Naig Family Chiropractic
Confidential Patient Intake and Health Form

▪ Personal Information

Name (Legal):		Preferred name (Nickname):
Address:		Referred By:
City:	State: Zip:	Date of Birth:
Social Security # :	Sex: M / F	Marital Status: Married / Single
E-Mail Address:		Parent/Guardian:
Home Phone:	Work Phone:	Cell Phone:
Cell Phone Carrier:	Text Message Appointment Reminders (please circle): Yes or No_____	
Occupation:		Employer:
Typical Job duties:		
Spouse's Name:		Spouse's occupation:
Emergency Contact:		Emergency contact phone #:

Is this appointment related to an auto accident? Yes / No
(If this injury is related to an auto accident, please fill out auto accident questionnaire)

Name of person(s) we can discuss your care/account with (name, address, phone)

Name of Nearest Relative: Phone:

Have you ever had the same or similar condition? If yes, please describe:

Have you been treated by another physician for this condition? Y / N
Doctor's Name(s)

Have you ever had Chiropractic care before? Yes / No (If yes, how long ago and name?)

Were you pleased with you care?

▪ Payment Information

Person responsible for account and payment:		Parent/Guardian:
Social Security #:	Phone:	Date of Birth:

▪ Insurance Information

Do you have health insurance? _____ Yes _____ No

Please check any & all medical coverage that may be applicable in this case:

__ Major Medical __ Medicare __ Medical Savings (FSA/MSA)
__ Worker's Compensation __ Auto Accident __Other

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Policy Holder's Social security #:	Policy Holder's Social security #:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

- History

Date of Last Physical exam: ____ / ____ / ____
Height _____ Weight _____
On a scale of 0 to 100, how healthy do you think you are? 0--------25---------50--------75--------100

List vitamins/supplements/homeopathies taking and amount:	List any medications you are taking and what is their intended use:

Do you drink alcoholic beverages? Y N If so, how many per week? _____
Do you use any tobacco products? Y N Smoke/Chewing Tobacco Cans/Packs per week: ___
Do you consume caffeine? Y N If so, how many cups/day? ____
Do you exercise? Y N If yes, what type & how frequent? _____
What are your hobbies? _____
What percentage of your day (at home/work) do you: ___ Lift ____ Sit ____Bend ____Work at Computer
What is your work schedule?
Describe your work environment.

List any and all accidents, falls, or traumas that you have had in your lifetime (include car accidents and injuries sustained). Women include information about childbirth and dates

1) 5)

2) 6)

3)

4)

Do you have any specific illnesses?

What allergies do you have?

What surgeries have you had and dates?

What is the cause and age of deaths with parents or siblings?
Parents: Father Living?_____ If living, current age:_____
Deceased? _____ If deceased, cause of death & date: _____

Mother Living?_____ If living, current age:_____
Deceased? _____ If deceased, cause of death & date: _____
____ As an adopted child, little is known about birth parents &/or family medical history (check, if applicable)

Family Diseases (check if applicable & indicate whether family member is **F**ather, **M**other, **S**ister or **B**rother):

___ Tuberculosis	___ Arthritis	___ Kidney Disease	___ Heart Disease
___ Diabetes	___ Cancer	___ Liver Disease	___ Lung Disease
___ Stroke	___ Asthma	___ Mental Illness	Other _____

List the names, ages, and health conditions of your children?

- CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

___Alcoholism	___Diabetes	___Measles	___Stroke
___Anemia	___Diphtheria	___Multiple Sclerosis	___Tonsillitis
___Appendicitis	___Eczema	___Mumps	___Tuberculosis
___Arteriosclerosis	___Emphysema	___Pleurisy	___Typhoid Fever
___Asthma	___Epilepsy	___Pneumonia	___Venereal Disease
___Osteoarthritis	___Rheumatoid Arthritis	___Cancer	___Goiter
___Polio	___Whooping Cough	___ Pacemaker	___Cold Sores
___Seizures/Convulsions	___ HIV Positive	___ Eating disorder	___ Drug addiction
___Chicken Pox	___Heart Disease	___ other heart problems	___Rheumatic Fever
___Hypoglycemia	___Scarlet Fever	___ _____	___ _____

___Broken Bones Where and when-_____

CHECK ANYOF THE FOLLOWING SYMPTOMS WHICH YOU HAVE NOW (N) OR THE PAST (P):

Now	Past	*GENERAL:*
___	___	Severe or frequent Headaches
___	___	Sinus Infections
___	___	Frequent Colds
___	___	Depression
___	___	Loss of Sleep
___	___	Loss of Weight
___	___	Nervousness
___	___	Tremors
___	___	Arthritis
___	___	Bursitis
___	___	Dizziness
		PAIN/NUMBNESS In:
___	___	Neck
___	___	Upper Back
___	___	Shoulders
___	___	Elbows
___	___	Hands
___	___	Lower Back
___	___	Hips
___	___	Legs
___	___	Knees
___	___	Feet
___	___	Sciatica
		GASTRO-INTESTINAL:
___	___	Belching/Gas
___	___	Ulcer/Colitis
___	___	Constipation
___	___	Diarrhea
___	___	Liver Trouble
___	___	Gall Bladder Trouble
___	___	Acid Reflux/Difficult Digestion
___	___	Jaundice
		SKIN:
___	___	Bruise Easily
___	___	Hives or Allergy
___	___	Itching or Rashes

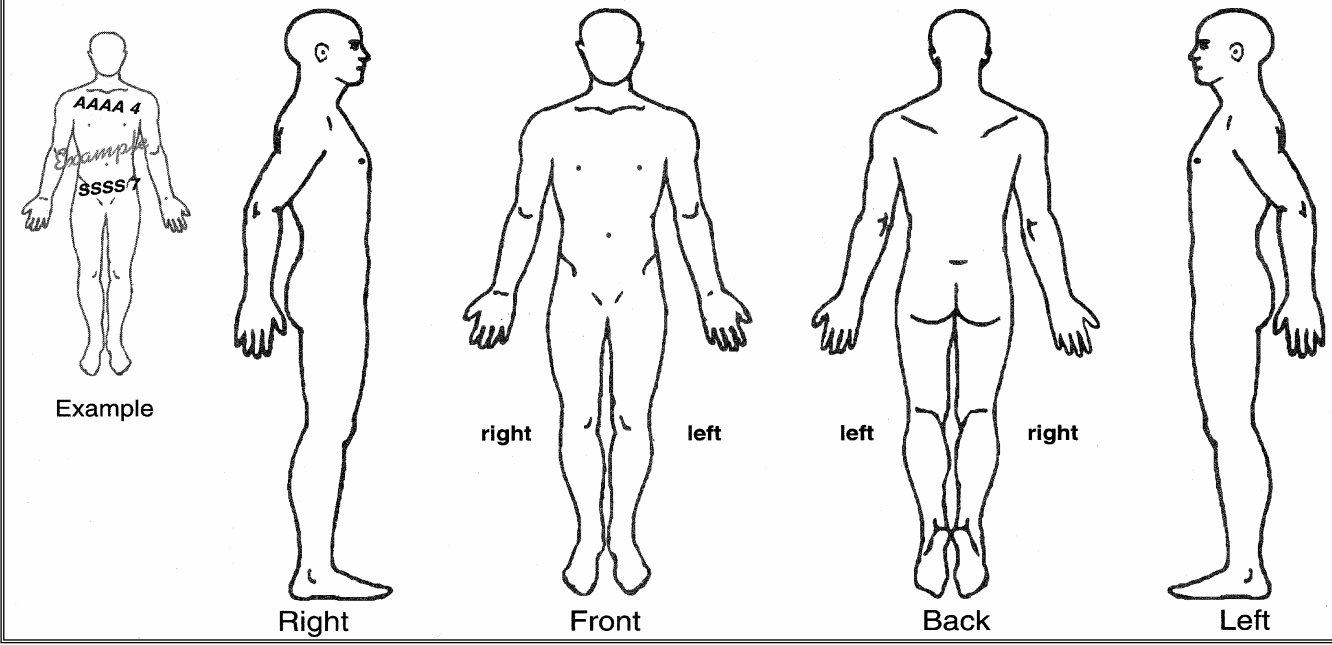
Now	Past	*E.E.N.T.:*
___	___	Deafness
___	___	Earache
___	___	Eye Pain
___	___	Hay Fever
___	___	Sore Throat
___	___	Nasal Obstruction
___	___	Hoarseness
___	___	Nosebleeds
		CARDIOVASCULAR:
___	___	High Blood Pressure
___	___	Low Blood Pressure
___	___	Cold Hand/Feet
___	___	Heart Surgery/Pacemaker
___	___	Rapid/Slow Beating Heart
___	___	Swelling Ankles
___	___	Varicose Veins
		RESPIRATORY:
___	___	Chest Pain
___	___	Chronic Cough
___	___	Difficulty Breathing
___	___	Wheezing
		GENITO-URINARY:
___	___	Bed Wetting
___	___	Blood/Pus in Urine
___	___	Frequent Urination
___	___	Can't Control Urine
___	___	Painful Urination
___	___	Prostate Trouble
		FOR WOMEN ONLY:
___	___	Cramps or Backache
___	___	Excessive Flow / Discharge
___	___	Hot Flashes (Menopausal Symptoms)
___	___	Irregular Cycle / Painful Menses
___	___	Miscarriage

ARE YOU PREGNANT? YES____ NO_____

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

◯ Circle any area of pain not represented by a symbol.



- Major Complaint - Naig Family Chiropractic

What is your primary complaint?

When did it start?

What were you doing?

Where is the symptom?

Where does it travel?

Describe the symptom

Sharp Dull Aching Burning Numb Throbbing Radiating

How severe is it? 1-2-3-4-5-6-7-8-9-10

How often do you have it?

Constant 100% Frequent 75% Intermittent 50% Occasional 25% Rare 10%

Anything make it better?
or worse?

What movements are difficult?

What have you done for this already?

What activities can you NOT do because of this?

What would you like to gain from Chiropractic care?

Goals for your care and overall health and wellness? (top 3, list more if have them)

Activities of Daily Living No Answer = No Limitations

(fill out items when applicable)

1) Standing: I can stand ___ minutes before I must rest.
2) Sitting: I can sit ___ minutes before I must stand or lie down.
3) Lying down: I can lie down for ___ minutes/hours before I have to change positions.
4) Sleeping: I've been losing ___ hours of sleep at night because of my condition.
5) Getting out of a chair: I am unable to get out of a chair without (assistance, pain).
6) Walking: I can walk ___ (blocks, miles) before I have to stop.
7) Work: I am (slightly limited, very limited, unable) to work due to my condition.
8) Running: I can run ___ (blocks, miles) before I have to stop.
9) Driving: I can drive ___ (hours) before I have to stop.
10) Reaching Up: I am unable to reach up with my (R, L) arm.
11) Reaching Behind: I am unable to reach behind with my (R, L) arm.
12) Lift Weight: I can lift ___ lbs off the floor due to my condition.
13) Desk-work: I am able to work at a computer ___ hours before I have to stop.
14) Opening Jars: I can open a (loosely, moderately, very) tightened lid due to my condition.
15) Housework: I am unable to (dush, wipe surfaces, move furniture, vacuum).
16) Personal Care: I need (little help, some help, full help).
17) Reading: I can read for ___ hours before I have to stop.
18) Recreational: My condition has (moderately, severly, totally) limited my activities.
19) Social Life: Restricted, slightly limited, normal
20) Traveling: Mild pain, moderate pain, severe pain, unable to travel.

Naig Family Chiropractic

Please read this entire document before signing it. It is important that you understand the information contained in this document. Please ask questions before you sign it if there is anything that is unclear.

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 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 a lessening of the body's innate ability to express its maximum health potential.

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 a health care provider who specializes in that area. **Contra-Indications to Care:** Where vertebral subluxations are detected, the chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to injury. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you are aware that you are suffering from: pathological conditions, illnesses, injuries, or deformities, it is your responsibility to inform me.

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 subluxation. **The Nature of the Chiropractic Adjustment :** The primary treatment a Doctor of Chiropractic uses is spinal manipulative therapy. This procedure will be used to treat you whether it may be by hand or via a hand-held mechanical instrument. When your joints are adjusted, you may feel a sense of movement and it may cause an audible 'pop' or 'click', much as you have experienced when you 'crack' your knuckles. **Analysis/Examination/Treatment**: As part of the analysis, examination, and procedure you are consenting to the following procedures: postural analysis, vital signs, range of motion testing, muscle strength testing, basic neurological testing, orthopedic testing, palpation, spinal & extremity manipulative therapy, Active Release Techniques, EMS, ultrasound, and any other modalities or tests that may be relevant to your condition.

The Material Risk Inherent in the Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. These complications are general described as rare. Some types of manipulations of the neck have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. Stroke has been the subject of tremendous disagreement; the incidences are exceedingly rare and estimated to occur between one in one million and one in five million cervical adjustments. More commonly, patients may feel some stiffness and soreness following the first few days of treatment as their body accommodates to the adjustment. Due to the complexities of medical conditions and the many variables that can affect a patient's response, no specific results or guarantees can be promised or implied. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may grant or withhold your consent for procedures described to you for the treatment of your condition.

The Availability and Nature of other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammato
- Hospitalizations and/or Surgery
- and pain-killers

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduced mobility, progression of symptoms, and deterioration of your condition which may reduce your functioning and overall health. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I voluntarily request Dr. Jeremiah Naig to be my physician and such associates to examine and treat my condition as they deem necessary. 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 doctors feels at the time, based upon the facts known to him or her, is in my best interest. By signing below, I affirm that I have been open and truthful in disclosing my health history. I have had all my questions answered to my satisfaction and have decided that it is in my best interest to undergo the recommended treatment. I intend this consent form to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I therefore accept chiropractic care on this basis.

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signature Relationship to Patient Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature Relationship to Patient Date

Insurance

Your insurance company will only pay for services that they determine are medically necessary. As a patient you must understand that some or all services provided for your care might not be covered by your contract benefits. You as a patient are liable for all charges that your plan does not cover. I have been notified by my physician that my insurance may not cover all the services provided for my care. If payment is denied for these services, I agree to be personally and fully responsible for payment. Any co-pay, coinsurance, or deductible is due at the time of service.

Signature Relationship to Patient Date

Personal Financial Responsibility

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize Dr. Naig to release any medical records concerning my physical condition to any insurance company, attorney, or adjustor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by him and release him of any consequence thereof. I authorize the release of all information necessary to communicate with personal physicians and other healthcare providers to collaborate care for my condition. Furthermore, I understand that Dr. Naig will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Naig will be credited to my account on receipt and I agree that a reproduced copy of this authorization will be as valid as the original. I do understand that insurance companies do not pay for services that they determine to be not "medically necessary" and therefore, may deny payment for services provided to me by the chiropractor. I understand that regardless of my insurance coverage, I am responsible for all costs of chiropractic care or any amount not covered by my insurance plan. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature Relationship to Patient Date

Staff Only:

Information Taken By_____ Date _____

Reviewed By_____ Date _____