

CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
LAST NAME

Address _____
FIRST NAME MIDDLE INITIAL

City _____ State IL

Home Phone _____ Zip _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age _____ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

If you are already experiencing a symptom, what is it? _____

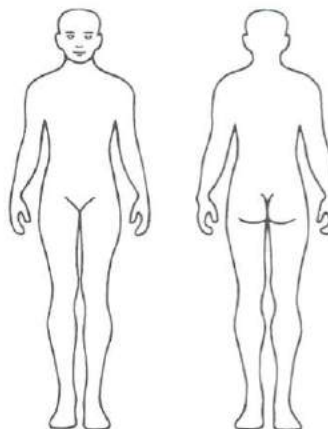
How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10
NO SYMPTOMS INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:

What does it feel like? (check where appropriate)

- | | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Nagging | <input type="checkbox"/> Other _____ |



IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10
NOT COMMITTED VERY COMMITTED

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages? _____

Childrens' health concerns? _____

Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Arteriosclerosis
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma/Allergies
<input type="checkbox"/> Back Pain
<input type="checkbox"/> Cardiovascular Issues
<input type="checkbox"/> Cancer | <input type="checkbox"/> Circulation Issues
<input type="checkbox"/> Childhood Illness
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Digestive Issues
(Constipation/Diarrhea/GERD/IBS)
<input type="checkbox"/> Elbow/Wrist/Hand Issues
<input type="checkbox"/> Endocrine Issues (Thyroid)
<input type="checkbox"/> Foot/Ankle Issues
<input type="checkbox"/> Gout | <input type="checkbox"/> Headaches / Migraines
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Hip Issues
<input type="checkbox"/> Immune Issues
<input type="checkbox"/> Lymphatic Issues
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Reproductive Issues | <input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Shoulder Issues
<input type="checkbox"/> Stroke
<input type="checkbox"/> TMJ Issues
<input type="checkbox"/> Urinary Issues
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Other _____
_____ |
|---|--|---|---|

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

MEDICATIONS (list)

SUPPLEMENTS (list)



Electronic Health Records Intake Form

In compliance with Medicare 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: _____

X	Height: _____	X	Weight: _____	Blood Pressure: _____ / _____
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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Ben Tapper and/or other licensed doctors of chiropractic who now or in the future work at The Wellness Pointe.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain **ALL** risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date _____

Witness Signature _____ Date _____



the
WELLNESS POINT

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge the information I have provided is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child ever has a change in health.

I certify that I, and/or my dependent has coverage with _____
Name of Insurance Company Policy #

and assign directly to Dr. Tapper and/or The Wellness Pointe all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Tapper and/or The Wellness Pointe may use my health insurance information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X _____
Signature of Patient, Parent, Guardian or Personal Representative

Social Security #

X _____
Date

Print name of Patient, Parent, Guardian of Personal Representative

Policy Holder Date of Birth

Relationship to Patient

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

Patient Name: _____

I was offered/ have received **The Wellness Pointe Notice of Privacy Practices** _____
Initial Here

X _____
Signature of Patient/Parent/Legal Guardian

X _____
Date

Relationship to Patient

Witness

Documentation of Good Faith Effort

- ☐ Attempted to distribute the Notice of Privacy Practices to the Patient/Parent/Legal Guardian, but the Patient, Parent, Legal Guardian declined to acknowledge the receipt of the Notice of Privacy Practices
- ☐ Patient/Parent/Legal Guardian stated they had already received the privacy notice.
- ☐ Patient/Parent/Legal Guardian directed our clinic's website to view the Notice of Privacy Practices.
- ☐ The Notice of Privacy Practices was mailed to the Patient/Parent/Legal Guardian.
- ☐ Other: _____

Witness

Date

The Wellness Pointe

16906 Burke St Ste 124

Omaha, NE 68118

402-933-4463

YOUR RIGHTS TO PRIVACY:

- ❖ **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy your medical information, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy & Security Office at the address on the top of this Notice. If you request a copy of information, we may charge a fee for the cost of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request the denial be reviewed. For more information call (402) 471-8417.
- ❖ **Right to Amend.** If you feel that medical information about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for DHHS. To request an Amendment, your request must be made in writing and submitted at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy & Security Office. In addition you must provide a reason which supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
 - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
 - Is not part of the medical information kept by or for DHHS;
 - Is not part of the information which you would be permitted to inspect and copy; or,
 - Is accurate and complete.
- ❖ **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy & Security Office address on the top of this Notice. Your request must state a time period for the disclosures, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list to be provided to you: for example, on paper, or by e-mail.
- ❖ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not use or disclose information about a surgery you had performed.

- ❖ **We are not required to agree to your request for restrictions.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy & Security Office at the address on the top of this Notice. In your request you must tell us: (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply; for example, disclosures to your spouse.
- ❖ **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy & Security Office. Your request must specify how or where you wish to be contacted.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with DHHS or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with DHHS, you may contact our Privacy Contact, DHHS HIPAA Privacy & Security Office at (402) 471-8417 Monday through Friday from 9:00 a.m. to 4:30 p.m., except State holidays, or hipaa.office@dhhs.ne.gov for further information about the complaint process. To file a complaint with HHS, contact: Secretary, Health and Human Services, Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 1-866-OCR-PRIV (627-7748), 1-866-778-4989-TTY. You will not be penalized for filing a complaint.

Changes to the Notice of Information Practices

The State of Nebraska Department of Health and Human Services reserves the right to amend this Notice at any time in the future. Until such amendment is made, DHHS is required by law to abide by the terms of this Notice. HHSS will provide notice of any material change in revision of these policies.

Contact Information

This notice fulfills the "Notice" requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at the State of Nebraska, Department of Health and Human Services please direct them to: The HIPAA Privacy & Security Office, 301 Centennial Mall South, Lincoln, Nebraska 68509-5026. By e-mail to hippa.office@dhhs.ne.gov

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NOTICE OF INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Effective:04/14/2003

The Department of Health and Human Services of the State of Nebraska, and those Agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the Nebraska Partnership for Health and Human Services Act, are required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information.

PRACTICES AND USES:

DHHS may access, use and share medical information for purposes of:

- ❖ **Treatment:** We may use your medical information to provide you with medical treatment or services. For Example; a doctor may need to tell the dietitian if you have diabetes so that appropriate meals can be prepared.
- ❖ **Payment:** We may use and disclose your medical information so that the treatment and services you receive can be billed. For example, we may use your medical information from a surgery you received at the hospital so that the hospital can be reimbursed.
- ❖ **Operations:** We may use and disclose medical information about you for medical operations. For example, we may use medical information to review your treatment and services and to evaluate the performance of the staff.

OTHER PERMITTED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT CONSENT:

- ❖ **Required By Law:** We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. You will be notified, if required by law, of any such uses or disclosures.
- ❖ **Public Health:** We may disclose your Protected Health Information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- ❖ **Communicable Diseases:** We may disclose your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- ❖ **Health Oversight:** We may disclose Protected Health Information to a health oversight agency for activities authorized by law, or other activities necessary for appropriate oversight of the health care system, government benefit programs, other government regulatory programs, and civil rights laws.
- ❖ **Abuse or Neglect:** We may disclose your Protected Health Information to a public health authority that is authorized by law to receive reports of abuse or neglect. The disclosure will be made consistent with the requirements of applicable federal and state laws.
- ❖ **Legal Proceedings:** We may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions

- ❖ **Law Enforcement:** We may also disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- ❖ **Food and Drug Administration:** We may disclose your Protected Health Information to a person or company as required by the Food and Drug Administration.
- ❖ **Coroners, Funeral Directors, and Organ Donation:** We may disclose Protected Health Information to a coroner or medical examiner for identification purposes, cause of death determinations, or for the coroner or medical examiner to perform other duties authorized by law.
- ❖ **Research:** We may disclose your Protected Health Information to researchers when their research has been approved by an institutional review board to ensure the privacy of your Protected Health Information.
- ❖ **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- ❖ **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel.
- ❖ **Workers' Compensation:** We may disclose your Protected Health Information as authorized to comply with workers' compensation laws and other similar legally established programs.
- ❖ **Inmates:** We may use or disclose your Protected Health Information if you are an inmate of a correctional facility in the course of providing care to you.
- ❖ **Required Uses and Disclosures:** Under the law, we must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR, Title II, Section 164, et. seq.

OTHER USES OF MEDICAL INFORMATION

DHHS Privacy & Security Office, 301 Centennial Mall South, 5th Floor, P.O. Box 95026, Lincoln, NE 68509-5026