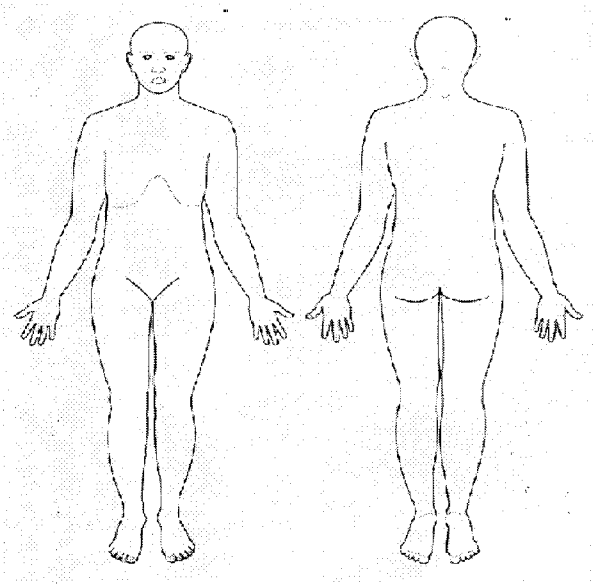
New Patient Intake Form

First Name _____ **Middle** ____ **Last Name** _____
Preferred Name (if different from above) _____
Street Address _____
City _____ **State** _____ **Zip Code** _____
Home Phone (____) _____ **Cell Phone** (____) _____
Email _____
Date of Birth _____/_____/_____ **Sex:** ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Other **Children:** ☐ Yes ☐ No
Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Other_____
Employer _____
Emergency Contact _____ **Phone** (____) _____
Relationship to Patient _____
How did you hear about our office? _____

Do you have a primary complaint? _____
Is this related to an accident? ☐ Automobile ☐ Work Injury ☐ Home/Other _____
When and how did it begin? _____
What makes it better? _____ **Worse?** _____
(*Women Only) Are you pregnant? Yes _____ **No** _____ **Uncertain** _____



Mark on the diagram where your pain is occurring.
If you are currently experiencing pain, is it:
(Mark all that apply)

☐ **Sharp**	☐ **Dull/Ache**	☐ **Burning**
☐ **Numbness**	☐ **Shooting**	☐ **Tightness**
☐ **Throbbing**	☐ **Tingling**	☐ **Stiffness**

Does the pain: ☐ Come and go ☐ Constant

How often does the pain occur?
☐ Hourly ☐ Daily ☐ Weekly ☐Occasionally

If the pain travels, where does it go?_____

How would you rate your pain? *(0 = no pain, 10 = worst):*
0 1 2 3 4 5 6 7 8 9 10

Since the onset, has the complaint?
☐ Improved ☐ Worsened ☐ Stayed the same

Have you ever received chiropractic care? If so, when?
_____

Following, is a list of diseases/conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.
Mark the following conditions that are CURRENTLY a cause of significant concern.

MUSCULOSKELETAL concerns:

☐ Back/Neck Pain ☐ Carpal Tunnel ☐ Scoliosis ☐ Joint Pain
☐ Leg Pain/Sciatica ☐ Headaches ☐ Arthritis ☐ Swollen Join

CARDIOVASCULAR concerns:

☐ Chest Pain/Angina ☐ Blood Pressure Issues ☐ Anemia ☐ Cold Extremities
☐ Varicose Veins ☐ Heart Problems ☐ Arterio/Athero Sclerosis ☐ Stroke

GASTRO-INTESTINAL concerns:

☐ Abnormal Appetite ☐ Nausea ☐ Constipation ☐ Bad Breath ☐ Ulcers
☐ Increased Thirst ☐ Vomiting ☐ Bloating/Gas ☐ Heartburn ☐ Diarrhea
☐ GERD/Acid Reflux ☐ Gall Stones

URINARY/REPRODCUTIVE concerns:

☐ Kidney Infection ☐ Bladder Trouble ☐ Fibroid ☐ Cramps
☐ Cysts ☐ Impotence ☐ Kidney Stones ☐ Frequent Urination ☐ PMS
☐ Excessive Menstruation ☐ Prostate Problems ☐ Painful Urination ☐ STD's
☐ Decreased Sex Drive ☐ Painful Menstruation ☐ Endometriosis ☐ Pregnant
☐ Discolored Urination ☐ Hemorrhoids ☐ Hot Flashes

NERVOUS SYSTEM concerns:

☐ Nervousness ☐ Shooting Pain ☐ Seizures ☐ Dizziness/Vertigo
☐ Anxiety ☐ Paralysis ☐ Loss of Balance ☐ Loss of Taste
☐ Numbness/Tingling ☐ Forgetfulness ☐ Loss of Smell

GENERAL concerns:

☐ Allergies ☐ ADD/ADHD ☐ Diabetes ☐ Herpes ☐ Zoster/Simplex
☐ Fatigue ☐ Colic ☐ Autism ☐ Hearing ☐ Insomnia
☐ Lung Problems ☐ Dental ☐ Heart Disease ☐ Depression ☐ Cancer
☐ Chicken Pox ☐ Vision

List any major surgeries: _____

_____

List any medications, vitamins or supplements you are taking: _____

_____

Have you been treated for any conditions in the last year? ☐ Yes ☐ No
If yes, please explain:_____

Please include any additional information, concerns, or questions you would like to add:

_____

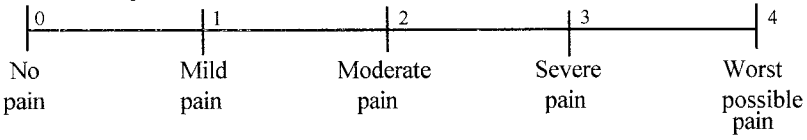
The statements made as to the questions asked on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation. I understand that any and all information on this form and in the file will remain confidential to myself, the doctor, and any other authorized personnel. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office.

Signature_____ Date_____

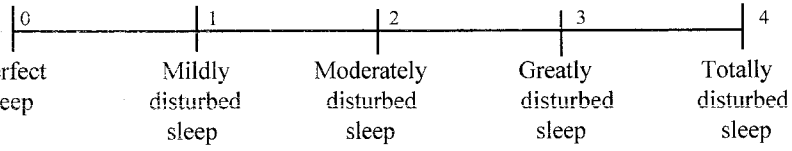
Functional Rating Index

In order to properly assess your condition, we must understand how much your **whole body problems** have affected your ability to manage everyday activities.
For each item below, **PLEASE CIRCLE THE NUMBER WHICH MOST CLOSELY DESCRIBES YOUR CONDITION RIGHT NOW.**

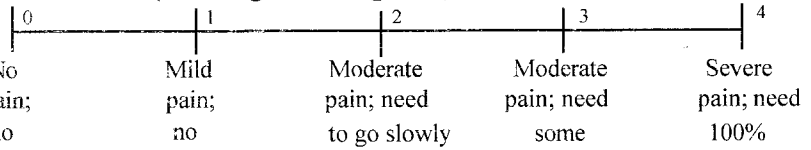
1. Pain Intensity



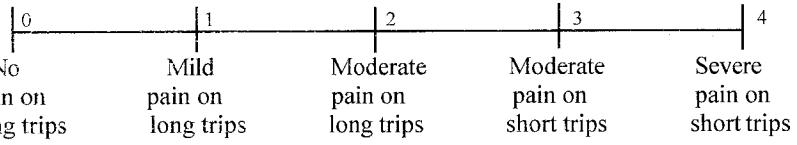
2. Sleeping



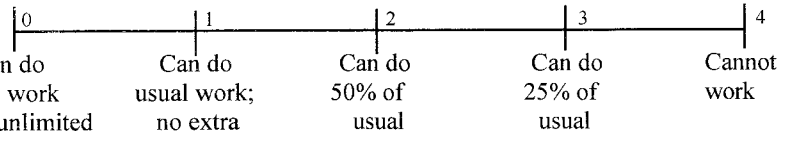
3. Personal Care (washing, dressing, etc.)



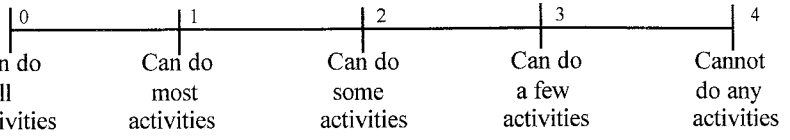
4. Travel (driving, etc.)



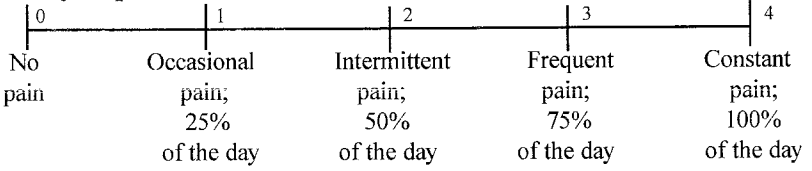
5. work



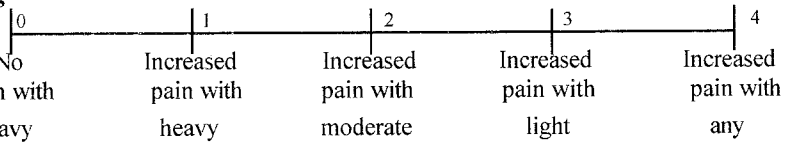
6. Recreation



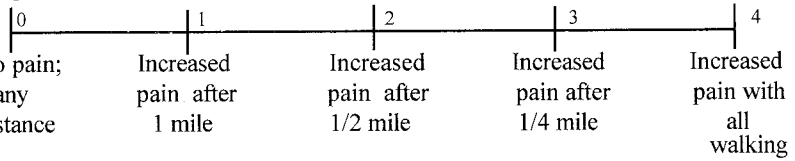
7. Frequency of pain



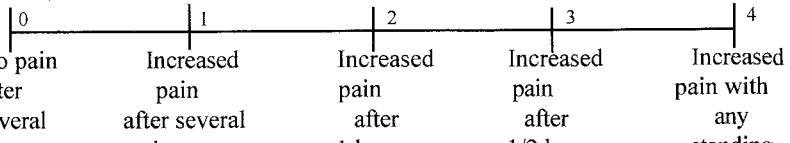
8. Lifting



9. walking



10. Standing



Total Score_____

Name _____
PRINTED

_____
Signature

_____
Date

Cervical Screening Questionnaire

1. Have you had recent trauma to the head or neck?
   Y / N
2. Have you been experiencing a new type of headache? Y / N
3. Are you experiencing vertigo ("spinning" sensation)?
   Y / N
4. Have you had a recent acute respiratory infection with antibiotic use? Y / N
   If Y, did you use Fluoroquinolone? Y / N
5. Do you have a medical history of arterial abnormalities? Y / N / Unsure
6. Do you have a medical history of connective tissue disorders? Y / N / Unsure
7. Do you have a family history of cervical artery dissection? Y / N / Unsure
8. Circle any of the following that you have experienced recently:
   Weakness Numbness Speech Deficit
   Visual Impairment Difficulty Walking/Falls
   Difficulty Swallowing Nausea Confusion
   Anxiety Rapid Involuntary Eye Movement

KERNERSVILLE CHIROPRACTIC CENTER

DARIAN J. SMITH, D.C., B.S.

(336) 996-2462 Telephone
(336) 996-9878 Fax
127 North Main Street
Kernersville, NC 27284
**Mailing: P O Box 707
Kernersville, NC 27285

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Please read this consent form and discuss it, if you would like to, with your doctor, and then sign where indicated at the bottom of the page. Clinicians who use spinal manual therapy techniques, such as joint manipulation, mobilization, or adjustment are required to inform their patients that there may be some risks associated with such treatment.

Treatments provided at this clinic, including the spinal adjustment, manipulation and/or mobilization, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulder/arms/legs, for headaches and other neuromuskuloskeletal symptoms. Treatment provided at this clinic may also contribute to your overall well-being. The risk of injury or complication from manual treatment is *substantially lower* than the risk associated with many standard medical treatments given for the same forms of musculoskeletal pain, such as muscle relaxing drugs, anti-inflammatory drugs such as aspirin, or pain pills. The most frequent risk that occurs in a chiropractic clinic is from burns associated with hot packs. Our office does not even use hot packs. *Rarely* some patients have reported muscle or ligament sprains or strains or rib fractures following an adjustment, however, our low amplitude techniques make that extremely improbable. There have been some "reports" of disc injury following an adjustment, however, there is NO scientific study that has ever demonstrated that such injuries are caused, or may be caused, by adjustments or manipulative techniques. In fact there is much scientific evidence to the contrary. Chiropractic adjustments offer disc patients significant relief and a speedier recovery without the need to resort to surgery. There have also been "reports" of injuries to a vertebral artery following neck adjustments. Usually these patients have a predilection for vertebral artery dissection prior to their chiropractic visit. These patients are already at risk for stroke under many positional activities. They are already at risk for serious neurological injury and impairment, and are no more likely to have such an incident in a chiropractic office than they are in a medical clinic or a beauty salon. This form of complication is astronomically rare occurring about 1 in 12- 50 million and has little or no correlation with the chiropractic adjustment.

Your clinician will evaluate your individual case, provide an explanation of care and a suggested treatment plan, or alternatively a referral for outside consultation and/or further medical evaluation if deemed necessary.

Acknowledgement: I acknowledge that I have read, discussed, or have been given the opportunity to discuss , with my clinician the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.
Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilization to the joints of my spine (neck and back), pelvis and extremities (shoulder, upper limbs and lower limbs), including various modes of physical therapy, and if necessary, diagnostic x-rays. I intend this consent to apply to all my present and future treatments at this clinic.

Patient signature_____ Printed name_____ Date_____

KERNERSVILLE CHIROPRACTIC CENTER

DARIAN J. SMITH, D.C., B.S.

(336) 996-2462 Telephone
(336) 996-9878 Fax
127 North Main Street
Kernersville, NC 27284
**Mailing: P O Box 707
Kernersville, NC 27285

FINANCIAL POLICY

FEES

$25 - Returned Check Fee

$10 - MISSED/CANCELLED/RESCHEDULED APPOINTMENTS (24 HR NOTICE REQUIRED)

(Money collected will be donated to the Kernersville Chiropractic Center Charitable Trust Fund)

I understand that I am financially responsible for all charges whether or not paid by insurance. If you do not have insurance, our office offers a 20% discount on most services received. We also have a Wellness Program that offers even more savings!

WELLNESS PROGRAM

The Wellness Program is a Discount Pre-Pay plan that can be used for non-insurance patients or insurance patients that are coming for a "wellness visit". If you purchase the Wellness Program, it cannot be transferred to any other family members and no other services can be exchanged for the services offered with the program. Your visits will never expire and you can use them whenever you wish.

PAYMENT TYPES

Payment is due at the time services are rendered. This includes payment for returned check fees, missed or cancelled appointment fees (payment in cash or check only), non-insurance services, co-payments, deductibles, and/or co-insurance. We accept cash, check, Visa, MasterCard, American Express, Discover, and CareCredit. We will apply any credit balances on charges incurred by you to any other outstanding charges still owed by you, your spouse, or dependents, regardless of whether these other charges are related to your condition.

Any accounts with balances not paid in full will be placed with Tek Collect for payment recovery. Your file will be placed in all three major credit bureaus for 7 years and you will not be able to receive future care in our office until your account has been paid in full.

CARECREDIT®

CareCredit patient payment plans available on approved credit. CareCredit has No Interest payment plans, if paid within the promotional period. CareCredit has flexible financing options, convenient low minimum monthly payments, no annual fees or prepayment penalties, and a credit decision can be received immediately.

INSURANCE

If we are providing the service of filing health insurance for you, you will be informed of your chiropractic coverage prior to your treatment. Your insurance company does not guarantee benefits over the phone and what they tell us at the time of the call may not be accurate; therefore, the amount we collect at the time of service is only our best estimate of your co-payment/co-insurance. Your insurance coverage is a contract between you and your insurance company. You are responsible for paying any charges not covered by your insurance company.

WELLNESS/MAINTENANCE VISITS

Once your initial rehabilitation is complete, our doctors always recommend wellness care, or preventative maintenance to prevent future spinal problems. Insurance companies are becoming stricter about chiropractic benefits. Most policies state that they only cover a rehabilitation situation or a re-aggravation of an old problem. They will not pay if it appears to be a once-a-month habit. Because so many insurance companies are excluding wellness/maintenance care from their benefits, we will NOT file these types of visits to any insurance company. You are expected to pay out-of-pocket for these type visits. You will be eligible for our 20% discount on your services or you can purchase the Wellness Program.

CHANGES

Please notify us BEFORE your services are rendered if: you have a new insurance card/policy, you were injured at work, you were injured in an automobile accident, or you have had recent surgery or other medical conditions.

I have read and agree to the above terms.

_____ (printed name)

_____ _____

Signature Date

HIPAA Authorization for PHI Disclosure Form

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you**
  We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization**
  We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*
- **Bill for your services**
  We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

Help with public health and safety issues
We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date

Kernersville Chiropractic Center – 127 N Main Street, Kernersville NC 27284

HIPAA Authorization for PHI Disclosure Form

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

Get an electronic or paper copy of your medical record
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information