Health History Intake Form

Name________________________________ Gender: M F Date______________________________

Address____ State____________ Zip________________

Phone (_______)____________ Email:_________________________ Date of Birth_____________ Age__________

Referred by ____________________________________ Social Security #____________________________

Emergency Contact : ______________________________ Phone: __________________________________

Have you ever received Chiropractic Care? Yes / No If yes, when and by whom?___________________________

Insurance Information

Name of party responsible for payment: ____

Insurance Company Name: ____________________________

If auto accident, please provide: Date of Accident: ____________________ Area of concern: ____________________

Insurance Company: ____ Claim number: ____________________

Primary reasons for seeking chiropractic care:

Primary reason: ____ Date complaint began: ________________

Secondary reason / other concerns: ______________________________ Date complaint began: ________________

Please answer YES or NO to the following questions about your primary area of pain / complaint :

Does it radiate? ___________ Do you have numbness/tingling? __________ Does it interfere with sleep? ____________

Worse during certain times of day? ______________ Do you wear orthotics? ______________

Have you had x-rays or an MRI taken? ___________ If so, when and where? ______________

Does your pain interfere with any of the following: (circle all that apply)

Sitting Walking Standing Lifting Traveling Personal Care Social Activities

Grade Intensity/Severity (circle one) : (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Frequency of Pain (circle one) : Occasional Intermittent Only with certain movements Constant

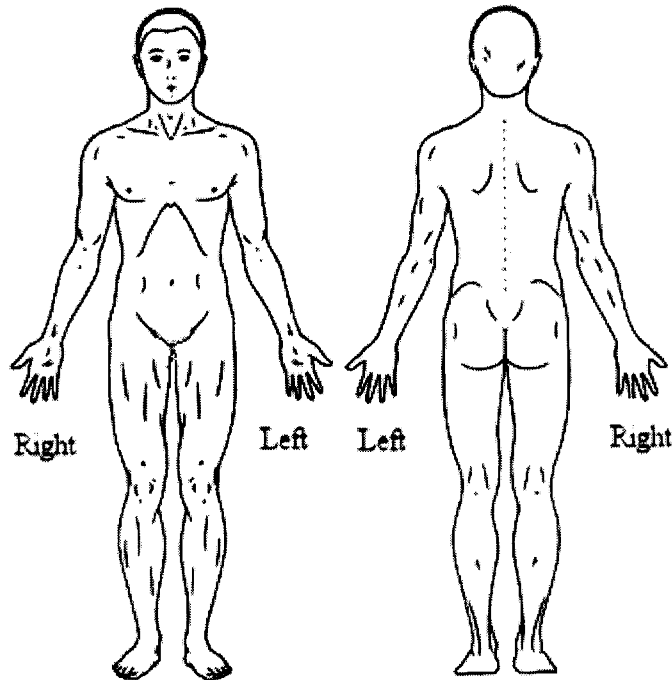
What aggravates symptoms? ____________________ What improves symptoms? ____________________________

Previous interventions, treatments, medications, or surgery sought for this concern : ______________________________

____

Please circle the affected area and use the following letters to indicate TYPE and LOCATION of symptoms you are currently experiencing:

A: Dull Ache B: Burning S: Stabbing N: Numbness P: Pins and Needles T: Throbbing D: Deep SH: Sharp TI: Tingling



Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing
__ Cancer

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Gait Issues
__ Sprains/Strains
__ Broken Bones
__ Scoliosis Diagnosis
__ Sciatica

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Poor Circulation
__ Cold Extremities
__ Strokes
__ Swelling Ankles

EAR/NOSE/THROAT
__ Earache
__ Enlarged Thyroid
__ Frequent Colds
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats

GASTRO-INTESTINAL
__ Constipation
__ Diarrhea
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Bruising Easily
__ Eczema/Rash/Dermatitis
__ Itching

FOR WOMEN ONLY
__ Birth Control _________
__ Hormone Replacement
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Breast Pain

Pregnant at this Time Y/N

3. **Past Health History:**

A. Any significant current or previous illnesses?: ____________________

B. Any previous injuries or traumas? ____________________ Any Hospitalizations? ____________________

C. Have you ever broken any bones? Which? ____________________ Any Sprains/Strains? ____________________

D. Allergies: ____________________

E. Taking any vitamins / supplements? : ____________________

F. Surgeries:

Type of Surgery	Date

4. **Family Health History:** Please list any medical/health history of family members: (heart disease, diabetes, cancer, etc)

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5. **Life and Social History:**

A. Occupation: ____________________ Employer: ____________________

B. Recreational activities: ____________________ Workout/Exercise habits: ____________________

C. Lifestyle: (please mark appropriate box)

	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Exercise				
Sleep				
Water				
Appetite				

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate m y care/treatment, any fees for professional services rendered to me will be immediately due and payable. Furthermore, I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient (or guardian's) Signature ____________________ Date____________________

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures, disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes. There is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does no cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidents of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1,219 events/per one million persons/year and risk of death has been estimated as 104 per 1,000,000 users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over the counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and healthcare as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ____________________ Signature: ____________________ Date: __________

Parent or Guardian: ________________ Signature: ____________________ Date: __________

Witness Name: ____________________ Signature: ____________________ Date: __________

HIPPA Release/Privacy Form

Patient Name: ______________________________ Date of birth: ____________________

RELEASE of information:

- ☐ I authorize the release of information including the diagnosis, records, examination, rendered to me and claims information

This information may be released to:

- ☐ Spouse: ______________________________
- ☐ Children: ______________________________
- ☐ Other: ______________________________
- ☐ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

For phone messages, please call my...

- ☐ Home phone: ________________________
- ☐ Cell phone: ________________________
- ☐ Work phone: ________________________

If unable to reach me,

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Do not leave a message

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out: treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), obtaining payment from third party payers (i.e. insurance companies), and the day to day healthcare operation of Knoxville Spine and Sports.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these restrictions. However, if you do agree, then you are bound to comply with this restriction. I understand that I may revoke this consent in writing at any time.

Patient (or parent/guardian) Signature: ______________________________ **Date:** ____________

Chiropractic Sport Physician CCEP, ART   Dr. Bert Solomon   knoxvillespineandsports.com

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: ______________________ Last Name: ______________________

Date of birth: ___/___/______ Gender: male / female Preferred language: ______________________

Email address: ______________________ Phone number: ______________________

***Please circle responses**: (CMS require providers to report both race and ethnicity)*

Preferred method of communication for patient reminders: Email / Phone / Mail

Smoking Status: every day smoker / occasional smoker / former smoker / never smoked

Race: American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)

Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

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Are you currently taking any medications? (include regularly used over the counter medications)

Medication	Dosage / Frequency

Do you have any medication allergies?

Medication	Reaction	Onset

☐ 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: ______________

For office use only:

Height:	Weight:	Blood Pressure:	Pulse: R R A C :