Patient Intake Form

Patient Information

Full Name:_____ Date:_____
First MI Last

Address: _____City:_____State:_____Zip:_____

Age:_____Birth Date:_____ Female: Male:

Social Security Number:_____ Email Address:_____

Home Phone:_____ Work Phone:_____ Cell/Other:_____

I prefer to receive calls at (*circle*) Home/Work/Cell

I am (*circle*) Under age 18/Single/Married/Divorced/Widowed/Separated

Employer:_____ Occupation:_____

Business Address:_____ City:_____ State:_____ Zip:_____

Spouse's Name:_____ Spouse's Date of Birth:_____

Emergency Contact:_____ Emergency Contact Phone Number_____

How Did You Hear About Us? _____

Payment Information

Person Responsible for Payment: _____

Social Security Number:_____ Phone:_____ Date of Birth:_____

Insurance Information

Do you have health insurance? _____Yes _____No Are you the Policy Holder? _____Yes _____No
Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release - By signing below, I authorize Chiropractic health of matthews to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Chiropractic Health of Matthews and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operation.

By signing below, I give my consent for examination and the performance tests or procedures needed. If the patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Signed_____ Date:_____

Health Questionnaire

Patient Information

Patient Name:_____Date of Birth:____/____/____Height:_____Weight:_____

Medical History

Describe the reason for your doctor visit today:

_____

When did your symptoms start?_____**How did your symptoms begin?**_____

How often do you experience symptoms? (*circle one*) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (*circle all that apply*) Sharp Dull ache Numbness Burning Tingling Shooting

Are your symptoms? (*circle one*) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities? _____

Have you experienced these symptoms in the past? _____

On a scale of one to ten how intense are your symptoms? *Not Intense* 0 1 2 3 4 5 6 7 8 9 10 *Unbearable*

History of Treatment

Primary care physician:_____ **Phone**:_____

Date last seen:_____ **May we update them on your condition?** _____ Yes _____ No

Have you seen a chiropractor before? _____ Yes _____ No If yes, when was your last visit? _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider:

_____

List all prescription, non prescription medication and other supplements you take as well as the associated condition:

_____

List anything you are allergic to:

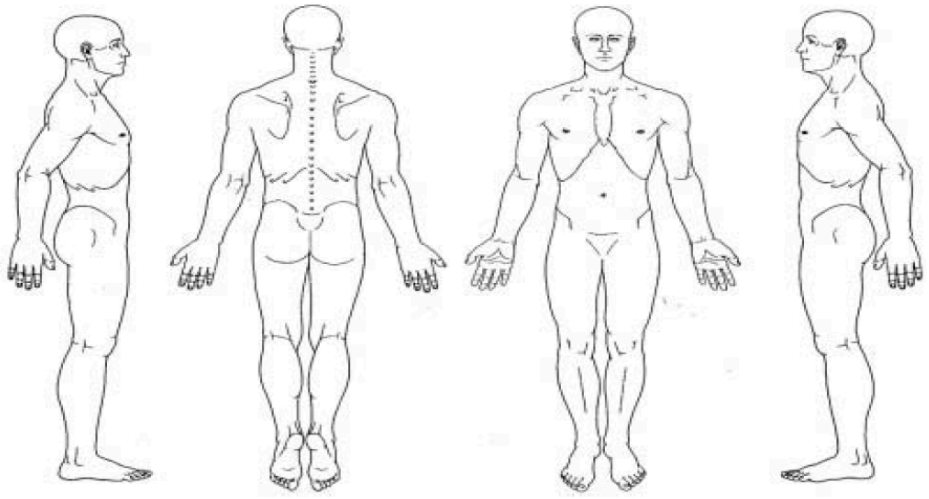
_____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

_____

Do you smoke? _____ Yes _____ No If yes, packs per day. _____ **Are you pregnant?** _____ Yes _____ No

Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.



For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Pesent	Condition	Past	Present	Condition
☐	☐	Abdominal Pain	☐	☐	Elbow/upper arm pain	☐	☐	Liver/Gall bladder disorder
☐	☐	Abnormal Weight gain/loss	☐	☐	Epilepsy	☐	☐	Loss of Bladder control
☐	☐	Allergies headache	☐	☐	Excessive Thirst	☐	☐	Low back pain
☐	☐	Angina	☐	☐	Frequent Urination	☐	☐	Mid back pain
☐	☐	Ankle/foot pain	☐	☐	General Fatigue	☐	☐	Neck Pain
☐	☐	Arthritis	☐	☐	Hand Pain	☐	☐	Painful Urination
☐	☐	Asthma	☐	☐	Heart Attack	☐	☐	Prostate Problems
☐	☐	Bladder Infection	☐	☐	Hepatitis	☐	☐	Shoulder Pain
☐	☐	Birth Control Pills	☐	☐	High Blood Pressure	☐	☐	Smoking/tobacco use
☐	☐	Cancer	☐	☐	Hip/upper leg pain	☐	☐	Stroke
☐	☐	Chest Pains	☐	☐	HIV/AIDS	☐	☐	Systematic Lupus
☐	☐	Chronic Sinusitis	☐	☐	Hormone Therapy	☐	☐	Thoracic Outlet Syndrome
☐	☐	Depression	☐	☐	Jaw Pain	☐	☐	Tumor
☐	☐	Dermatitis/Eczema	☐	☐	Joint swelling/stiffness	☐	☐	Ulcer
☐	☐	Dizziness	☐	☐	Kidney Stones	☐	☐	Upper back pain
☐	☐	Drug/Alcohol Use	☐	☐	Knee/lower leg pain	☐	☐	Wrist pain

Patient's signature _____Doctors's signature_____

INFORMED CONSENT FORM TO CHIROPRACTIC TREATMENT

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	palpation	vital signs
range of motion testing	orthopedic testing	basic neurological testing
muscle strength testing	postural analysis	ultrasound
hot/cold therapy	Electrical Stim	
radiographic studies	mechanical traction	
Other (please explain)		

_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of

stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *(insert doctor’s name)* and have had my questions answered to my satisfaction. 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. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient’s Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Dated: _____

_____
Doctor’s Name

_____
Signature

AUTHORIZATION / ASSIGNMENT

I authorize the office of Chiropractic Health of Matthews to release any and all information concerning my physical condition to any insurance company, adjuster, or attorney in order to process any of my claims for reimbursement of charges incurred by me as a result of professional chiropractic services rendered by Dr. Bryan A. Mozingo or Dr. Remi Jeffries. I also authorize the release of any and all information concerning my physical condition to my employer, if and when applicable.

I also authorize Dr. Bryan A. Mozingo and/or his office to be given Power of Attorney to endorse/sign my name on any and all checks issued to this office toward the payment of my bill. I release Dr. Bryan A. Mozingo and/or his office of any consequence thereof and understand that if this office should receive more than owed, I will receive a refund of credit balance due to me, the patient.

I authorize any insurance company, attorney, adjuster, or employer to make direct payment to Dr. Bryan A. Mozingo for any sum I should owe, now or hereafter. This authorization includes payment of any disability medical payment, no-fault, or other insurance benefit on my behalf to protect the interest of Dr. Bryan A. Mozingo.

I understand that if any insurance company, attorney, adjuster, or employer involved refuses to protect the interest of Dr. Bryan A. Mozingo or his office, then payment is due IN FULL when services are rendered.

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

24 Hour Appointment Cancellation Policy

Chiropractic Health of Matthews, Dilworth and University City Chiropractic have a 24 hour cancellation/rescheduling policy.

If you miss your appointment, cancel or change your appointment with less than 24 hour notice you will be charged a non-refundable fee of $45.00.

This policy is in place out of respect for our staff and our clients, including yourself. We are considerate of everyone's time; however we are very busy in our office and lack of keeping a scheduled appointment prevents others, who may have wished to come in, from scheduling during that time.

By signing below, you acknowledge that you have read and understand the **Cancellation Policy for Chiropractic Health of Matthews,Dilworth and University City Chiropractic** as described above.

Thank you for your understanding and cooperation.

_____ _____

Printed Name Signature

_____

Date

By signing below you understand and agree that we will be collecting credit card information during your first appointment to store on file for processing related to your appointment and any fees associated as well as any missed appointments or cancellations done with less than 24 hours notice.

_____ _____

Signature Date