Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: ­­(­­­ ) - \_ .

Work Phone: ­­(­­­ ) - .

Who Referred You? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In Case of Emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex:Sex: \_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Single Married

Divorced Separated Widowed

Spouse’s Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason For Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Treatments For This Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Doctors Seen For This Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When Did Your Symptoms Begin? \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Came On Gradually

Were You In An Accident? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_ Date of Accident: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If Yes, Auto \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ W/C \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Have An Attorney? Yes \_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Consent For Treatment of Minor

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Mother, Father, Other

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and **ASSIGN BENEFITS OTHERWISE PAYABLE TO ME, TO THE DOCTOR, OR GROUP INDICATED ON THE CLAIM.**

A copy of this signature is as valid as the original.

I attest that the above information is accurate to the best of my ability.

Patient Signature

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **A** | **NECK OR CERVICAL SPINE** | **NONE** | **MILD** | **MODERATE** | **SEVERE** |
| A | Neck Pain and Soreness | A | B | C | D |
| B | Loss or Pain upon Movement | A | B | C | D |
| C | Shoulder Pain | A | B | C | D |
| D | Pain/Numbness/Tingling into  arm or hand | A | B | C | D |
| E | Weakness in arm or hand | A | B | C | D |
| **B** | **MID-BACK OR THORACIC SPINE** | **NONE** | **MILD** | **MODERATE** | **SEVERE** |
| A | Mid-back Pain | A | B | C | D |
| B | Rib or Chest Pain | A | B | C | D |
| **C** | **LOWER BACK OR LUMBAR SPINE** | **NONE** | **MILD** | **MODERATE** | **SEVERE** |
| A | Lower Back Pain or Soreness | A | B | C | D |
| B | Loss or Pain with Movement | A | B | C | D |
| C | Pain into Hips or Buttocks | A | B | C | D |
| D | Pain into Legs, Knees, or Feet | A | B | C | D |
| E | Numbness/Burning in  Legs or Feet | A | B | C | D |
| **D** | **OTHER COMPLAINTS:** | **NONE** | **MILD** | **MODERATE** | **SEVERE** |
| A | Headaches | A | B | C | D |
| B | Visual Disturbances/ Blurry Vision | A | B | C | D |
| C | Ringing or Buzzing in Ears | A | B | C | D |
| D | Nausea or Vomiting | A | B | C | D |
| E | Difficulty Breathing | A | B | C | D |
| F | Dizziness | A | B | C | D |
| G | Recent Weight Loss | A | B | C | D |
| H | Bowel or Bladder Dysfunction | A | B | C | D |
| **E** | **AGGRAVATED BY:** | **NONE** | **MILD** | **MODERATE** | **SEVERE** |
| A | Coughing | A | B | C | D |
| B | Sneezing | A | B | C | D |
| C | Prolonged Sitting | A | B | C | D |
| D | Prolonged Standing | A | B | C | D |
| E | Prolonged Riding in a Car | A | B | C | D |
| F | Lying on Stomach | A | B | C | D |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | No Pain | Slight Pain | Mild Pain | Moderate | Severe Pain | Very Severe |
| A | Pain Intensity | A | B | C | D | E | F |
| B | Personal Care | A | B | C | D | E | F |
| C | Lifting | A | B | C | D | E | F |
| D | Walking | A | B | C | D | E | F |
| E | Sitting | A | B | C | D | E | F |
| F | Standing | A | B | C | D | E | F |
| G | Sex Life | A | B | C | D | E | F |
| H | Social Life | A | B | C | D | E | F |
| I | Sleeping | A | B | C | D | E | F |
| J | Traveling | A | B | C | D | E | F |

**Please CIRCLE any of the following diseases you may have had:**

Group 1

1. Anemia
2. Measles
3. Arthritis
4. Smallpox
5. Pleurisy
6. Stroke
7. Bursitis
8. Pneumonia
9. Epilepsy
10. Neuritis
11. Hay Fever
12. HepatitisGroup 2
13. Diphtheria
14. Hypertension
15. Emphysema
16. Chickenpox
17. Malaria
18. Diabetes
19. Tuberculosis
20. Rheumatism
21. Osteoporosis
22. Hypoglycemia
23. Encephalitis
24. Meningitis

Group 3

1. Polio
2. Ulcer
3. Eczema
4. Asthma
5. Colitis
6. Gout
7. Mumps
8. Hernia
9. Typhoid Fever
10. Scarlet Fever
11. Thyroid Disease
12. ShinglesGroup 4
13. Whooping Cough
14. Migraine Headache
15. Gallbladder Disease
16. Tumor or Cancer
17. Heart Disease
18. Diverticulitis
19. Rheumatic Fever
20. Venereal Disease
21. Kidney Disease
22. Bowel Obstruction
23. Alcoholism
24. Chemical Dependency

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Are You Pregnant? Y N**

**Surgical History: Indicate the Year Family Health History:**

|  |  |  |
| --- | --- | --- |
| **Father** |  | **Mother** |
| Age: \_\_\_\_\_ |  | Age: \_\_\_\_\_ |
| Y N | Deceased | Y N |
| ( ) | Good Health | ( ) |
| ( ) | Heart Disease | ( ) |
| ( ) | Diabetes | ( ) |
| ( ) | Stroke | ( ) |
| ( ) | Cancer | ( ) |
| ( ) | Gout | ( ) |

|  |  |
| --- | --- |
| A) Stomach \_\_\_\_\_\_\_ | H) Thyroid \_\_\_\_\_\_\_ |
| B) Rectum \_\_\_\_\_\_\_ | I) Hernia \_\_\_\_\_\_\_ |
| C) Tonsils \_\_\_\_\_\_\_ | J) Uterus \_\_\_\_\_\_\_ |
| D) Ovaries \_\_\_\_\_\_\_ | K) Breast(s) \_\_\_\_\_\_\_ |
| E) Gallbladder \_\_\_\_\_ | L) Prostate \_\_\_\_\_\_\_ |
| F) Appendix \_\_\_\_\_\_\_ | M) Spinal \_\_\_\_\_\_\_ |
| G) Colon \_\_\_\_\_\_\_\_ | Other: \_\_\_\_\_\_\_\_ |

Please specify other: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of the Occurrence**

Did your symptoms: A) Come on suddenly (example awoke with pain)  
 B) Came on gradually over the last (circle one from each column below

few days  
 several weeks  
 months  
 years

Are your symptoms: ( ) getting worse ( ) staying about the same ( ) slowly improving

**Work Status History**

Occupation or Job Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you missed time from work? Y or N

If yes: Full Time off work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Returned to Modified Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) Been unable to work since the illness began.

**Notice of Privacy Practices Acknowledgement  
Notto Chiropractic Health Center**

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of the Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I authorize Notto Chiropractic Health to release my medical information to the following person(s):

Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

None of the above: \_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient Name or Legal Guardian (print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature

We have made the following attempt to obtain the patient’s signature acknowledging receipt of the   
Notice of Privacy Practices:

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attempt \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

|  |  |
| --- | --- |
| **First Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Last Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Email address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:**  \_\_\_/\_\_\_/\_\_\_\_\_\_ **Gender (Circle one):**  Male / Female **Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

**Smoking Start Date (Optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*CMS requires providers to report both race and ethnicity*

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

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

|  |  |
| --- | --- |
| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|  |  |
|  |  |
|  |  |

**Do you have any medication allergies?**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Reaction | Onset Date | Additional Comments |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| ***For office use only***  Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_ Blood Pressure: \_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_ |

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_