

Chiropractic Intake Form



PATIENT:

Last Name: _____ First Name: _____ Middle: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ Work #: _____
Cell #: _____ Other #: _____
Marital Status: _____ Single _____ Married _____ Domestic Partner _____ Divorced _____ Widow/er _____
Birthdate: ____/____/____ Age: _____ Gender: _____ Male _____ Female _____
SSN: _____ Email: _____
Referred by: _____ Physician's Name and #: _____

EMPLOYER:

Employer: _____ Occupation: _____
Address: _____ Suite: _____
City: _____ State: _____ Zip Code: _____

SPOUSE/ GUARDIAN/ PARTNER OR EMERGENCY CONTACT:

Last Name: _____ First Name: _____ Relationship: _____
Cell #: _____ Other #: _____

RESPONSIBLE PARTY: (Complete this section if you are not the patient but are responsible for the account)

Name: _____ DOB: _____ Relationship: _____
Address: _____ SSN: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ Work #: _____

☐ I, _____, give Clearwater Clinic permission to treat my minor son/daughter.

Health Insurance Portability and Accountability Act (HIPAA):

Effective Date: May 1, 2007

Clearwater Clinic is dedicated to preserving your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and Clearwater Clinic's duties with respect to your PHI. Clearwater Clinic may use or disclose your PHI for the purpose of diagnosing or providing treatment, obtaining payment for healthcare bills or to conduct health care operations.

We may be required by law to use and disclose your medical information for other purpose without your consent or authorization. Your PHI means health information including your demographic information collected by health care providers, health care clearinghouse or an employer. This PHI relates to your past, present or future physical or mental health or condition and identifies you, or there is reasonable basis to believe the information may identify you.

You have the right to amend or correct your medical information and obtain an accounting of our disclosures of your medical information. You also have a right to request that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing. We may revise our NOTICE from time to time.

Financial Policy

In the interest of good health care practice, it is desirable to establish a financial policy to avoid misunderstandings. All accounts are payable in full at the time of service. We accept cash and checks, as well as Visa and MasterCard for your convenience. A \$30 charge will be imposed for all returned checks. Any balance outstanding more than 60 days will bear interest at 18% per annum. Any missed or cancelled appointments without 24 hour notice will be charged a minimum of \$35. This will ensure keeping cost to a minimum and using treatment time effectively. Patients that pay in full at the time of service, receive a discount as a special thank you from our office.

I have read this policy and understand that **I am responsible for payment on my account.** I understand that delinquent accounts will be assigned to a credit reporting collection agency. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agree to pay for all costs and expenses, including reasonable attorney fees.

My account is (please choose one):

☐ **Self Pay** I will receive a 35% discount on services when I pay at the time of service.

☐ **Insurance** Please bill my insurance carrier (complete Insurance Assignment). I understand by choosing to bill my insurance I forfeit the self pay discount.

Signature _____

Date _____



ID: _____

YOUR PERSONAL INJURY INSURANCE:

Primary Insurance: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Adjuster: _____ Phone: _____
Claim #: _____ Date of accident: _____

OTHER VEHICLE'S INSURANCE: (If you don't have this information then leave this section blank)

Primary Insurance: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Adjuster: _____ Phone: _____
Claim #: _____

ATTORNEY:

Law Firm: _____ Attorney Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

Insurance Assignment and Release

I certify that I and/or my dependant(s) have insurance coverage with the insurance listed above and assign directly to Clearwater all insurance benefits otherwise payable to me for services rendered. **I understand financially responsible for all charges whether or not paid by insurance.**

I understand insurance is billed as a courtesy to Clearwater patients, when Clearwater is provided my social security number, and credit card (see below). The patient is responsible to obtain the information that is required to bill the insurance company. **Clearwater Clinic cannot accept responsibility for collecting from the insurance company or negotiating a disputed claim.** Insurance reimbursement is a contract between the patient and his or her insurance company. I understand that I, the patient, am responsible for payment on my account.

I understand that my Personal Injury Insurance has 60 days to pay or deny a claim. At 60 days, I authorize Clearwater to charge my credit card should any overdue balance remain unpaid. Any overpayments on accounts will be refunded.

I authorize Clearwater to charge my Visa or MasterCard at 60 days for any amount my insurance has not paid.

☐ Visa ☐ MasterCard ☐ CareCredit

Card # _____
Expiration: _____ Last 3 digits on the back: _____

Signature of Patient, Guardian or representative

Date

Please print name of Patient, Guardian or representative

Relationship

Chiropractic Intake Form

ID: _____



Name: _____

Date: _____

Current Symptoms:

Date Symptom(s) Started: _____

Are your symptoms from an "on job injury" or Car Accident? Yes** No

****If the answer to the above question is yes, please ask for the Personal Injury form.**

Primary Symptom: _____ Secondary Symptom: _____

Describe Onset: _____

Do you have radiating pain into your arms or legs? Yes No

What makes it better: _____

What makes it worse: _____

Pain Severity: 0 = No Pain, 10 = Worst Pain Ever. (0-10) Your Average: _____ At Worst: _____

Are your pains worse at any time during the day, if so when? AM or PM Other: _____

What types of exercise are you doing? 1. _____ 2. _____

Are you taking prescription medication? Yes No If yes, what type? _____

Do you use nutritional supplements? Yes No If yes, what type? _____

How old is your mattress? _____ Is it comfortable? _____

Pain Drawing:

- Mark the areas of your body where you feel pain. Include all affected areas.
- If your pain radiates, draw an arrow from where it starts to where it stops.
- Extend the arrow as far as the pain travels.
- Use the appropriate symbol(s) below.

ACHE >>>>>

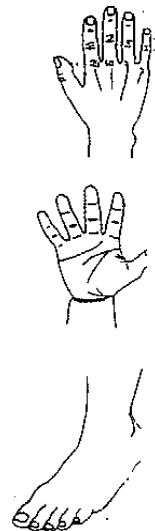
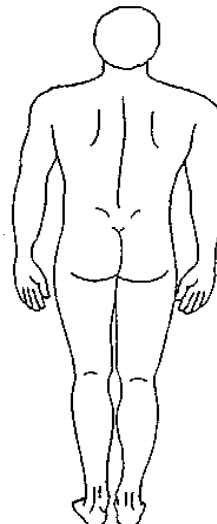
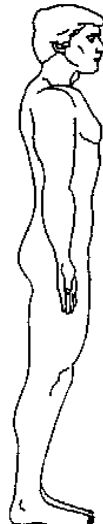
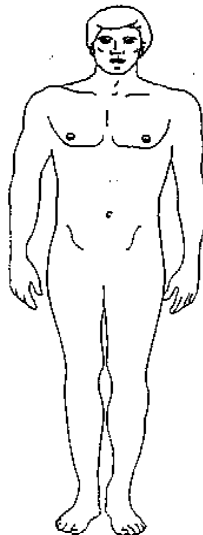
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NUMBNESS =====

PINS & NEEDLES oooooo

STABBING /////

THROBBING -----



Chiropractic Health Questionnaire

ID: _____

Name: _____ Date: _____

Have you been treated before for this problem?

Yes

No

Have you ever had chiropractic care previously?

Yes

No

If Yes, when and what type of treatment was rendered?

Was the treatment helpful?

Yes

No

Date of last comprehensive physical exam?

Female: Date of last female specific exam or OB/GYN exam?*Male*: Date of last male specific exam or prostate exam?

Check all examinations below that have shown any abnormal findings:

- ☐ Bone Scan
- ☐ CT Scan
- ☐ MRI
- ☐ X-Ray
- ☐ Mammogram
- ☐ Upper GI
- ☐ Lower GI
- ☐ Nerve Conduction Study
- ☐ Urinary test
- ☐ DEXA or Bone Scan
- ☐ Blood test

Sleep hours per night: _____

Do you awake rested?

Yes

No

Is your pillow comfortable?

Yes

No

Do you use a heel lift?

Yes

No

Do you use orthotics?

Yes

No

Are they comfortable?

Yes

No

Surgeries: _____

*Check all that apply:***GASTROINTESTINAL**

- ☐ Acid reflux
- ☐ Anemia
- ☐ Bloating
- ☐ Bowel changes
- ☐ Change in weight
- ☐ Chew Tobacco
- ☐ Colitis
- ☐ Constipation
- ☐ Difficulty swallowing
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gallbladder pain
- ☐ Hemorrhoids
- ☐ High alcohol intake
- ☐ Indigestion
- ☐ Intestinal gas
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Vomiting

METABOLIC

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hepatitis
- ☐ Kidney stones
- ☐ Osteoporosis
- ☐ Thyroid problems

NEUROMUSCULOSKELETAL

- ☐ Arthritis
- ☐ Blurred vision
- ☐ Bone disease
- ☐ Carpal tunnel syndrome
- ☐ Cataracts
- ☐ Degenerative joint disease
- ☐ Depression
- ☐ Fatigue/Exhaustion
- ☐ Forgetfulness
- ☐ Fractures
- ☐ Glaucoma
- ☐ Headache
- ☐ Hearing loss
- ☐ Infection
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Multiple sclerosis
- ☐ Psoriasis
- ☐ Rheumatoid arthritis
- ☐ Ringing in ears
- ☐ Seizures
- ☐ Sleep loss
- ☐ Sweats
- ☐ Tiredness
- ☐ TMJ pain

CARDIOVASCULAR

- ☐ Asthma
- ☐ Bleeding gums
- ☐ Bruise easily
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Dizziness
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol

CARDIOVASCULAR cont'

- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Poor circulation
- ☐ Rheumatic fever
- ☐ Smoke Tobacco
- ☐ Stroke
- ☐ Swelling of ankles/legs
- ☐ Tuberculosis
- ☐ Varicose veins

❖ FEMALE GENITOURINARY

- ☐ Abnormal pap smear
- ☐ Bladder control problems
- ☐ Bladder infections
- ☐ Bleeding between periods
- ☐ Blood in urine
- ☐ Breast lump
- ☐ Endometriosis
- ☐ Frequent urination
- ☐ Hernia
- ☐ Hot flashes
- ☐ Infertility
- ☐ Premenstrual syndrome
- ☐ Currently Pregnant

❖ MALE GENITOURINARY

- ☐ Bladder control problems
- ☐ Blood in urine
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Frequent urination
- ☐ Hernia
- ☐ Infertility
- ☐ Prostate hypertrophy

PERSONAL INJURY/MOTOR VEHICLE ACCIDENT QUESTIONARE

Name: _____ Date of accident: _____ Time: _____ AM / PM

Where did the accident happen? _____

Describe the accident in your own words: _____

What was your position in the vehicle? ☐ Driver ☐ Passenger

If passenger, were you sitting in: ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike the other vehicle? ☐ Yes ☐ No Does your vehicle have airbags? ☐ Yes ☐ No

Did the other vehicle strike your vehicle? ☐ Yes ☐ No Did the airbag release? ☐ Yes ☐ No

Was the impact from: ☐ The front? ☐ The right side? ☐ The left side? ☐ The rear?

At the time of impact were you looking.... ☐ straight ahead? ☐ right? ☐ left? ☐ down?

Were both hands on the steering wheel? ☐ Yes ☐ No Was your foot on the brake? ☐ Yes ☐ No

Were you braced for impact? ☐ Yes ☐ No Were you wearing a seatbelt? ☐ Yes ☐ No

Where in the vehicle were you after the accident? _____

Did you strike anything in the vehicle at the time of impact? ☐ Yes ☐ No

If yes, please specify: ☐ steering wheel ☐ dashboard ☐ windshield ☐ side door ☐ armrests

☐ side window ☐ air bag other: _____

Please state part of body: ☐ knee ☐ shoulder ☐ arm ☐ hand ☐ chest ☐ chin ☐ head

Immediately following the accident how did you feel? _____

Were you unconscious? ☐ Yes ☐ No Did you feel nauseous? ☐ Yes ☐ No In a daze? ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No

If yes, when: ☐ at time of accident ☐ next day ☐ other, please specify: _____

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Did ambulance attendants place you in: ☐ Neck collar ☐ Splint ☐ Brace

Name of hospital: _____ Attended by doctor: _____

Were you X-rayed at the hospital? ☐ Yes ☐ No If yes, what was the diagnosis? _____

Were you admitted to hospital? ☐ Yes ☐ No If yes, how long did you stay: _____

Did you receive stitches? ☐ Yes ☐ No Were any surgical procedures performed? ☐ Yes ☐ No

If yes, what type: _____

What treatment was rendered? _____

What recommendations were made? _____ See your own doctor? Yes No

See orthopedic doctor? ☐ Yes ☐ No Physical therapy? ☐ Yes ☐ No

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No Doctors name: _____

Is your pain: Constant? ☐ Yes ☐ No Is the pain off and on? ☐ Yes ☐ No

Sharp? ☐ Yes ☐ No Dull? ☐ Yes ☐ No Other: _____

Is your pain worse: When arising from a chair? ☐ Yes ☐ No By straining? ☐ Yes ☐ No

By coughing? ☐ Yes ☐ No By sneezing? ☐ Yes ☐ No When you move? ☐ Yes ☐ No

Do you have any numbness or tingling: In your arms? ☐ Yes ☐ No In your hands? ☐ Yes ☐ No

In your fingers? ☐ Yes ☐ No In your legs? ☐ Yes ☐ No In your feet? ☐ Yes ☐ No

In your toes? ☐ Yes ☐ No On your face? ☐ Yes ☐ No

What is your most comfortable position: ☐ Sitting ☐ Lying on your right side ☐ Lying on your left side

☐ Lying on your back ☐ Lying on your stomach ☐ Standing ☐ Other: _____

Is it difficult for you to move around in bed? ☐ Yes ☐ No

Does stretching and twisting increase the pain? ☐ Yes ☐ No

Do any of the following ease your pain? ☐ heating pad ☐ bath ☐ shower ☐ ice pack

Does a brace (if you have tried one) help relieve the pain? ☐ Yes ☐ No

Does a change in heel height worsen the pain? ☐ Yes ☐ No

Do you feel better moving around? ☐ Yes ☐ No Or resting? ☐ Yes ☐ No

Do you have a firm mattress? ☐ Yes ☐ No Do your knees ache or hurt? ☐ Yes ☐ No

Do you have cramps in your legs? ☐ Yes ☐ No In arms? ☐ Yes ☐ No

Have you had any changes in bowel habits? ☐ Yes ☐ No

Have you lost any time from work because of this accident? ☐ Yes ☐ No

If yes, please give dates of time lost. From _____ To _____

Totally disabled From _____ To _____ Partially disabled From _____ To _____

PERSONAL INJURY/MOTOR VEHICLE ACCIDENT QUESTIONARE

Name: _____ Date of accident: _____

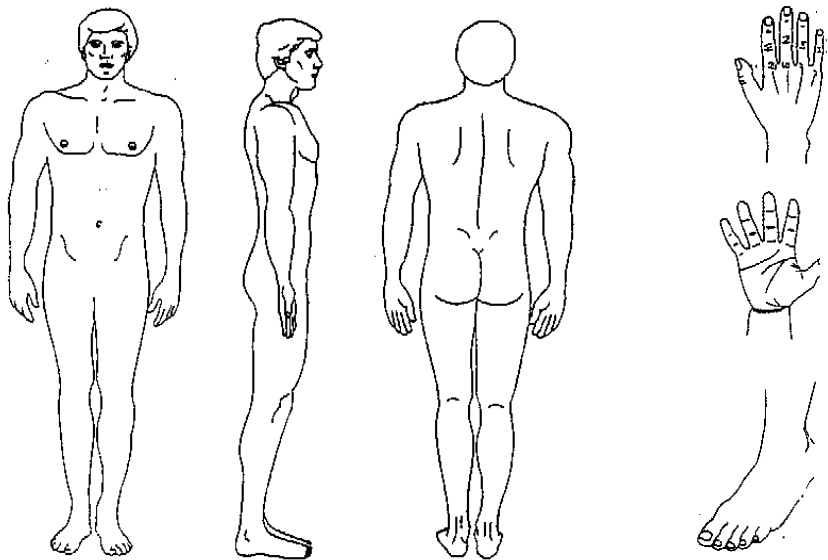
Indicate your BEFORE Injury capacity (mark 'B') and your AFTER injury capacity (mark 'A') for performing the following activities:

1. Walking	Normal _____	Limited _____	Difficult _____	Painful _____
2. Standing	Normal _____	Limited _____	Difficult _____	Painful _____
3. Sitting	Normal _____	Limited _____	Difficult _____	Painful _____
4. Bending	Normal _____	Limited _____	Difficult _____	Painful _____
5. Stooping	Normal _____	Limited _____	Difficult _____	Painful _____
6. Lifting	Normal _____	Limited _____	Difficult _____	Painful _____
7. Pushing	Normal _____	Limited _____	Difficult _____	Painful _____
8. Pulling	Normal _____	Limited _____	Difficult _____	Painful _____
9. Climbing	Normal _____	Limited _____	Difficult _____	Painful _____
10. Reaching	Normal _____	Limited _____	Difficult _____	Painful _____
11. Gripping	Normal _____	Limited _____	Difficult _____	Painful _____
12. Kneeling	Normal _____	Limited _____	Difficult _____	Painful _____
13. Balance	Normal _____	Limited _____	Difficult _____	Painful _____
14. Fatigue	Normal _____	Limited _____	Difficult _____	Painful _____

Pain Drawing:

- Mark all affected areas of your body where you feel pain directly from the accident.
- If your pain radiates, draw an arrow from where it starts to where it stops.
- Extend the arrow as far as the pain travels.
- Use the appropriate symbol(s) below.

ACHE >>>>>>
 BURNING XXXXXX
 NUMBNESS =====
 PINS & NEEDLES oooooo
 STABBING /////
 THROBBING -----



Generally speaking, is your inability to perform these functions due to:

___ Pain ___ Weakness ___ Structural limitations ___ Nerves

Do you have normal sexual function? ___ Yes ___ No

Are you able to take care of yourself, such as dressing, bathing, etc.? ___ Yes ___ No

Or do you require assistance? ___ Yes ___ No

Do you feel your present condition is temporary? ___ Yes ___ No Or permanent? ___ Yes ___ No

Patient's Signature _____ Date _____

PERSONAL INJURY/MOTOR VEHICLE ACCIDENT QUESTIONARE

COMMON LAW ASSIGNMENT OF PROCEEDS FOR BENEFIT OF CREDITOR

I. RECITALS

A. The party to agreement is _____ assignor(s) and Clearwater Clinic, assignee.

B. Assignor(s) is/are unable to pay the claims and demands of assignee, its creditor, as those claims mature in ordinary course of business, yet desires to pay equally and proportionately the debt owed to assignee without the intervention of legal proceedings. Assignor(s) therefore transfer and assign to assignee all rights to that amount of proceeds obtained in any resolution, settlement or court or jury award in assignor's favor in claims or litigation arising from the incident of a personal injury and/or motor vehicle accident dated _____ that will fully satisfy the debt owed assignee for services rendered to the assignor(s) to date.

II. CONDITIONS

A. Assignee is willing to accept the assignment upon terms and condition set forth herein.

B. Assignor(s) grant, sell, assign, transfer, and convey to the assignee the proceeds obtained as described above to the extent of the debt incurred, as well as any choices in action, equities, rights, or claims, tangible or intangible, of whatsoever kind of nature received by assignor(s), or in which assignor(s) may have an interest in lieu of the payment to assignor(s) of actual monies in resolution, settlement or court or jury award.

C. Immediately upon assignor(s) receipt of those proceeds and/or choices, rights or claims, assignor(s) shall notify assignee and assignee shall determine the full amount of debt owed and so notify assignor(s) of that amount.

D. Immediately upon assign(s) receipt of those proceeds and/or choices, rights or claims, assignee shall be deemed to be able to take immediate possession of these proceeds and/or choices, right or claims in the amount determined, and shall have and possess the power to control, use, manage, operate, and dispose of them as though assignee were the absolute owner thereof. Assignee may incur all reasonable and proper expenses in connection with taking possession, but without incurring any personal liability for such expenses other than to bind the assigned property and its proceeds in the hands of assignee.

E. Assignee may include the expenses of administering this assignment, not to exceed 10% of the total amount owed to Assignee. Notwithstanding this Section E, Assignee shall be compensated for its reasonable attorney fees in connection with the enforcement and collection of this Assignment.

IN WITNESS WHEREOF, assignor(s), in a awareness of the rights affected by this agreement pursuant to advice of council, has/have caused this assignment to be signed this _____ day of _____, 20____, and assignee has caused this agreement to be signed this _____ day of _____, 20____.

Assignor(s):

Clearwater Clinic:

By: _____

By: _____