New Hanover Chiropractic – Patient Intake Information

General Information

Date: ___/___/___

First Name _____

Middle Initial _____

Last Name _____

Called Name _____

Address _____

City _____ State _____

Zip Code _____

Home Phone _____

Cell Phone _____

Email Address _____

Account Number _____

Please Circle Race and Ethnicity Below

Race American Indian, Alaska Native, Asian, Black or African American, White Native Hawaiian, Other Pacific Islander, Declined to State

Ethnicity Declined to State, Hispanic or Latino, Not Hispanic or Latino

Language _____

Sex Male Female

Marital Status Single Married Other _____

Birthdate _____/_____/_____

Social Security _____ - _____- _____

Referred By: _____

Work Status Employed Full-time student Part-time student

Employer Information

Employer: _____ Work Phone : ____-____-_____

Condition Information

Related to Employment **Yes No** Related to Auto Accident **Yes No** Related to Other Accident **Yes No**

Condition Date _____/_____/_____ Have you ever had similar symptoms? _____

Insured's Information

Please give receptionist your insurance cards. ***If insured person is other than patient, please continue BELOW.***

Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured

Full Name _____

Address _____

City, State, Zip _____

Social Security _____ - _____ - _____

Date of Birth _____

Sex Male Female Unknown

Employer Information

Employer _____

Authorization to pay benefits to Physician

I hereby authorize payment from my insurance company directly to the physician of chiropractic benefits, if any, otherwise payable to me for this service as described including Medicare Benefits. I further authorize the release of medical information about me to process my medical claims in accordance with the Notice of Privacy furnished to me upon request. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY INSURANCE POLICY. This payment will not exceed my indebtedness to New Hanover Chiropractic Clinic, and I agree to pay, in a current manner, any balance of professional charges over and above this insurance payment.**

Acknowledgement of Notice of Privacy Practice

The undersigned hereby acknowledges that upon request I may receive a copy of the Notice of Privacy Practices of New Hanover Chiropractic Clinic. By my signature below, I give my permission to use and disclose my health information, for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Patient Signature: _____ ***DATE:*** _____/_____/_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) 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 Physician of Chiropractic named here, **Dr. William Genther**, 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 **Dr. William Genther** and/or with other office or clinic 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 course of 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 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. I intend this consent form 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.

To be completed by the patient:

_____
Print Patient's Name

Patient Signature: _____

DATE: _____/_____/_____

To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

_____
Print Name of Patient

_____
Print Name of Representative

Representative Signature: _____

DATE: _____/_____/_____

This form should be maintained in the patient's health record.

New Hanover Chiropractic - Patient Health History

Name: ___________________________________ **Date:** ____/____/_______ **ACCOUNT #** ________ **(office use only)**

List symptoms you are experiencing today: **Choose the severity level associated with each symptom**

_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

List any Doctors seen, tests, studies or medications received for this condition:

❑Tests/Studies/Doctors: ____

Are your present problems due to an ***injury?*** ❑Yes ❑No **(if No, proceed to next section)** Date of the injury: _____________

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: ____

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: _________________

Briefly describe the accident, injury or illness:____

____

List symptoms experienced ***immediately after the injury***: Choose the severity level associated with each symptom

_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Where you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ______________________Transported by? ❑Ambulance ❑Police ❑Other: ____________________

Date Admitted: _______________ Date Released: ____________ Length of Stay: ______________

List the hospital procedures received: ____

Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: ____________________ To: ____________________

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) ___________________________________

What type of work do you do?____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No

List an past conditions you may have had: ____

HABITS (Please check all that apply)

❑Current Every Day Smoker ❑Current Some Day Smoker ❑Former Smoker ❑Never Smoker

❑Drinking Alcohol: (Cups/day): _____ ❑Coffee Cups/Day: _______

❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _______

EXERCISE ❑None ❑Moderate ❑Daily

FAMILY HISTORY	MOTHER	FATHER	SIBLING (S)	
Back pain	❑	❑	❑	
Cancer	❑	❑	❑	Other: _____
Diabetes	❑	❑	❑	

Are you taking any medication (prescription or over the counter)? ❑Yes ❑No If Yes, please indicate the following:

Medication: _____ **Medication:** _____ **Medication:** _____
Medication: _____ **Medication:** _____ **Medication:** _____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:
Allergy: _____ Reaction _____ Allergy: _____ Reaction _____

Have you ever had any **surgeries**? ❑Yes ❑No (If yes, please enter the approximate **date** and **type** of surgery.

Back Operation _____ Hernia _____ Gall Bladder _____ Female Organs _____

Thyroid _____ Stomach _____ Other _____

Have you ever had **X-rays** taken? ❑Yes ❑No When? _____ By Whom? _____

For what **ailments** were these X-rays taken? _____

Please check the box for each current or past symptoms listed below

GENERAL SYMPTOMS

- ❑ Allergy(What) ____ _____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

EENT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck
- ❑ Spinal Curvature
- ❑ Swollen Joints
- ❑ Tremors

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation
- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ Strokes
- ❑ Swelling Ankles
- ❑ Varicose Veins

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?

_____ Last Pap Date

_____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

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Types of care offered at New Hanover Chiropractic

Please check the <u>one</u> type of care listed below that you are most interested in receiving, so that we may be guided by your wishes whenever possible.

❑ **Relief Care:** Relief care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, *but not fixing the leak.*

❑ **Corrective Care:** Corrective care differs from relief care in that its goal is to get rid of symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

I also understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Genther's office will prepare reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Dr. Genther's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

Patient's/Guardian's Signature: _____ **Date:** _____