LINDLEY CHIROPRACTIC - INTAKE PAPERWORK

PATIENT INFORMATION	CONTACT INFORMATION
Today's Date: ____________________ Name: _________________________ Preferred Name: ________________________ Birth Date: _____________ Age: ___________ Sex at Birth: ☐ M ☐ F Gender Identity: ________ Address: ____________________ City: _______________ State: _____ Zip: _________ How did you hear about us?: ___________________	Home: ______________________ Cell: ______________________ Email: ________________________________ Preferred Communication: ☐ Email ☐ Phone Do we have your expressed permission to send occasional educational and promotional content to your email? ☐ Yes ☐ No EMERGENCY CONTACT: ______________________ Relationship: ______________________ Phone Number: ______________________
EMPLOYMENT STATUS	**PHYSICIAN INFORMATION**
Past / Current Occupation: _____________________ Employer: ________________________________ Employed: ☐ Full-Time ☐ Part-Time ☐ Retired If you're unemployed, is this due to your present condition: ☐ Yes or ☐ No If you are unemployed, indicate how long you have been off of work: ______________________	Primary or Referring MD: _____________________ Clinic Name & Ph: __________________________ Other Physician: ___________________________ Clinic Name & Ph: __________________________
INSURANCE INFORMATION	**ACCIDENT INFORMATION**
☐ Commercial Health Insurance ☐ Self-Pay Insurance Co.: ________________________ ID #: ____________________________ Group: __________________ SS#: __________________ Subscribers Name: ________________________ Relationship to Patient: ________________________	Is this condition due to an accident: ☐ YES ☐ NO If known, what was the date of the injury: (____/____/____) ● Worker's Compensation ● Personal Injury / Liability ● Other: __________________ To whom have you made a report of this accident: ● Auto Insurance ● Employer ● Workers Compensation ● Other: __________________ Attorney Name & Phone Number (if applicable): ________________________________ ________________________________

CHIEF COMPLAINT*:* What is the single most important complaint / problem for which you are seeking treatment? Describe how it feels. (Additional complaints can be listed on the next page)

____

____

ONSET: When/How did your complaint start? (check appropriate boxes)

When did it first start? __________years _________months ________week _______days

☐ Suddenly ☐ Gradually ☐ Bending ☐ Pulling ☐ Lifting ☐ Fall ☐ Injured at work

☐ Injured during sports ☐ Injured in auto accident ☐ Unknown ☐ Other __________________________

What is the <u>range of the severity</u> of this complaint 0-10 (0=best, 10=unbearable, hospital required) ____________

What makes the complaint worse? ____

What makes the complaint better? ____

SEVERITY OF PAIN: Please describe the intensity of your complaint:

☐ Mild ☐ Moderate ☐ Moderate - Severe ☐ Severe ☐ Unbearable

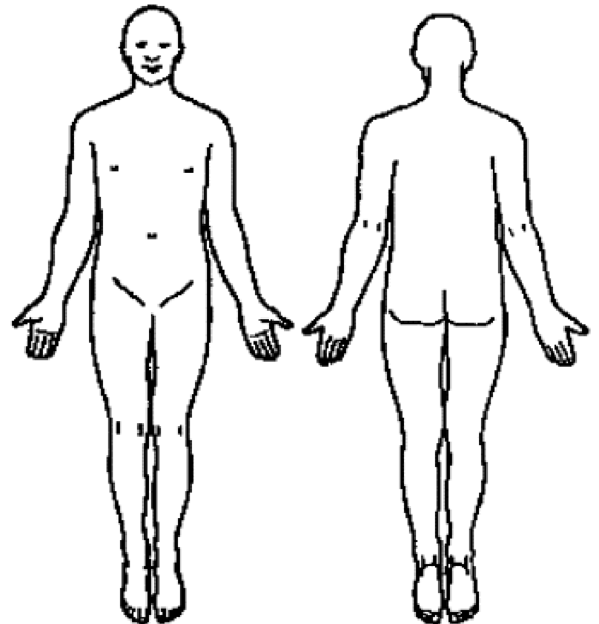
TIMING OF PAIN: How often do you have your complaint? ☐ Constant ☐ Intermittent ☐ Occasional

Is your sleep disturbed by your complaint? ☐ Yes - How many times do you wake/night ________ ☐ No

Is the complaint getting worse? ☐ Yes – describe:______________________________ ☐ No

How are the following affected by your complaint (please check one for each item)?

	Aggravated By:	Not Affected	Improves By:
Bending Fully			
Bending Slightly			
Coughing/Sneezing			
Driving			
Exercise			
House Cleaning			
Hygiene / Bathing			
Lying Down			
Raising Arm Overhead			
Sitting			
Sit & Pushup on hands			
Sit with Support			
Standing			
Walking			



PAIN LOCATION: Please mark the location(s) of your **primary** complaint symptoms on the diagrams using: **X=Pain B=Burning C=Cramping N=Numbness S=Soreness ST= Stiffness T=Tingling W=Weakness R=Radiating**

Have you taken any recent falls? ☐ Yes ☐ No

How many blocks can you walk? #______Blocks

To assist walking, I use a: ☐ Cane ☐ Walker ☐ Wheelchair ☐ None

Have you unintentionally dropped objects recently:: ☐ Yes ☐ No

MOTIVATION / COMMITMENT:

What is the most important thing you hope to regain from successful treatment?

____

____

How important is it to you, to do whatever it takes to regain these aspects of your life? (1-10) _____________

SECOND COMPLAINT:____

When & how did this complaint start?____

What makes the complaint worse? ____

What makes the complaint better? ____

What words would you use to describe this complaint? ______________________________________

Does your condition radiate anywhere? ____

What is the severity of your complaint 0-10 (0=best, 10=unbearable, hospital required) ________________________

What time of the day is your complaint the worst? ____

Before this complaint began, had you ever experienced this type of problem before______________________

What lifestyle changes have you had to make due to this complaint?____________________________

DIAGNOSTIC STUDIES:

X-Rays: Yes (of what)_____________________ CT (Computed Tomography) Scan: Yes (of what)____________

Discogram: Yes (of what)__________________ Electromyogram (EMG) / NCV: Yes (of what________________

MRI: Yes (of what)______________________ DEXA (Bone Density Testing): Yes (of what)_______________

REVIEW OF CURRENT SYSTEMS: [please READ CAREFULLY and check appropriate boxes]

☐ Back problems, poor posture, arthritis. ☐ Recent or sudden weight loss, fever, chills, weakness or fatigue.

☐ Recent or sudden difficulty concentrating or memory issues. ☐ Recent headache, dizziness or syncope.

☐ Recent or sudden change in smell, vision or hearing. ☐ Recent or current enlarged lymph nodes.

☐ Recent unexplained skin rash or itching. ☐ Recent sweating, cold or heat intolerance.

☐ Recent anemia, bleeding or sudden unexplained or excessive bruising.

☐ Recent or sudden shortness of breath, coughing, chest pain/pressure/discomfort or heart palpitations.

☐ Recent burning on urination, change in bowel / bladder control or recent increase in Erectile Dysfunction.

PAIN TREATMENTS: Please check your response to the treatments you have tried.

TREATMENT	NEVER TRIED	NO RELIEF	MILD RELIEF	MODERATE RELIEF	EXCELLENT RELIEF	DETAILS
TRACTION						
PHYSICAL THERAPY						
ACUPUNCTURE						
CHIROPRACTIC						
ORTHOTICS						
MASSAGE THERAPY						

CURRENT MEDICATIONS or SUPPLEMENTS:

Name	Dose/ Frequency	Reason

My pain medications provide relief: ☐ None ☐ Some ☐ All of the time ☐ Not Applicable

Do you take Blood thinners ie. Aspirin, Plavix or Coumadin? ☐ Yes ☐ No

PAST MEDICAL HISTORY:

Have you had any of the following health problems (please check all that apply)?

☐ Angina or chest pain
☐ Anxiety
☐ Arthritis
☐ Bleeding/Clotting
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Epilepsy or Seizures

☐ Fibromyalgia
☐ Heart Attacks / TIAs
☐ Hepatitis / Liver Problems
☐ High Cholesterol
☐ HIV / AIDS
☐ Hypertension
☐ Spine Trauma
☐ Cancer- specify type ________________________________

☐ Kidney Disease
☐ Lyme's Disease
☐ Multiple Sclerosis
☐ Stroke
☐ Thyroid Disease
☐ Weight Loss Resistance

SOCIAL HISTORY:

Do you smoke/ chew / Vape nicotine ? ☐ Yes _____________ /day ☐ Yes -In the Past ☐ No - Not ever

How much alcohol do you drink on a weekly basis? ____________________ ☐ Yes - In Past ☐ No – Never

How much caffeine do you drink daily? ___________________ How much water do you drink daily? ___________

Your Height: _____________ Current Weight: ___________ Your Current Exercise Routine: _______________________Frequency: _______________

PAST SURGICAL HISTORY:

DATE	TYPE OF OPERATION AND OUTCOME OF THE SURGERY

Hospitalizations other than Surgery listed above:

Year	Hospital	Reason for Hospitalization and Outcome

Pregnancies:

Year of Birth	Sex of Birth	Complications, if any

IMMEDIATE FAMILY HISTORY:

☐ I Decline to Disclose my family Health History

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✔) if your immediate blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis, Rheumatoid, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes, Clotting	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	

ALLERGIES:

Any known allergies to medications, foods or the environment?

____

Additional Complaints/Symptoms/Conditions/Notes:

____

____

____

ASSIGNMENT OF BENEFITS

I, ____ authorize and assign payment of benefits due under terms of any insurance policy or policies that may cover the medical procedure(s) performed at the address provided on any claim form submitted to my insurance carrier(s). I hereby instruct and direct my insurance company to make payment by check made out to Three Pillars Body Restoration Clinic. I understand and agree that I am financially responsible for charges not covered by the assignment authorization, payment of bills and any deductibles or co-payment / co-insurance as determined by my insurance carrier's contract.

Signature: ____ Date: _____________________

HIPAA PRIVACY PRACTICES

I, ____ have received a copy of the HIPAA Notice of Privacy Practices. I have read and understand my rights as afforded to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that I may ask questions in the office.

Signature: ____ Date: _____________________

CONSENT TO RELEASE INFORMATION TO FRIENDS AND FAMILY

I give the providers and office staff of Three Pillars Body Restoration Clinic permission to discuss my medical condition with the following people listed below. The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Information to be shared:

☐ All health information

☐ Limited health information (describe here): ____

Name: ____ Relationship: _________________ Phone: _____________________

Name: ____ Relationship: _________________ Phone: _____________________

Signature: ____ Date: _____________________

ELECTRONIC COMMUNICATIONS AUTHORIZATION FORM

The Health Insurance Portability and Accountability Act (HIPAA) requires that all healthcare providers take reasonable measures to safeguard your Protected Health Information (PHI) at all times. This includes securing your PHI as much as possible when it is communicated electronically via facsimile, text or email. Unfortunately, even with appropriate safeguards in place it is impossible to ensure that electronic communications are entirely safe at all times. In order to accommodate requests for electronic communications for purposes such as appointment scheduling, billing, health record transmission,
and marketing, HIPAA requires that we obtain your written authorization.
We understand that you are on a path to better well-being and we would like to facilitate that process as much as possible. Electronically transmitting copies of your Electronic Health Record saves you time and money. Authorizing us to quickly communicate with you and/or others involved in the handling of your care will help us to better serve you. Please carefully read the risks listed below and ask any questions of us that you may have. You may revoke these authorizations at any time by speaking with our office staff.

Risks and Conditions of Using Electronic Communication:

Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties. Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information. Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings. Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the provider or patient. Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system. Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients. Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent. Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications. The physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The physician might use one or more of the services to communicate with those involved in your care. The physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.

- ☐ I understand the risks associated with secured and unsecured electronic transmissions and hereby authorize Lindley Chiropractic to communicate with me via email for the purpose of health care operations.
- ☐ I understand the risks associated with secured and unsecured electronic transmissions and hereby authorize Lindley Chiropractic to communicate with me via email for marketing purposes.
- ☐ I understand the risks associated with secured and unsecured electronic transmissions and hereby authorize Lindley Chiropractic to communicate with my Primary Care Provider as listed in my New Patient Intake.
- ☐ I understand the risks associated with secured and unsecured electronic transmissions and hereby authorize Lindley Chiropractic to transmit my Electronic Health Record though those involved in the handling of my care with my signed authorization. I understand that I will be notified beforehand so as to ensure that my PHI is sent only to the appropriate parties as requested by me.

I understand the risks associated with secured and unsecured electronic transmissions and therefore reserve my right to opt out of any electronic communications regarding my health care.

________________________________ ______________________________ ________________

Name (Printed) Signature Date

____ ______________________

My email address My cell number

INFORMED CONSENT FOR CHIROPRACTIC CARE

To the patient (or their parent, legal guardian, court appointed conservator, or agent): Please read this entire form prior to signing it. It is important that you understand the information contained in this form. Please ask any questions prior to signing this form if you are unclear about anything in this form.

Chiropractic Adjustments and Other Procedures -
The primary treatment rendered by the Doctor of Chiropractic to you will be chiropractic adjustments, which are purposely intentioned movements of bones with the desired effect being to remove interference to nerves, which then allows your body to use its innate ability to heal itself. Chiropractic adjustments also have the desirable effect enabling muscles, tendons, and ligaments to properly function and heal, and also allows blood flow to properly occur. Chiropractic adjustments can be made by either the use of hands or mechanical instruments to any bone or joint in the body including both spinal and extremity bones. You may or may not hear an audible sound, which is just air being released from the joint space as bones are moved into their proper positions.

There are a number of other procedures used by Doctors of Chiropractic that may be used on you. A physical examination will be performed to obtain a baseline level of functioning as well to partially determine an appropriate course of treatment and associated recommendations. The physical examination may include posture checks, range of motion testing, muscle strength testing, various neurological and orthopedic testing, and other testing. Radiology is the use of x-rays on the human body and is used to gain an inside perspective of the human body that cannot be obtained from a physical examination. Treatment may include chiropractic adjustments, physical therapy (such as ultrasound, interferential therapy, massage therapy, exercise recommendations, etc.). Additionally, there may referrals to other doctors as necessary, and their treatment should involve the same informed consent with disclosure of risks and benefits as is being done here. For example, there can be permanent pain as a side effect of surgery as one possible consequence of that procedure.

Material risks Inherent with Chiropractic Adjustments and Other Treatment -
As with any healthcare procedure, there are certain complications which may arise when chiropractic adjustments and other care/procedures are performed. These complications include but are not limited to fractures of bones, disc injuries, dislocations, muscle strains, cervical myelopathy, strokes, radiation exposure, costovertebral strains and separations, and burns. Some patients feel some stiffness and/or soreness following the first few days of treatment. The physical exam can temporarily worsen symptoms, but is a necessary part of chiropractic care. The Doctor of Chiropractic will make every reasonable effort during the examination to screen for contraindications to care, but remember it is your responsibility to inform the Doctor of Chiropractic of any conditions that would not otherwise come to their attention.

Potential Benefits of Chiropractic and Associated Care -
The vast majority of chiropractic patients tend to achieve good to excellent improvement in their physical conditions with chiropractic care. Improvement can be measured in many different ways, including reduction in pain, increased range of motion, less stiffness, increased athletic performance, and other ways. It must be remembered that different people get different results, different people have different pre-existing conditions, and are of different ages and occupations (with different types of physical stress). Your situation is unique, and no guarantees are given. You will have to determine what results you get for yourself and report them to your Doctor of Chiropractic.

Consequences of Not Obtaining Chiropractic Care -
Not obtaining chiropractic care will have the effect of not obtaining its benefits such as having your body function at its best ability, reducing pain, peak athletic performance, etc. Not obtaining chiropractic care may allow formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult, requiring more time (and money), and less effective when chiropractic care is obtained later in time. Not obtaining chiropractic care following trauma such as whiplash or other effects of automobile accidents will cause injured muscles, tendons, and ligaments to heal improperly and be significantly weaker and more prone to reinjury as compared to receiving proper chiropractic care.

I have read, understand and agree to the following consent.

______________________________	______________________________	________________
Name (Printed)	Signature	Date