINKING/ COGNITIVE | Feeling "in a fog" | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Feeling Slowed Down | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Difficulty concentrating | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Difficulty Remembering | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| SLEEP ISSUES | Trouble Falling Asleep | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Fatigue or low energy | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Drowsiness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| EMOTIONAL | Feeling more Emotional | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Irritability | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Sadness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Nervousness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

Do symptoms worsen with physical activity? Yes____ No_____ Not Applicable_____
Do symptoms worsen with thinking/cognitive activity? Yes_____ No_____ Not Applicable_____

Activity Level: Over the past two days, compared to what I would typically do, my level of activity has been _____% of what it would normally be.

Adapted from Oregon Concussion Awareness and Management Program (OCAMP)
http://media.cbirt.org/uploads/files/sports_concussion_management_guide.pdf