

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ **Date:** _____

Insurance: _____ (dd/mm/yr)

Date of Birth: _____ male female

Address: _____

Marital status

S	M	W	D	SEP
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Phone #: home: _____ work: _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Check and indicate the age when you had any of the following:

General

- Allergies
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Headaches
- Loss of sleep
- Mental illness
- Nervousness
- Tremors
- Weight loss / gain

Muscle / Joint

- Arthritis / rheumatism
- Bursitis
- Foot trouble
- Muscle weakness
- Low back pain
- Neck pain
- Mid back pain
- Joint pain

Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergies
- Itching
- Rash
- Varicose veins

Eye, Ear, Nose & Throat

- Colds
- Deafness
- Ear ache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Ringing of the ears
- Sinus infection
- Sore throat
- Tonsillitis
- Vision problems

Gastrointestinal

- Abdominal pain
- Bloody or tarry stool
- Colitis / Crohn's
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Diverticulosis
- Bloating abdomen
- Excessive hunger
- Gallbladder trouble
- Hemia
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Painful defecation
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

Genitourinary

- Bed-wetting
- Bladder infection
- Blood in urine
- Kidney infection
- Kidney stones
- Prostate trouble
- Pus in urine
- Stress incontinence
- Urination
- Overnight more than twice
- More than 8x in 24hrs
- Decreased flow/force
- Painful urination
- Urgency to urinate

Cardiovascular

- High blood pressure
- Low blood pressure
- Hardening of the arteries
- Irregular pulse
- Pain over heart
- Palpitation
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever
- Shortness of breath
- Spitting up phlegm / blood
- Wheezing

Women only

- Congested breasts
- Hot flashes
- Lumps in breast
- Menopause
- Vaginal discharge

Menstrual flow

Reg. Irreg. Pain / cramps

Days of flow: _____ Length of cycle: _____

Date - 1st day last period: _____

Are you pregnant? yes, no

If yes, how many months? _____

How many children do you have? _____

Birth control method: _____

Date of last PAP test: _____

normal, abnormal

Date of last mammogram: _____

normal, abnormal

Check any of the conditions you have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chicken pox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart burn
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV/AIDS
- Influenza
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness/tingling
- Pace maker
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

Please list any medication you are currently taking and why:

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

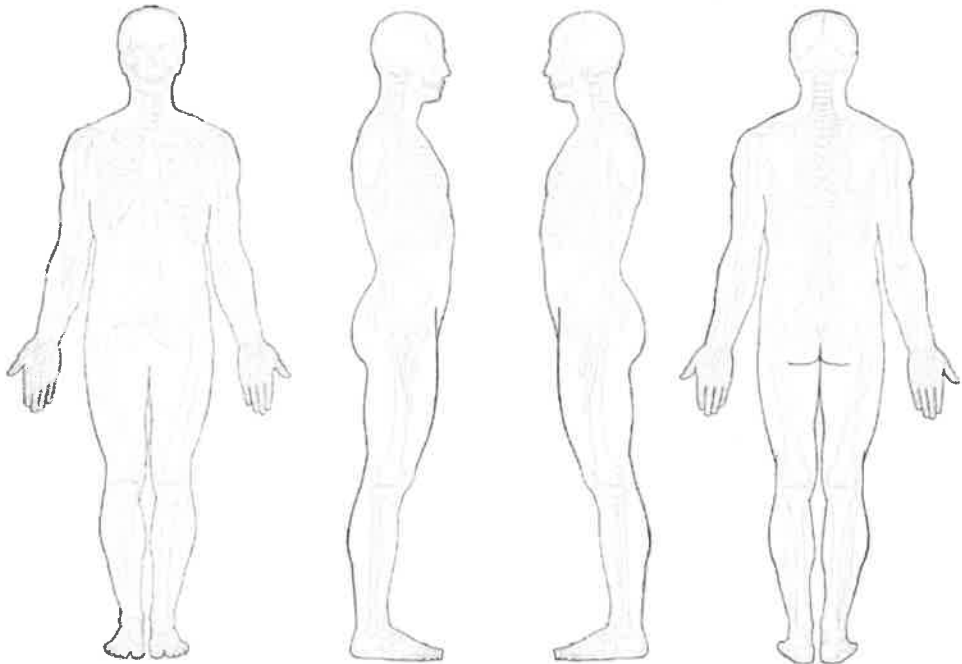
How long have you had this condition? _____ Is it getting worse? yes, no _____

Does it bother you (check appropriate box): work, sleep, other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... ever used orthotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How is most of your day spent?	<input type="checkbox"/> standing, <input type="checkbox"/> sitting, <input type="checkbox"/> other: _____		
How old is your mattress?	_____		
When was your last physical exam?	_____		

Habits	none	light	mod.	heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease |

Do you have any other health issues or concerns that our staff should be made aware of? _____

New Mexico Chiropractic Center (NMCC)

Informed Consent

To the patient: Please read this entire document prior to signing. It is important that you understand the information contained in this consent. Please ask questions before you sign if there is anything that is unclear to you. Thank you.

Analysis/Examination/Treatment:

I understand that I am consenting to a diagnostic and/or chiropractic adjustment and associated therapies. The examination may included but not limited to vital signs, neurological and orthopedic testing, palpation/ touch and radiographic images. The recommended treatment may include chiropractic spinal and extremity joint manipulations, trigger point acupressure, massage therapy, ice or heat therapy, electrical muscle stimulation, intersegment traction, manual traction and professional advice. The primary treatment employed is manipulative therapy in which I might feel movement and/or hear an audible 'pop'. I understand, as with all health care approaches, results are not guaranteed and there is no promise to cure.

Material risks inherent in the chiropractic adjustment and/or therapy:

I understand that there are certain risks to the procedures especially if I have any predisposing conditions. These complications include but are not limited to muscle soreness, muscle spasm, joint pain and stiffness, inflammation, headache, back pain, or bruising. More serious injuries can occur, such as cardiovascular complications like stroke, fracture or disc complications. While many of the risks are rare, I understand that they are inherent in physical medicine. I understand that the doctors at NMCC will make every reasonable effort during the examination to screen for complications or contraindications to care; however, if I have a condition that would otherwise not come to her attention, it is my responsibility to inform my doctor.

The availability and nature of other treatment options:

Rest, self-administered over the counter medications, medical care and prescription medications, Oriental medicine and acupuncture, Physical Therapy, bracing, injections, hospitalization or surgery. You have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. If you choose one of the options above, you should be aware that there are risks and benefits associated with these options and you should discuss those with your primary care provider.

DO NOT SIGN THIS DOCUMENT UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatments. I recognize that informed consent is a dynamic process that fully rests on open and honest communication by all parties and can be changed at any time. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended by NMCC. Having been informed of the risks, I hereby give my consent to the recommended treatment.

Patient's name (Printed): _____

Patient's Signature: _____ Date: _____

Signature of Parent or Guardian _____ Date: _____

Witness: _____ Date: _____

NMCC - Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between New Mexico Chiropractic Center and the patient who is receiving services. Your clear understanding of our financial policy is important to our professional relationship.

Welcome to our office! We are pleased you have chosen Chiropractic for your health care needs. Your health is your greatest asset, and, therefore one of the best things you can invest in financially.

Insurance

Dr. Alissa Albers and Dr. Amanda Smith do NOT participate in any private health insurance programs.

All payments are expected in full at time of service.

Personal Injury/ Motor Vehicle Accident

Please inform us if there is a lawyer handling your case, as we require a Letter of Protection (LOP). Obtaining legal representation does not negate the patient's responsibility of payment in any way. If for any reason, the case is dropped or does not result in settlement, ***you are responsible for payment of services rendered.***

Self-pay

Patients with no insurance coverage are expected to *pay in full at the time of service.*

Missed Appointments/ Cancellation fees

Missed appointments or cancellations with less than 24 hour notice will be charged a \$25.00 fee*.

If you have questions regarding prices, payment options or costs please feel free to ask the staff at New Mexico Chiropractic Center. We strive to make care affordable and convenient for you and your family.

I understand and will abide by the above policies,

Patient's name (print): _____

Patient's signature: _____

Date: _____

*exception at the doctor's discretion.

New Mexico Chiropractic Center

HIPAA = Health Information Portability and Accountability Act

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my health information to New Mexico Chiropractic Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health bills or to conduct health care operations of New Mexico Chiropractic Center. I understand that diagnoses or treatment may be continued upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. New Mexico Chiropractic Center is not required to agree to the restrictions that I may request; however, if New Mexico Chiropractic Center agrees to the restrictions, the restriction is binding on New Mexico Chiropractic Center

I have the right to revoke this consent, in writing, at any time, except to the extent that New Mexico Chiropractic Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review New Mexico Chiropractic Center Notice of Privacy Practices prior to signing this document. New Mexico Chiropractic Center Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of New Mexico Chiropractic Center. The Notice of Privacy Practices also describes my rights and New Mexico Chiropractic Center duties with respect to my protected health information.

New Mexico Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative: _____

PRINT Name of Patient or Personal Representative: _____

Date: _____

New Mexico Chiropractic Center
X-RAY PREGNANCY WAIVER

I hereby acknowledge New Mexico Chiropractic Center has informed me prior to being x-rayed of the risk and the probable consequences of receiving x-rays during pregnancy. Prior to being x-rayed, I state of my own volition I am not pregnant and do hereby release and hold harmless New Mexico Chiropractic Center from any legal action or responsibility associated with the x-ray procedure.

Print Name: _____ Date: _____

Signature: _____