# Patient Intake

Date: ____________________

Title: Mr. Mrs. Ms. Miss. Dr.  Date of Birth: _____/_____/_______  Sex: Male Female

First Name: ____________________ Middle Initial: _____ Last Name: ____________________

Address Line 1: ________________________________________

City: ____________________ State: ______________ Zip Code: ______________

Phone: (_____)________-____________  Cell Phone: (_______)_________-______________

Email: ________________________________________

Social Security Number: ________-_______-____________  Marital Status: Single Married Other

Employment Status: Employed Full Time Student Part Time Student Retired Non-Employed

Insurance: ______________________________ Policy Number: ______________________________

## Spouse Data:

Is your spouse a patient in the clinic? Yes No

First Name: ____________________ Middle Initial: _____ Last Name: ____________________

Home Phone: (_____)________-____________  Work Phone: (_____)________-____________

## Employer Data:

Name: ________________________________________

Address Line 1: ________________________________________

City: ____________________ State: ______________ Zip Code: ______________

## Emergency Contact:

Contact Name: ________________________________________

Contact Phone: (_______) ________-______________

How did you hear about Buchanan Health Center? ______________________________

If you were referred by someone please enter their name: ______________________________

# HIPPAA Patient Information Consent Form

**We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPAA NOTICE that is available to you at the front desk before signing this consent.**

1. **The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit release of all PHI to the minimum needed for what the insurance companies require for payment.**
2. **The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.**
3. **A patient s written consent need only be obtained one time for all subsequent care given the patient is this office.**
4. **The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.**
5. **For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designed to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.**
6. **Patient s have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.**
7. **If the patient refuses to sign this consent for the purposes of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.**

**I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.**

**Patient/Guardian Signature:**____________________________________________ **Date** __________

# HEALTH HISTORY

Patient name: ___________________________________________ DOB: ______________ Date: ______________

**Chief Complaint (What brought you in to see the Medical provider/Chiropractor today?):**

_______________________________________________________________________________________________

_______________________________________________________________________________________________

**History of Present Illness:**

**Onset** (when did your symptoms start?): _______________________________________________________________

**Location** (where is the pain/problem?): _________________________________________________________________

**Duration** (how long have you had this pain/problem?): ____________________________________________________

**Characteristics** (what describes the nature of your symptoms?):

___ Sharp ___ Dull ache ___ Numb ___ Shooting
___ Burning ___ Tingling ___ Stabbing Other:___________________

**Aggravating Factors** (what makes your symptoms worse?):

___ Sitting ___ Standing __Looking up/down ___ Coughing
___ Walking ___ Running ___ Looking left/right ___ Straining
___ Stooping ___ Lifting ___ Twisting ___ Driving
___ Chores ___ Exercise Other: _________ Other: _________

**Relieving Factors** (what makes your symptoms better?):

___ Sitting ___ Knees bent ___ Medication
___ Standing ___ Stretching ___ Heat
___ Laying down ___ Exercising ___ Ice
Other: _________ Other: _________ Other: _________

**Timing** (how often do you experience your symptoms?):

___ Constantly (76-100% of the time) ___ Frequently (51-75% of the time)

___ Occasionally (26-50% of the time) ___ Intermittently (0-25% of the time)

**Severity** (please indicate the average intensity of your pain/symptoms):

(0=None to 10=Unbearable)

0 1 2 3 4 5 6 7 8 9 10

**Have you had similar symptoms in the past? Yes**_________ **No** __________

**If you have received treatment in the past for the same or similar symptoms, who did you see?**

___ This Office ___ Other Chiropractor ___ Medical Doctor ___ Physical Therapist
___ No One Other: ________________

**What tests have you had?** ___ **XRays** ___**MRI** ___ **CT scan, Other:** _____________________

**When were they done?**

___ Within the last month ___ 2-3 months ago ___ 3-6 months ago ___ 6 months – 1 year ago
___ 1-2 years ago ___ 2-5 years ago ___ 5-10 years ago ___ >10 years ago

**What treatment did you receive for your symptoms?**

___ Adjustments ___ Physical Therapy ___ Medication Other: ____________

**When did you last receive this treatment?**

___ Within the last month ___ 2-3 months ago ___ 3-6 months ago ___ 6 months – 1 year ago
___ 1-2 years ago ___ 2-5 years ago ___ 5-10 years ago ___ >10 years ago

**How are your symptoms changing?**

___ Getting better ___ Not changing ___ Getting worse

**How much have symptoms interfered with your normal work (including in the home?)**

All the time ___ Most of the time ___ Some of the time ___
A little of the time ___ None of the time ___

**How much have symptoms interfered with your social activities?**

All the time ___ Most of the time ___ Some of the time ___
A little of the time ___ None of the time ___

**Past Medical History** (Have you ever had the following? Circle yes or no/leave blank if you are uncertain.)

| | | | | | |
|---|---|---|---|---|---|
| Measles | Yes/No | Anemia | Yes/No | Back Trouble | Yes/No |
| Mumps | Yes/No | Bladder infection | Yes/No | High Blood Pressure | Yes/No |
| Chicken Pox | Yes/No | Epilepsy | Yes/No | Low Blood Pressure | Yes/No |
| Whooping cough | Yes/No | Migraine Headaches | Yes/No | Hemorrhoids | Yes/No |
| Scarlet Fever | Yes/No | Tuberculosis | Yes/No | Date of last CXR_____ | |
| Diphtheria | Yes/No | Diabetes | Yes/No | Asthma | Yes/No |
| Small Pox | Yes/No | Cancer | Yes/No | Hives/Eczema | Yes/No |
| Pneumonia | Yes/No | Polio | Yes/No | AIDS/HIV | Yes/No |
| Arthritis | Yes/No | Hernia | Yes/No | Bronchitis | Yes/No |
| Venereal Disease | Yes/No | Blood/Plasma transfusion | Yes/No | Mitral Valve Prolapse | Yes/No |
| Stroke | Yes/No | Rheumatic Fever | Yes/No | Glaucoma | Yes/No |
| Mononucleosis | Yes/No | Hepatitis | Yes/No | Ulcer | Yes/No |
| Kidney Disease | Yes/No | Thyroid disease | Yes/No | Bleeding tendency | Yes/No |
| Mental Illness | Yes/No | Heart Disease | Yes/No | Other: _____________ | |
| Any others : | | _____________________ | | _____________________ | |
| Did you receive childhood immunizations? | Yes/No | | | | |
| Are you Pregnant? | Yes/No | | | | |
| | | Last Menstrual Period? | | _____________________ | |
| Sexually Active? | Yes/No | | | | |
| | | Birth Control? | Yes/No | Type: _______________ | |

**Previous Hospitalizations/Surgeries/Serious Illnesses:**

| | ***When?*** | ***Hospital/City/State*** |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |

**Social History:**

Occupation: ______________________________

| | | | | | |
|---|---|---|---|---|---|
| Marital Status: | Single ___ | Married ___ | Separated ___ | Divorced ___ | Widowed ___ |
| Alcohol Use | Never ___ | Rarely ___ | Moderate ___ | Daily ___ | Type: ___________________ |
| Tobacco Use | Never ___ | Current ___ | Former ___ | | Type: ___________________ |
| Drug Use | Never ___ | Current ___ | Former ___ | | Type: ___________________ |

**Family Medical History:**

| | Age | Disease(s) | If Deceased, Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Sibling | | | |
| Sibling | | | |

**Current Medications:** (please include prescription and non-prescription/vitamins/supplements)

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Allergies to Medications:**_____________________________________________________

**Preferred Pharmacy:**__________________________________________________________

**Patient/Guardian Signature:**_______________________________ **Date** ___________

**Please indicate below which of the following you have experienced in the last 1-2 months:**

***Auto Accident Patients: Please circle below which of the following you have experienced since the accident.***

| General | Eyes/Ears/Nose/Throat | Respiratory | Cardiac | Neurological | Musculoskeletal | GI |
|---|---|---|---|---|---|---|
| Fatigue | Asthma | Cough | Chest Pain | Headaches | Muscle Aches | Constipation |
| Malaise | Stuffy Nose | Chest congestion | Irregular pulse | Migraines | Fibromyalgia | Diarrhea |
| Weakness | Hay Fever | Shortness of Breath | Palpitations | Dizziness | Arthritis | Heartburn |
| Tiredness | Sore Throat | Wheezing | Swelling in legs | Numbness | Joint Pain | Changes in Appetite |
| Lightheadedness | Frequent Sneezing | Snoring | Difficulty breathing when lying down | Tingling | Low Back Pain | |
| Irritability | Itchy/watery eyes | | | Pins/needles in hands or feet | Neck Pain | |
| Feeling foggy | Nasal Drainage | | | | Elbow Pain | |
| Forgetfulness | Earache or ear infection | | | | Wrist/Hand Pain | |
| Difficulty Sleeping | Itching | | | | Shoulder Pain | |
| Unexplained weight loss/gain | Hoarseness | | | | Hip Pain | |
| Fever/Chills/Night sweats | Nosebleeds | | | | Knee Pain | |
| | Vision changes | | | | Ankle/foot pain | |
| | | | | | Pain between shoulder blades | |
| **Endocrine** | **Skin** | **Psychiatric** | | | | |
| Heat or cold intolerance | Rash | Feeling down or depressed | | | | |
| Hair Loss | Wounds/lesions | Anxiety | | | | |
| Excessive thirst | Nail discoloration | Unusual Stress | | | | |
| Excessive urination | | | | | | |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

**Patient/Guardian Signature:**______________________________________ **Date** _________

# General Consent for Care and Treatment-Medical Consent

**This consent provides us with your permission to perform reasonable and necessary medical and/or chiropractic examinations, testing and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.**

**You have the right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.**

**I voluntarily request a physician, and/or medical provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical and/or chiropractic examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).**

**I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.**

**Patient/Guardian Signature**_______________________________________ **Date** __________________

## AUTHORIZATION TO RELEASE INFORMATION

**I hereby authorize the release of any information to my health care companies, Medicare or legal representative with a Request Authorization.**

**Patient/Guardian Signature**_______________________________________ **Date** __________________

**Witness** _________________________________________________________ **Date** ________________

# Assignment of Health Plan Benefits and Rights
# As well as an
# Appointment and/or Designation as my Personal Representative and an ERISA/PPACA Representative and Beneficiary

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Buchanan Health Center as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms, or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denies or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPAXA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan (s) or health insurance policy (ies). I also hereby appoint and designate that healthcare Provider can act on any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this ___________ day of _______________, 20_____.

X__________________________________________________________________________ **(patient signature)**

X______________________________________________________________ **(signature of Guardian if applicable)**

X____________________________________________________________________ **(Please print patient name)**