New Patient Intake

Name: _____ Date: _____

Mailing Address: _____

City _____ State _____ Zip _____

Email address: _____

Phone # (H)_____ (W)_____ (Other)_____

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Emergency contact:_____ Relation:_____

Phone #: (H) _____ (W) _____ (C) _____

May we collaborate and share your progress with your PCP? **Yes ❑ No ❑**

Primary Care Physician Name:_____Phone #:_____

How did you hear about our practice? _____

What is your chief complaint today? _____

Please list any additional health complaints _____

Please list any surgeries (with dates) and/or medical conditions (past & present) _____

_____

Family History: Please specify members of your family including extended family who have these illnesses.
Cancer: _____ Hypothyroidism:_____
Heart Disease: _____ High Blood Pressure: _____
Hypoglycemia: _____ Obesity: _____

Current Medications/Supplements		
Medication/Dose/How often	Reason for taking	Prescribing M.D.

Please list any allergies _____

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time. Are You Pregnant? Yes ❑ No ❑

Signature: _____ Date: _____

Review of Systems

Name: _____ Date of Birth: ____/____/____ Date: ____/____/____

Please mark if you have experienced any of these symptoms within the ***last month****:*

Neurological
___ Migraines
___ Headaches
___ Slurring of speech
___ Ringing in ear
___ Dizziness
___ Pins/Needles Arms
___ Pins/Needles Legs
___ Cold Feet
___ Fainting
___ Fever

Ear/Nose/Throat
___ Altered taste/smell
___ Night Blindness
___ Sore Throat
___ Gingivitis
___ Nose bleeds
___ Blurred Vision
___ Light bothers eyes

Cardiovascular
___ Chest pain
___ Palpitations- racing heart beat
___ Swelling in hands/feet
___ Anemia

Respiratory
___ Recurrent respiratory infections
___ Asthma
___ Chest congestion
___ Wheezing
___ Frequent sneezing
___ Shortness of breath

Gastrointestinal
___ Stomach pains or cramping
___ Constipation
___ Reflux or heartburn
___ Bloating
___ Gas
___ Nausea or vomiting
___ Bowel/ bladder changes

Musculoskeletal
___ Joint pain
___ Arthritis
___ Chronic pain
___ Muscle aches
___ Neck pain
___ Back pain
___ Arm pain
___ Knee/leg pain
___ Night pain
___ Jaw problems

Skin
___ Eczema
___ Dermatitis
___ Excessive sweating
___ Rashes
___ Brittle nails
___ Hair loss
___ Increased bleeding
___ Easy bruising
___ Numbness/tingling
___ Cold sweats

Genitourinary
___ Uterine fibroids
___ Ovarian cysts
___ Cancer (breast, ovarian, prostate,uterine)
___ Prostate problems

Emotional/Mental
___ Depression
___ Anxiety
___ Mood swings
___ Irritability
___ Memory loss
___ Confusion
___ Nervousness

Energy
___ Fatigue
___ Hyperactivity
___ Restlessness
___ Insomnia
___ Decreased libido
___ Stress
___ Tension

Weight
___ Decreased appetite
___ Weight gain
___ Inability to lose weight
___ Food cravings
___ Binge eating
___ Water retention
___ Sudden weight loss

Allergies
___ Hives
___ Runny nose
___ Itchy/Watery eyes
___ Congestion

___ **None of the above**

Functional Rating Index

In order to assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one which most closely describes your condition ***right now***.

Pain Intensity

No pain	*Mild pain*	*Moderate pain*	*Severe pain*	*Worst possible pain*

Sleeping

Perfect sleep	*Mildly disturbed sleep*	*Moderately disturbed sleep*	*Greatly disturbed sleep*	*Totally disturbed sleep*

Personal Care (washing, dressing, etc.)

No pain with no restrictions	*Mild pain with no restrictions*	*Moderate pain; need to go slowly*	*Moderate pain; need some assistance*	*Severe pain; need 100% assistance*

Travel (Driving, etc.)

No pain on long trips	*Mild pain on long trips*	*Moderate pain on long trips*	*Moderate pain on short trips*	*Severe pain on short trips*

Work

Can do usual work plus unlimited extra work	*Can do usual work with no extra work*	*Can do 50% of usual work*	*Can do 25% of usual work*	*Cannot work*

Recreation

No pain	*Mild pain*	*Moderate pain*	*Severe pain*	*Worst possible pain*

Frequency of pain

No pain	*Occasional pain; 25% of the day*	*Intermittent pain; 50% of the day*	*Frequent pain; 75% of the day*	*Constant pain; 100% of the day*

Lifting

No pain with heavy weight	*Increased pain with heavy weight*	*Increased pain with moderate weight*	*Increased pain with light weight*	*Increased pain with any weight*

Walking

No pain with any distance	*Increased pain after 1 mile*	*Increased pain after 1/2 mile*	*Increased pain after 1/4 mile*	*Increased pain with all walking*

Standing

No pain after several hours	*Increased pain after several hours*	*Increased pain after 1 hour*	*Increased pain after 1/2 hour*	*Increased pain with any standing*

HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Patient Signature_____**Date**_____

Authorization and Assignment

Please initial next to each line that applies to you. Thank you.

__ **AUTHORIZATION TO RELEASE INFORMATION (*if applicable):*** You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

__ **ASSIGNMENT OF PAYMENT (*if applicable*):** My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any money due to him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that is not covered by my policy or if for any other reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

__ **MEDICARE ASSIGNMENT (*if applicable*):** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

__ **ACKNOWLEDGEMMENT AND UNDERSTANDING:** I hereby acknowledge;

A. That there is no insurance company obligated to pay for the services, or if the insurance company involved, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or
B. If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Total Heath Systems P.C., will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

Patient Signature_____**Date**_____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE.

I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Advanced Health Institute South Loop, LLC and Options Medical, LLC. I understand and am informed that, while extremely rare, there are some risks to treatment, including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient Signature_____**Date**_____

Parent/Legal guardian name (please print)_____

Guardian Signature_____ **Date**_____