Eagle Valley Chiropractic New Patient Intake Form

Patient Data **Date:**

First Name _____ Middle Initial ____ Last Name _____
Address Line 1 _____
Address Line 2 _____
City _____ State _____ Zip Code _____
Primary Phone (_____) _____-_____ Work Phone (_____) _____-_____
Email _____
Date of Birth _____/_____/_____ Sex: ___Male ___Female
Social Security Number: _____-_____-_____ Marital Status: ___Single ___Married __Widowed
Employment Status: __Employed __Unemployed __FT Student __PT Student __Other: _____
Your Occupation _____
How did you hear about our office? _____

Emergency Contact

Contact Name _____ Relationship to Patient _____
Contact Phone (_____) _____-_____

Medical Conditions: (Check all that apply to you now or in the past)

___Arthritis ___Cancer ___Diabetes ___Heart Disease
___Hypertension ___Psychiatric Illness ___Skin Disorder ___Stroke
___Other: _____

Past Trauma: (Check all that apply to you)

___Auto Accident ___Abuse ___Sports ___Other:_____

Surgeries: (Check all that apply to you)

___Appendectomy ___Cardiovascular Procedure ___Cervical Spine ___Hysterectomy
___Joint Replacement ___Prostate ___Lumbar Spine ___Gall Bladder
___Brain ___Shoulder ___Thoracic Spine ___Knee
___Carpal Tunnel ___Gastrointestinal ___Urogenital ___Hernia
___Other: _____

Social History: (Check all that apply to you)

___Caffeine Use ___Drink Alcohol ___Exercise ___Tobacco Use

Family History: (Check all that apply)

___Arthritis ___Diabetes ___Cancer ___Heart Disease
___Thyroid ___Other: _____

Allergies:

1)_____ 2)_____
3)_____ 4)_____

Medications:

1)_____ 2)_____
3)_____ 4)_____

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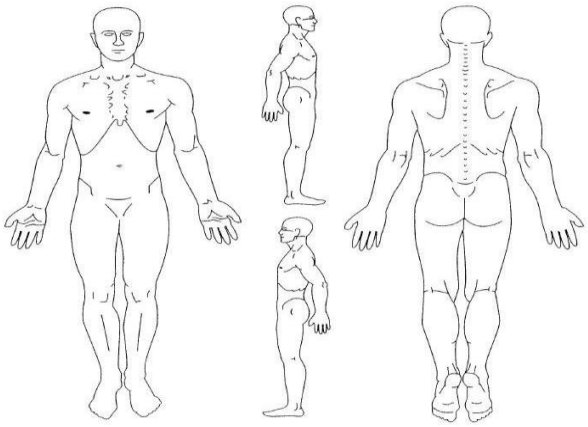
By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1:

_____

_____

_____

_____

_____

How would you rate your pain on a scale of 0-10? (10 being the most severe): _____

When did your symptoms begin? _____

Are you pregnant? Yes_____ No _____ N/A_____

Health Goals:_____

_____

Payment/Insurance Information: (Who should the charges be billed to?)

___Self ___Health Insurance ___Worker's Comp ___Auto Insur.

Insurance Subscriber: _____ Subscriber's Date of Birth: _____

Financial Responsibility and Informed Consent to Chiropractic Treatment:

The patient is fully responsible for all charges incurred including but not limited to any deductibles and co-payments. Eagle Valley Chiropractic will file all charges with your insurance company (if you choose), and any unpaid amount is your responsibility.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy on me by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I further understand that such chiropractic services may be performed by the Eagle Valley Chiropractic clinic and/or other licensed physicians of chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with the physician and/or with other office 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 and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above financial responsibility and consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician and understand the financial terms indicated and that all information on the intake form is true to the best of my knowledge. I intend this consent to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Signature of Patient (OR if under 18, Parent/Guardian):_____**Date:**_____

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Notice of Privacy Policy:
Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Signature of Patient (OR if under 18, Parent/Guardian):_____**Date:**_____

Relationship to Patient (if applicable):_____

Office Personnel Signature:_____**Date:**_____