Confidential Patient Information

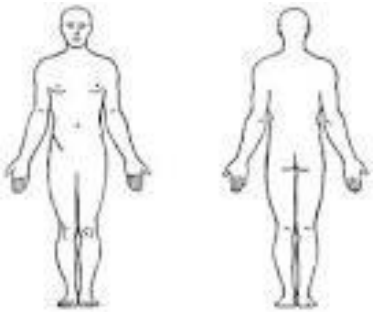
The following information is needed for our file so we can better serve you as a patient. Please fill in ***all*** *portions of the form. Print legibly. If you need any help, please ask the receptionist.*

Full Name: _____/____/_____ Preferred Nickname: _____
Address: _____
City: _____ State: _____ Zip:_____
Home Phone: _____ Cell Phone: _____
Email Address: _____(please print clearly)
Date of birth: _____ /_____ /_____ Age: _____ Marital Status: _____ # of Children: _____
SS#: _____ /_____ /_____ Driver's License: _____
Please tell us who referred you to us? _____
Employer: _____ Occupation: _____ Work Ph:_____
Spouse's Name: _____or Parent's Name:_____

If you are not the insurance holder, please fill out the following:
Subscriber Name: _____ DOB: _____ /_____ /_____ relationship:_____
Employer: _____ Occupation: _____ Work Ph:_____

Emergency Contact: _____ Ph #:_____
Is your visit due to an accident: (please circle) YES NO

Present complaint/s: (Please note on diagram where you feel pain) ---→
_____
_____



List other doctor(s) seen for this condition: _____
Family Physician: _____
City: _____ State: ___ Zip:_____
Permission to Notify: YES NO

Medical History: (If any of the following are relevant to your medical history, please place a check in front of word/s)

___ Cancer	___ Muscular Dystrophy	___ German Measles	___ Convulsions	___ Asthma
___Multiple Sclerosis	___ Scarlet Fever	___ Rheumatism	___ Hepatitis	___ Diabetes
___ Nervousness	___ High Blood Pressure	___ Rheumatic Fever	___ Neuritis	___ Arthritis
___ Heart Trouble	___ Concussion	___ Tuberculosis	___ Anemia	___ Numbness
___ Dizziness	___ Sinus Trouble	___ Epilepsy	___ Polio	___ Digestive
___ Backaches	___ Venereal Disease	___ Fibromyalgia		

What operations have you had and when?
_____
Have you been treated by a physician for any health conditions in the last year? YES NO
If so, describe condition: _____ Date of last physical: ____ /____ /_____
Are you pregnant? YES NO Date of last menstrual period: _____ /_____ /_____

This information is complete and correct to the best of my knowledge:
Signature _____ Date: _____

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

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

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? None ( ) *(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? None ( )			
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: _____

Height: _____ Weight:_____ Blood Pressure:_____/_____

OFFICE POLICY SHEET

Please initial each paragraph after reading and sign at the bottom.

In this office our major concern is to assist you in maintaining overall good health. We will do everything in our power to help you understand and utilize your insurance benefits. However, you are being informed of **your financial responsibility for all office visits/ care not paid by your insurance company** for any reason. If you need a referral from your PCP to be seen in this office, it is your responsibility to get that referral. If you fail to do so, we will charge you as a cash patient and you are totally responsible. **By initialing you agree to pay interest, late and collection fees on any balances over 90 days.**

Initial: _____

We request **24 hour notice of any change or cancellation** in your appointments. It is our policy to charge $25 for any missed or cancelled appointment without 24 hour notice.

Initial: _____

All employees of Integrative Chiropractic Clinic must hold **all information obtained about patients related to their examinations, care, and treatment confidential** and will not divulge any information without the patient or legal guardian's written authorization.

Initial: _____

Patient Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC / ACUPUNCTURE TREATMENT

Integrative Chiropractic Clinic:

I hereby request and consent to the performance of: (initial treatments you wish to consent to) chiropractic treatments_____, acupuncture treatments____, nutritional counseling ____, Massage____.

along with other Oriental Medicine procedures along with any other associated procedures such as physical examination, tests, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic/acupuncturist named above.

I understand, as with any health care procedures, that there are certain complications which may arise. **Complications of chiropractic treatment** include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

Complications/side effects of acupuncture may include, but are not limited to: bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist above uses sterile disposable needles and maintains a clean and safe environment. Burns and /or scarring are a potential risk of moxibusion.

The herbs and nutritional supplements (which are from plant, mineral and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that herbs need to be consumed according to the instructions provided. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the doctor of any unanticipated or unpleasant effects associated with the consumption of the herbs/supplements. I will notify the doctor if I am or become pregnant.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic, acupuncture and other recommended treatments. I have had my questions answered to my satisfaction. I also understand the specific results are not guaranteed.

I have read (or have had read to me) the above explanation. I state that I have been informed and weighted the risks involved in chiropractic treatment or acupuncture at this office. I have decided that it is in my best interest to receive treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.
SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Printed name of Patient

_____
Signature of Patient Date

_____
Signature of Representative (if applicable) Date

_____
Witness to Patient's Signature Date