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: _____

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

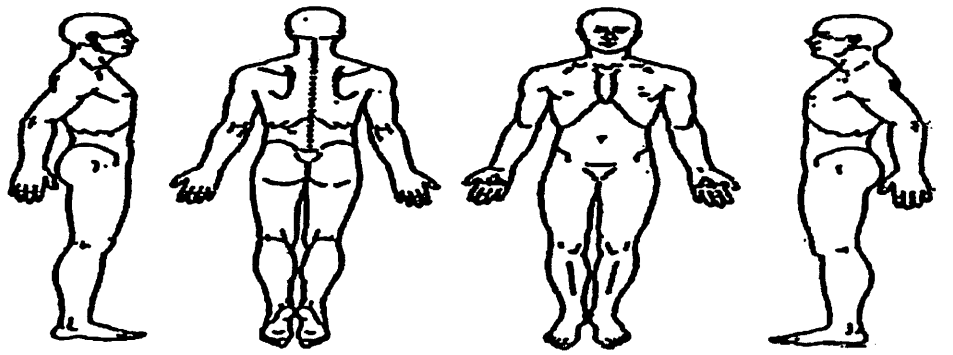
Does your pain wake you up at night? ◻ Yes ◻ No Do you take vitamins or supplements? ◻ Yes ◻ No

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? _____

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 _____

_____

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

NAME_____ DATE_____

CONSENT FOR TREATMENT

I, undersigned, hereby authorize Dr. 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 also 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

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 any and all drafts for payment of my bill.

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 make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly 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_____

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_____

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. Nicole Halkovic, DC** (Address)_____**1121-B Church Street Zachary, La 70791**_____

Patient's
Signature_____ Date_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $_____ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

_____

_____

_____

_____

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.