Patient Intake

Today's Date: ____/____/____

Name: _____ Age _____ Date of Birth _____

Local Address _____ City _____ State ____ Zip _____

Out of Town Address _____ City _____ State ____ Zip _____

Marital Status _____ Sex _____ S.S.# _____ Home Phone _____ Cell. Phone _____

Email Address: _____ Employer _____

Occupation _____ Address/Phone _____ Spouse _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about our office?

☐ Yellow Pages ☐ Drive By ☐ Walk-In ☐ Internet ☐ Referral (Please tell us who) _____ ☐ Other: _____

Health Insurance Information

Primary Insurance _____ Policy Holder's Name _____ DOB _____

Policy Holder's Relationship to Patient _____ Policy Holder's Employer _____

Accident Information (SKIP this section if you were not involved in an accident)

Is your condition due to an: ☐ ***Auto Injury*** ☐ ***Work Injury*** ☐ ***Slip and Fall*** ☐ ***Other Accident (describe below)***

Date of Accident _____ Place (City/State) _____

Auto/Work Insurance Company _____ Insured's Name and DOB _____

If Auto Injury, have you reported the accident to your insurance company? ☐ No ☐ Yes Claim # _____

If Work Injury, have you reported the accident to your supervisor/boss? ☐ No ☐ Yes Claim # _____

If Slip and Fall or Other Type of Injury, please describe: _____

*Do you have an **Attorney** for your Auto or Work Comp. Injury* ☐ Yes ☐ No

Please provide Attorney Name, address and phone # _____

Current complaint

I. Please list your **worst** complaint: _____ How long have you had it: _____

How did it start: _____ ***A) Is it:*** ☐ *Improving* ☐ *Worsening* ☐ *Staying the Same* ***B) Is it:*** ☐ *Mild* ☐ *Moderate* ☐ *Severe* ***C) What worsens it:*** ☐ *General activity* ☐ *Moving Wrong* ☐ *Bending* ☐ *Lifting* ☐ *Walking* ☐ *Sports* ☐ *Getting up from a chair* ☐ *Using a computer/desk work* ☐ *Other:* _____ ***D) What makes it better:*** ☐ *Rest* ☐ *General Activity* ☐ *Ice Packs* ☐ *Heating Pad* ☐ *OTC Meds* ☐ *Rx Meds* ☐ *Massage* ☐ *Chiropractic* ☐ *Other:* _____ ***E) Is it worse in the:*** ☐ *AM* ☐ *PM* ☐ *After day wears on* ☐ *Steady* ☐ *Off and on* ***F) Is the symptom:*** ☐ *Dull and Achy* ☐ *Tight and Stiff* ☐ *Sharp and Stabbing* ☐ *Numb and Tingly* ☐ *Shooting* ☐ *Burning* ☐ *Cramping*

II. Please list your 2nd **worst** complaint: _____ How long have you had it: _____

How did it start: _____ ***A) Is it:*** ☐ *Improving* ☐ *Worsening* ☐ *Staying the Same* ***B) Is it:*** ☐ *Mild* ☐ *Moderate* ☐ *Severe* ***C) What worsens it:*** ☐ *General activity* ☐ *Moving Wrong* ☐ *Bending* ☐ *Lifting* ☐ *Walking* ☐ *Sports* ☐ *Getting up from a chair* ☐ *Using a computer/desk work* ☐ *Other:* _____ ***D) What makes it better:*** ☐ *Rest* ☐ *General Activity* ☐ *Ice Packs* ☐ *Heating Pad* ☐ *OTC Meds* ☐ *Rx Meds* ☐ *Massage* ☐ *Chiropractic* ☐ *Other:* _____ ***E) Is it worse in the:*** ☐ *AM* ☐ *PM* ☐ *After day wears on* ☐ *Steady* ☐ *Off and on* ***F) Is the symptom:*** ☐ *Dull and Achy* ☐ *Tight and Stiff* ☐ *Sharp and Stabbing* ☐ *Numb and Tingly* ☐ *Shooting* ☐ *Burning* ☐ *Cramping*

[redacted]

Current Health

- Name and phone number of family doctor: _____
- List all CURRENT illnesses or diseases you have been diagnosed with (cancers, tumors, infections, diabetes, aneurysms, etc.):

_____ Date of late eye exam: _____

- If you are currently taking any prescription or nonprescription medications, please list them below with dosages:

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

- Please list any medications you are allergic to: _____
- Please indicate your height and weight _____What is your usual blood pressure_____/_____

Health History

- List any operations, surgeries or medical procedures:

Date:_____ Procedure: _____ Date:_____ Procedure: _____

Date:_____ Procedure: _____ Date:_____ Procedure: _____

- If you have ever had in the past or currently have any serious illnesses or injuries, please list:

Date:_____ Condition: _____ Date:_____ Condition: _____

Date:_____ Condition: _____ Date:_____ Condition: _____

Any current loss of bowel or bladder control: ☐Yes ☐No Any current seizures, paralysis, speech, vision problems: ☐Yes ☐No

Any unexplained recent weight loss: ☐Yes ☐No Current fever: ☐Yes ☐No Current nutritional problems: ☐Yes ☐No

- Please list any significant family illnesses_____
- Have you had spinal X-Rays within the past 5 years? If yes, when and where _____
- **Do you have a pacemaker? ☐Yes ☐No If yes, please ALERT our doctor and/or chiropractic assistant**
- Do you have any blood/lymph disorders? ☐Yes ☐No If yes, please list _____
- Do you have osteoporosis or rheumatoid arthritis? ☐Yes ☐No
- Please list any other electrical device that you currently wear_____
- Please select one: ☐ I have never smoked ☐ Former smoker ☐ Current smoker, if so how much: ____ pk./day ____ pk./wk.
- Please select one: ☐ I don't drink alcohol ☐ Rarely drink ☐ Social drinker ☐ Heavy drinker (_____ oz. per day/week)
- Have you ever had chiropractic care ☐Yes ☐No If yes, last date of treatment_____ By whom: _____

Similar or difference condition:_____ Results: _____

What are your overall expectations from your treatment with our doctor: _____

I, the undersigned, hereby give my consent for the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic care. I also give my consent to the doctor to take x-rays (if needed) or to perform other diagnostic aids as he/she deems appropriate in my case.

- ***WOMEN ONLY*** *I hereby declare that to the best of my knowledge* ☐***I am*** ☐***I am not pregnant.*** *If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.*

Patient Signature_____

(Parent/Guardian signature if under 18 years of age)

PATIENT INTAKE FORM

Please answer the following:

DATE OF ACCIDENT/ONSET OF SYMPTOMS_____

WHAT HAPPENED?

_____

_____

_____

_____

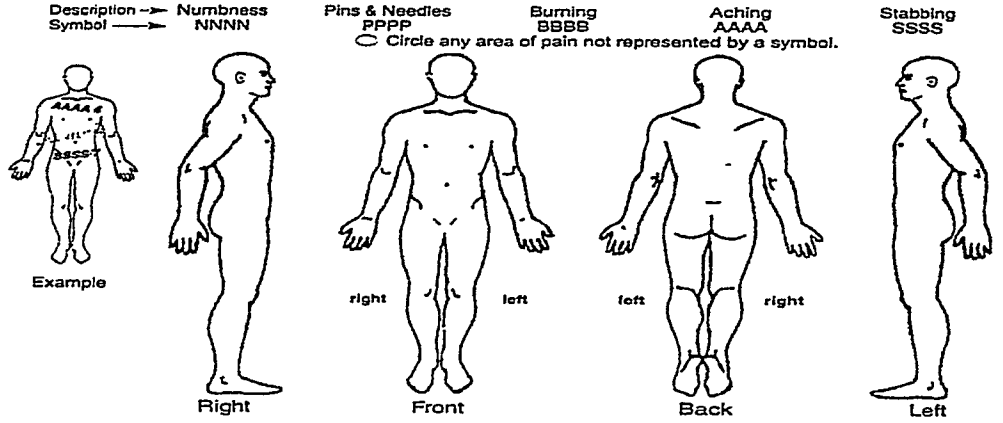
_____

_____

_____

_____

WHERE DOES IT HURT?



Date of Hospital Visit_____
Name of Hospital _____
Examining Physician_____
Were X-Rays Taken? Y N
What Areas?_____
Was an MRI performed? Y N
What Areas?_____
Was a CAT Scan performed? Y N
What Areas?_____

Were Medications Given? Y N
Describe:_____
Treatments:
Cervical Collar Ice Pack
Hot Pack Injections
Other_____
Diagnosis Given: _____
Follow up Directions:
_____

PLEASE LIST ALL PREVIOUS ACCIDENTS DATES AND THEIR RESULTS:

_____

_____

_____

APPOINTMENT REMINDERS, TEXT, E-MAIL and HEALTH CARE INFORMATION RELEASE

Dr. Paolini, his associates, and/or his staff may need to use your name, address, phone number, E-mail, and your clinical records to contact you with: **appointment reminders, requests or confirmations; patient satisfaction surveys; friend referrals both online and offline; information about treatment alternatives; or other health related information that may be of interest to you.** If this contact is made by phone and you are not at home, a message will be left on your answering machine.

Text messaging, E-mail and answering machines are **not** secure forms of communication. Information in these communications can be accessed by others who have access to your phone, email, or by other means.

By signing this form, you are giving us consent and authorization to contact you by phone, text or email with full understanding of the nature of each method of communication.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. Texting can be stopped at any time by texting back "STOP" and E-mail can be stopped at any time by the link at the bottom of the e-mail or e-mailing back the word "unsubscribe".

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternative, or other health related information at any time (§164.524).

This notice is effective as of _____. This information will expire seven years after the date on which you last received services from us.

I authorize you to contact me and use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this information.

_____ _____

Patient Name Date

_____ _____

Signature of Patient or Representative Representative relationship to patient

FOR THOSE WISHING TO OPT-OUT OF ONLINE COMMUNICATIONS

I do not wish to be contacted via E-mail. (Text messaging or phone only) Initial____
I do not wish to be contacted via text messaging. (E-mail or phone only) Initial____
I do not wish to be contacted by either text messaging or email. (Phone only) Initial____

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures including: various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me or on the patient named below for whom I'm legally responsible by Dr. Paolini and/or any other doctors or support staff in which care has been referred or delegated to now or in the future treat me while employed by working or associated with or serving as back up for Dr. Paolini including those working at the clinic or office listed below or any other office or clinic whether signatories to this form or not.

I have had an opportunity to discuss with the Dr. Paolini and/ or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as it is with all healthcare treatment, results are not guaranteed and there is no promise to cure.

I further understand and am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment including but not limited to: muscle spasms for short periods of times, aggravating and or temporary increase in symptoms, lack of improvement of symptoms, fractures, disc injury, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels that at the time, based upon the facts known, is in my best interest.

I further understand a chiropractic adjustment the supportive treatment is designed to reduce and/or correct subluxations allowing the body to improved health. it can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promised to cure. Accordingly, I understand that all payment(s) for treatment(s) are final, and no refunds will be issued. However, prorated fees for unused, pre-paid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include but are not limited to: self-administered over the counter medications, analgesics, herbs and vitamins and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxers, and pain killers; physical therapy; steroid injections; bracings; and surgery. I understand that have been informed that I have the right to a second opinion and secure other opinons if I have concerns as to the nature of my symptoms and treatment options.

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 attend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment

Name of patient:_____

Signature of patient:_____

Parent/Guardian Name printed:_____

Relationship to patient:_____

Parental/Guardian signature:_____

Date:_____

Doctor's name___Dr. David Paolini_____

Signature of Doctor:_____

Relief
Chiropractic Centers

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

Printed Name	Authorized Provider Representative
Signature	Date
Date	