

Patient Intake Form

For Office Use Only
Date: _____
Acct #: _____

Name: _____ Social Security # _____
 Address: _____ City _____ State _____ Zip _____
 E-Mail address: _____ Age _____ Birth Date _____ Race _____
 Marital: M S W D Cell Phone: _____ Home Phone: _____
 Employer's Address _____ Occupation _____ Office Phone _____
 Name of Emergency Contact _____ Address _____ Phone _____
 Family Medical Doctor _____

1-Are your present problems due to an injury? Yes No Enter the date of the injury: _____
 Was the injury? Job Related Auto Accident Personal Injury Other: _____
 Has the accident been reported? Yes No If so, to whom? To Employer Auto Carrier Other: _____
 Briefly describe the accident, injury or illness: _____

2-List any tests, studies or medications received for this condition:

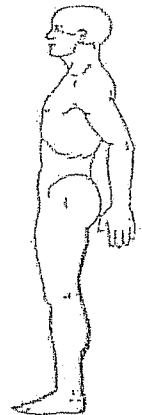
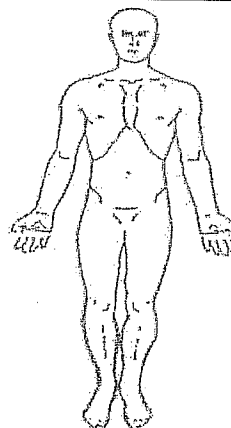
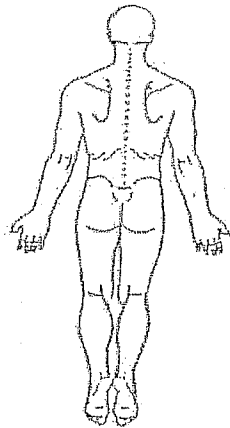
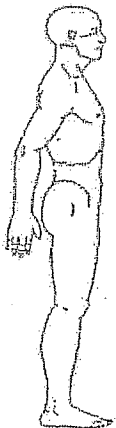
Tests/Studies: _____
 Medications: _____

3-Where you admitted to the hospital due to this condition: Yes No N/A - Proceed to #4

If yes, what hospital? _____ Transported by? Ambulance Police Other: _____
 Date Admitted: _____ Date Released: _____ Length of Stay: _____
 List the hospital procedures received: _____

4-List symptoms you are experiencing today: _____ Choose the severity level associated with each symptom

- _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe
- _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe
- _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe
- _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe
- _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe



When, or approximately when did the complaint start? _____
 Is your condition Constant Intermittent (occurs on and off)?
 What makes your pain decrease? _____
 What makes your pain increase? _____
 Has there been any changes in your bodily functions? Urination Defecation Vision Respiration Digestion
 Other: _____
 Does your condition affect your daily activities? Yes No If yes please explain: _____

What type of work do you do? _____
 Do you have any current work restrictions due to this condition?
 Off work: Yes No Previously From: _____ To: _____
 Light duty: Yes No Previously (If yes, what are/were your restrictions?) _____

Do you suffer from any condition other than that for which you are now consulting us? Yes No _____

List any past conditions you may have had: _____

HABITS		EXERCISE		FAMILY HISTORY			
<input type="checkbox"/> Smoking	Packs/day: _____	<input type="checkbox"/> None		Diabetes	Cancer	Back Pain	Other
<input type="checkbox"/> Drinking	Alcohol: (Cups/day): _____	<input type="checkbox"/> Moderate	Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Coffee	Cups/Day: _____	<input type="checkbox"/> Daily	Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Soft Drink	Bottles or Cans/Day: _____	Type: _____	Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Water	Cups/Day: _____	_____	Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc? Yes No
 If yes, which ones?: _____

Have you taken any medications in the past? Yes No If yes, which ones?: _____

Do you have allergies? Yes No If yes, please explain: _____

Have you ever had any surgeries? Yes No (If yes, please enter the approximate date of surgery.)

DATE	DATE	DATE
_____ Back Operation	_____ Hernia	_____ Gall Bladder
_____ Female Organs	_____ Thyroid	_____ Stomach

Other _____

Do you have a Pacemaker? Yes No

Any Unexplained weight loss (more than 10 lbs)? Yes No

Have you ever had X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS

- Allergy (What) _____
 - Bronchitis
 - Chills (Constant)
 - Convulsions
 - Dizziness
 - Fainting
 - Fatigue
 - Headache
 - Loss of Sleep
 - Loss of Weight
 - Nervousness
 - Night Sweats
 - Numbness or Pain
in arms/legs/hands
 - Wheezing
- #### MUSCLES & JOINTS
- Backache
 - Foot Trouble
 - Hernia
 - Pain Between Shoulders
 - Twitching
 - Painful Tail Bone
 - Stiff Neck
 - Spinal Curvature
 - Swollen Joints
 - Tremors

GASTRO-INTESTINAL

- Belching or Gas
 - Colon Trouble
 - Constipation
 - Diarrhea
 - Gall Bladder Trouble
 - Hemorrhoids (piles)
 - Jaundice
 - Liver Trouble
 - Nausea
 - Stomach Pain
 - Vomiting
 - Vomiting Blood
 - Heart Burn
 - Bloody Stools
 - Acid Reflux
 - Irritable Bowel
- #### CARDIO-VASCULAR
- High Blood Pressure
 - Low Blood Pressure
 - Chest Pain
 - Heart Trouble
 - Poor Circulation
 - Rapid Heart
 - Slow Heart
 - Strokes
 - Swelling Ankles
 - Varicose Veins

EYE/EAR

NOSE/THROAT

- Asthma
 - Deafness
 - Earache
 - Ear Discharge
 - Ear Noises
 - Thyroid Problems
 - Frequent Colds
 - Hay Fever
 - Nasal Obstruction
 - Nose Bleeds
 - Pain in Eyes
 - Poor Vision
 - Blurred Vision
 - Sinusitis
 - Sore Throats
 - Tonsillitis
- #### SKIN OR ALLERGIES
- Bruising Easily
 - Dryness
 - Eczema
 - Hives or Allergy
 - Itching
 - Sensitive Skin
 - Skin Eruptions

RESPIRATORY

- Chest Pain
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Bed Wetting
- Blood in Urine
- Frequent Urination
- Inability to Control
Urine
- Kidney Infection
- Kidney Stones
- Painful Urination
- Prostate Trouble

FOR FEMALES ONLY

- Cramps
- Hot Flashes
- Irregular Cycle
- Painful Periods
- Vaginal Discharge
- Pregnant Now?
- _____ Last Pap Date
- _____ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- | | | | | | |
|---------------------------------------|--------------------------------------|--|------------------------------------|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> HIV Positive |
-
-

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ Date: _____

Informed Consent To Treatment

Patient Name: _____ Date: _____

Hoang Chiropractic Center is a licensed professional chiropractic clinic. The primary treatment used by the Doctor of Chiropractic is the spinal adjustment. We will use that procedure to treat you.

- **The nature of the Chiropractic Adjustment**

The Doctor of Chiropractic will use her/ his hands or a mechanical device upon body in such a way as to move your joints. This may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- **Associated Risks and the Probability of those risks occurring**

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Other complications may include: dislocations; muscle strains; Horner's syndrome; costovertebral strains and separations; carotid artery dissection and vertebral artery dissection both with which can cause stroke. These complications are generally described as "rare".

- **Why Chiropractic is important and what you can expect**

Most injuries treated by the Doctor of Chiropractic involve the Musculoskeletal System, however, most therapies involve the care of the muscular portion of this system only. It is essential for all components of a system to function properly as a whole to obtain maximum healing and health potential. An adjustment will "align your spine." If you have never been adjusted before or, if you have not been adjusted in many years, you may experience some stiffness and soreness following the first few treatments.

- **Ancillary Treatment**

In addition to Chiropractic Adjustment we intend to use the following treatments:

- *Electrical stimulation carries the following significant risks: skin reactions (itchy, red); Interference with blood pressure if treated in the cervical spine; Spread of unknown infection.
- *Ultrasound therapy carries the following significant risks: physical pain due to a burning feeling possibly resulting in difficulty breathing, dizziness, nausea and disorientation.
- *Intersegmental Distraction, Flexion Distraction and Flexion Extension all carry the following significant risks: Aggravation of current condition.

I have read and understand the above. All of the questions concerning this care and treatment have been answered to my satisfaction.

Signature _____

Date: _____

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of _____ This authorization will expire six years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient name printed

Date

Patient Signature

Authorized provider representative

Personal representative Printed

Personal representative signature

Description of personal representative's authority to act for the patient.

- F) You will allow patients to amend their health information and incorporate any amendments to the patient's health information file in accordance with our policies and procedures and §164.526;
- G) You will make available patient's health information as required to provide an accounting of disclosures in accordance with § 164.528;
- H) You will make your internal practices, books, and records relating to the use and disclosure of protected health information received from, or created or received by you on our behalf available to the Secretary of Health and Human Services for purposes of determining our compliance with this portion of the law; and
- I) At termination of the contract you must return all of the patient's protected health information that you created or received from any source. You may not retain any copies of that information. If the return of any patient health information is not feasible, you must inform us and you agree to extend the protections of this contract to this information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- J) You will obtain reasonable assurances from the person or organization to whom a patient's health information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed; and the person agrees to notify you of any instances of which they become aware that the confidentiality of the patient's health information has been breached.

Termination of this contract

You agree that we may terminate our contract with you if we determine that you have violated a material term of this contract addendum.

I agree to the terms of this privacy addendum. I am also acknowledging that I have received a copy of this notice.

Printed Name

Printed Name Employer

Signature

Signature Employer

Date

Date