Porters Neck Chiropractic New Patient Intake Form

Date_____

First Name _____ Middle Initial ____ Last Name _____

Nickname _____ Marital Status: □ Single □ Married □ Other

Sex: □ Male □ Female **Date of Birth** ____/_____/_____ **Social Security #: _____-____-_____**

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Email _____

Local Address (If Different from mailing) _____

City _____ State _____ Zip Code _____

How did you hear about our office? _____

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Employer Data_____

Employer's Name _____

Your Occupation _____ Your Job Description _____

Who is responsible for your bill? □ Self □ Health Insurance □ Spouse □ Worker's Comp
□ Auto Insurance □ Other _____

If your injury was work related, have you filed an injury report with your employer? □Yes □No
Date: ____/____/____ Time: _____am / pm

Spouse/Parent Data_____

First Name _____ Middle Initial _____ Last Name _____

Employer's Name _____

Work Phone (_____) _____-_____ Date of Birth ____/_____/_____

Patient Name_____Date_____

Emergency Contact_____

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Consent to Care

I hereby request and consent to chiropractic adjustments and other procedures including various modes of physical therapy, diagnostic x-rays and/or tests recommended by Porters Neck Chiropractic and their staff. I understand that results are not guaranteed and I am informed of the advantages and possible complications, if any, to treatment. I wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest.

Initials_____

I understand that acupuncture is an integral part of treatment at Porters Neck Chiropractic. I hereby give my consent to have acupuncture if it is recommended by my doctor.

Initials_____

Consent to treat if patient is a minor: (Minor's Printed Name) _____

I hereby certify that I have read and fully understand the above authorization for chiropractic treatments and by signing below I agree to the above terms and procedures.

Patient or Guardian's Signature Authorizing Care _____

Date_____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review Porters Neck Chiropractic's Notice of HIPAA Privacy Practices for protected health information. I hereby give consent to Porters Neck Chiropractic, Inc. and all health care providers furnishing care within Porters Neck Chiropractic's facilities to use and disclose my protected information for the purposes of treatment, payment and health care operations.

Print Patient's Name _____

Patient's (Guardian's) Signature _____Date_____

Doctor's Signature _____

Patient Name_____Date_____

Financial Policy & Assignment of Benefits

Primary Health Insurance:_____ Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Relationship to Insured _____

Policy Holder's Employer_____

Secondary Health Insurance: _____ Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Relationship to Insured _____

I hereby assign payment to Porters Neck Chiropractic, Inc or any physician rendering services and instruct my insurance company to make payment to this office directly for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

I authorize Porters Neck Chiropractic Inc and any physician rendering service to release medical records or other information which may be necessary for completion of insurance claims. I understand that I am financially responsible for all charges not paid by my insurance company. Porters Neck Chiropractic, Inc files health insurance claims, but cannot guarantee insurance payments. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

There will be a $20 charge for missed appointments unless a cancellation notice is received 24 hours in advance of the appointment time.

I understand and agree that I am personally responsible for payment of this charge should I fail to comply with this policy and that this charge in no way will be billed to my insurance company.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I intend this to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic.

_____ _____

Signature of Policyholder or Claimant Date

Doctor's Signature _____

Patient Name **Date**

What is your race? _____

What is your ethnicity? (Please circle one) Hispanic/Latino Not Hispanic/Latino

What is your preferred language? _____

What is your preferred method of communication for private health data? (Please circle one and provide information)

Home Phone Work Phone Mobile Phone Standard Mail Email _____

Surgeries: (Check all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia

□ Other _____

Allergies: (Check all that apply to you)

□ Eggs	□ Fish and Shellfish	□ Milk or Lactose	□ Peanuts
□ Soy	□ Sulfites	□ Wheat/Glutens	□ Other _____

Medication allergies: _____

Social History: (Check all that apply to you)

Caffeine use: □ occasional □ often □ never
Drink Alcohol: □ occasional □ often never
Exercise: □ occasional □ often □ never
Chew Tobacco: □ occasional □ often □ never
Cigarettes: □<1 pack/day □ >1 pack/day never smoked former smoker
Wear Seat Belts: □ occasional □ always □ never
Other _____

Family History: (Check all that apply)

Arthritis: □ Mother Father Sister Brother
Diabetes: □ Mother Father Sister Brother
Hypertension □ Mother Father Sister Brother □
Thyroid □ Mother Father Sister Brother
Heart Disease: Mother Father Sister Brother
Stroke: Mother Father Sister Brother
Cancer (type): Mother_____ Father_____ Sister_____ Brother_____

Other _____

Doctor's Signature _____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken _____

_____

_____

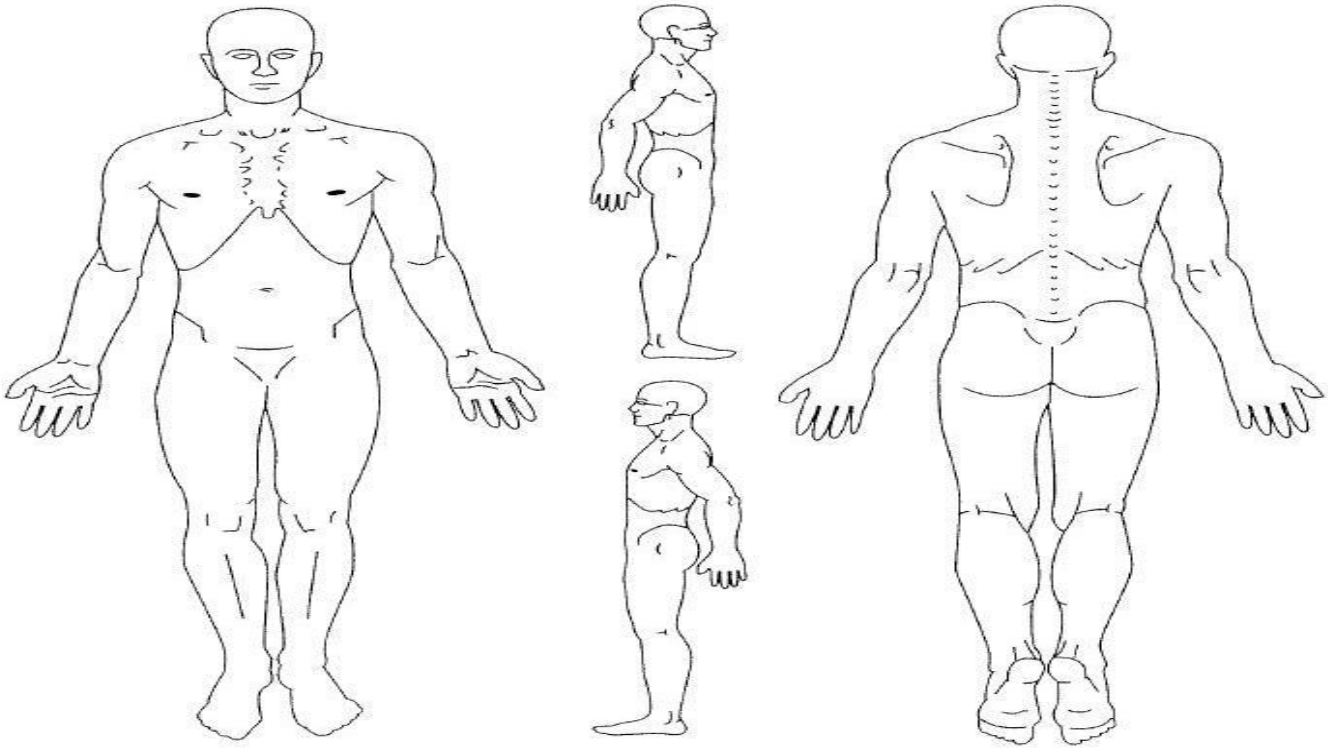
Doctor's Signature _____

Patient Name_____Date_____

Are you pregnant? Yes_____ No _____N/A_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

When & how did your symptoms begin? _____

_____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident □ Other____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day) □ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

How are your symptoms changing?

□ Getting better □ Not changing □ Getting worse

SIGNATURE OF PHYSICIAN: _____Date: _____

Patient Name_____ **Date**_____

Employment, ADL, and Recreation Information

Outcomes Assessment Tool Used _____ **Score** _____

Description of Work: _____

Condition's Effect On Job Performance: ☐ **No Effect** ☐ **Mild** (painful can do) ☐ **Mod** (painful limited ability)
☐ **Mod/Sev (**limited duty) ☐ **Sev (**no limited duty) ☐ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Care –Infirm Family:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climb Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Pet Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reading (Concentration):	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Bathing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Shaving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sexual Activities:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

Doctor's Signature _____

Porters Neck Chiropractic, Inc.
8207 D Market Street
Wilmington, NC 28411
910-686-6508

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Porters Neck Chiropractic, Inc. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Our treatment rooms are not completely private as the walls do not go all the way to the ceiling. However, private areas are available upon for discussions that a patient does not want overheard or arrangements can be made for an appointment at a time when the office is otherwise empty. These arrangements will be handled upon request.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date