PATIENT INTAKE INFORMATION

DATE:_____

_____

(Legal) First Name (Legal) Middle Initial (Legal) Last Name DOB Age

Street_____Apt._____

City_____State_____Zip_____

Social Security#_____Marital Status [ ] S [ ] M [ ] W [ ] D Spouse_____

Language:____English _____Spanish ____Indian ____ Japanese ____ Chinese ____ Korean ____French ____German

_____Russian Other_____

Race/Ethnicity: ____White___American Indian or Alaska Native____Asian___Native Hawaiian/OtherPacific Islander

____Black or African American _____Hispanic or Latino_____Decline to Answer

Contact Info: Home Phone:_____Work Phone:_____Cell Phone:_____

Cell Carrier:_____EMail Home_____

Email Work:_____

Contact preference:_____Home _____Work Phone_____Cell Phone____Email Home____Email Work____Postal Mail

Emergency Contact:_____Phone:_____

Who referred you to our office?_____Phone:_____

Occupation:_____ Employer:_____

Employer Address:_____

Street City State Zip

Verification Question:

__In what city were you born?
__What high school did your attend?
__What is your favorite color?
__What is your favorite movie
__What is the name of your favorite pet?
__What street did you grow up on?
__What was the make of your first car?
__When is your anniversary?

Verification Answer:_____

Name of Primary care Physician:_____

Have you ever consulted a chiropractor before: _____Yes ____No

If so, who:_____

Last visit:_____

Referred by:_____

Date: _____

First Name MI Last Name

Patient History

Please give a brief description of the problem[s] you are experiencing:

_____

_____

_____

Is/Are the problem[s] getting better? [ ] Y [ ] N or getting worse? [ ] Y [ ] N When did the problem[s] start?_____

_____

What appears to be the initial cause? _____

_____

Are you seeing any other providers for other problems or health conditions? [ ] Y [ ] N

Please list the problem[s], date problem[s] began and Provider[s] treating you for the condition[s]:

_____

_____

_____

Past History

Have you --- If yes, please list the date and the name of the treating provider.

ever been diagnosed with hypertension? [ ] Y [ ] N _____

been hospitalized in the last 5 years? [ ] Y [ ] N _____

been diagnosed with Diabetes? [ ] Y [ ] N _____

Type I ___ Type II___

Do you smoke? ___Never ___Former Smoker ___Current/Every Day Smoker ___Current Some Day[s] Smoker

Vitals (for office use only) Height _____ Weight _____ Blood Pressure _____

Medications

What medications are you currently taking? Please includle all non-prescription and over the counter vitamins, herbs, minerals, etc.:
List Date Started, Brand Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by:
Please be as specific as possible.

_____

_____

_____

_____

_____

Do you have allergies? [ ]Food [ ]Environmental [ ]Medication

List Type of Allergy and Reaction[s]

_____

_____

_____

_____

Thank you for your cooperation!

Describe your problem:_____

_____.

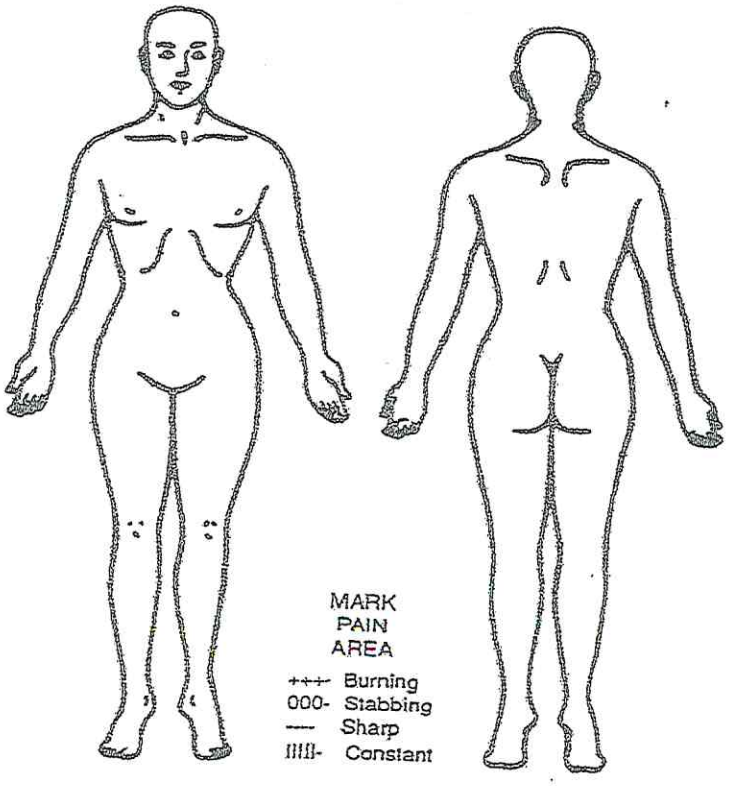
When did your problem begin?_____

_____

	Cervical Neck	Thoracic Mid Back	Lumbar Low Back
Pain Level 1-Mild to 10- Severe:	_____	_____	_____
Please circle what applies:			
Nature of symptoms:	Achy	Achy	Achy
	Burning	Burning	Burning
	Dull	Dull	Dull
	Sharp	Sharp	Sharp
	Stiff	Stiff	Stiff
	Throbbing	Throbbing	Throbbing
	Stabbing	Stabbing	Stabbing
	Dizziness	Dizziness	Dizziness
Worse:	Nothing	Nothing	Nothing
	Resting	Resting	Resting
	Sleeping	Sleeping	Sleeping
	Walking	Walking	Walking
	Working	Working	Working
	Movement	Movement	Movement
	Standing	Standing	Standing
	Lifting	Lifting	Lifting
	Looking Down	Looking Down	Looking Down
	Driving	Driving	Driving
	Sitting	Sitting	Sitting
	Bending	Bending	Bending
	Coughing	Coughing	Coughing
	Looking Up	Looking Up	Looking Up
	Lying Supine	Lying Supine	Lying Supine
	House Chores	House Chores	House Chores
	Sneezing	Sneezing	Sneezing
	Twisting	Twisting	Twisting
	Lying Prone	Lying Prone	Lying Prone
	Stretching	Stretching	Stretching
	Stress	Stress	Stress

Cervical Neck Pain	Thoracic Mid Back Pain	Lumbar Low Back Pain
Better:		
Nothing	Nothing	Nothing
Cold	Cold	Cold
Chiropractic Care	Chiropractic Care	Chiropractic Care
Massage	Massage	Massage
Medication	Medication	Medication
Movement	Movement	Movement
Resting	Resting	Resting
Sleeping	Sleeping	Sleeping
Walking	Walking	Walking
Warmth/Heat	Warmth/Heat	Warmth/Heat
No Movement	No Movement	No Movement
Leaning against support	Leaning Against support	Leaning Against support
Sitting	Sitting	Sitting
Standing	Standing	Standing
Lying	Lying	Lying
Lying with Knees bent Up	Lying with Knees bent up	Lying with Knees bent up
Analgesic Gel	Analgesic Gel	Analgesic Gel
Physical Therapy	Physical Therapy	Physical Therapy
Stretching	Stretching	Stretching
Twisting	Twisting	Twisting

Location Of Symptoms:



Employment Information

* Denotes required information

*Occupation: _____
Employer Name: _____
Employer Address: _____
Employer City: _____
Employer State: _____
Employer Zip: _____
Work Phone: _____
May we call your cell phone at work: __ Yes __ No
May we call your work phone: __ Yes __ No

Other Health Care Providers

* Denotes required information

*Provider Name: _____
Provider Type: _____
Provider City: _____
Provider State: _____
Provider Phone: _____
*I have seen this provider for my primary problems: __ Yes __ No

*Provider Name: _____
Provider Type: _____
Provider City: _____
Provider State: _____
Provider Phone: _____
*I have seen this provider for my primary problems: __ Yes __ No

*Provider Name: _____
Provider Type: _____
Provider City: _____
Provider State: _____
Provider Phone: _____
*I have seen this provider for my primary problems: __ Yes __ No

Allergies

* Denotes required information

*Name: _____
Medication related: __ Yes __ No
Symptom: _____
*Start Date: _____
Comments: _____

*Name: _____
Medication related: __ Yes __ No
Symptom: _____
*Start Date: _____
Comments: _____

Personal Medical History

Illnesses

Illness: _____ Illness: _____
Start date: _____ Start date: _____
End date: _____ End date: _____

Surgeries

Surgery: _____ Surgery: _____
Date: _____ Date: _____

Hospitalizations

Reason: _____ Reason: _____
Date: _____ Date: _____
Duration: _____ Duration: _____

Injuries

Injury: _____ Injury: _____
Date: _____ Date: _____

Family Medical History

Illnesses

Illness: _____ Illness: _____
Relation: _____ Relation: _____
Age of onset: _____ Age of onset: _____

Illness: _____ Illness: _____
Relation: _____ Relation: _____
Age of onset: _____ Age of onset: _____

Smoking History

* Denotes required information

*Do you currently smoke: __ Yes __ No

Years smoked: _____

Packs a day: _____

Interest in quitting on a scale of 0-10: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest

How long since you stopped: _____

Social History

* Denotes required information

Consumption

How much alcohol do you drink daily: _____

How many cups of coffee do you drink daily: _____

How much soda pop do you drink daily: _____

How much water do you drink daily: _____

How much do you depend on pain relievers: _____

Do you use recreational drugs: __ Yes __ No

Stress Information

*How much physical stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot

*How much emotional stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot

What are the major stressors in your life: _____

Sleeping Information

How many hours do you sleep per night: _____

What is your preferred sleeping position: _____

What type of mattress & pillow do you have: _____

How old are your mattress & pillow: _____

Healthy Eating & Exercise Information

How much regular exercise do you perform: _____

*Rate your healthy eating habits: Not healthy - 0 1 2 3 4 5 6 7 8 9 10 - Healthy

Typical eating habits: __ Skip Breakfast __ 2 meals per day __ 3 meals per day

__ Snacking between meals

What would be the most significant thing that would improve your health:

_____

_____

What additional health goals do you have:

_____

_____

ACKNOWLEDGEMENTS

Chiropractic Care	I instruct the chiropractor to deliver the care that in his/her professional judgement can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.
Privacy Policy	I may request a copy of the privacy policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties, grant permission to be called or texted to confirm or reschedule and appointment and to be sent occasioinal cards, letters, emails, or health information to me as an extension of my care in this office.
Permission to contact	I grant permission to be called or texted to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Payment Verification	I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
X-ray Verification	If female, I realize that an x-ray examination may be hazardous to an unborn child and I certify to the best of my ability that I am not pregnant or that I understand the risks.
General Verification	To the best of my ability the information that I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

Signature_____Date_____

Massage Therapy Information

1. Have you had a professional massage before?	Yes	No
2. Have you ever had surgery?	Yes	No
3. Do you wear contact lenses?	Yes	No
4. Do you wear dentures?	Yes	No
5. Do you have skin problems or skin sensitivities?	Yes	No
6. Do you have allergies?	Yes	No
7. Do you take prescribed medication?	Yes	No
8. Do you take any other medication?	Yes	No
9. Have you suffered an acute injury recently?	Yes	No
10. Have you been diagnosed with varicose veins or blood clots?	Yes	No
11. Have you been diagnosed with arthritis?	Yes	No
12. Have you been diagnosed with any heart problems?	Yes	No
13. Have you been diagnosed with blood pressure problems?	Yes	No
14. Have you been diagnosed with any spinal problems?	Yes	No
15. Do you exercise regularly of participate in any sports?	Yes	No
16. For women, are you pregnant?	Yes	No
17. Are you taking any herbal supplements?	Yes	No
18. Do you have any other medical conditions of which I should be aware of before giving you massage therapy?	Yes	No

If yes please explain:_____
_____.

I understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation and energy flow.

I understand that the massage therapist does not diagnose illness, disease or any medical treatment or pharmaceuticals,nor perform any spinal manipulations. It has been made very clear to me that massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

I HAVE READ AND UNDERSTAND THE FOREGOING PARAGRAPH.

NAME:_____ Date_____

REASOR CHIROPRACTIC CENTER
1670 WEST MAIN STREET
PAOLI, IN 47454
LOLITA REASOR-BURTON, D.C.
812-723-2277

ACKNOWLEDGEMENT OF REASOR CHIROPRACTIC CENTER'S NOTICE OF HIPPA PRIVACY-I have received or read a copy of the Notice of HIPPA Privacy for Reasor Chiropractic Center and AGREE to its provisions. ***I also, give permission for Reasor Chiropractic Center to text me for appointments.***

Patient Name:_____Date of Birth_____

Signature of
Patient/Parent/Guardian_____Date_____

DESIGNATION OF OF CERTAIN RELATIVES, CLOSE FRIENDS, AND OTHER CAREGIVERS:

I agree that the practice may disclose my health information to a family member, close personal friend, or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, Reasor Chiropractic Center will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner.

_____Home or cell telephone/Answering machine

_____Work Telephone/Voice Mail

_____OK to leave message with detailed information

_____OK to leave message with Doctors name

_____Leave message with call back numbers only

_____Text message

_____Home Address

_____Work Address

_____OK to mail to home address

_____OK to mail to work address

_____Other_____

PLEASE NOTE THAT IF THE ABOVE SECTIONS ARE NOT COMPLETED, WE WILL ASSUME THAT WE HAVE YOUR APPROVAL TO CONTACT YOU USING ANY OF THESE METHODS.

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name:_____Relationship to Patient_____

Print Name:_____Relationship to Patient_____

Print Name:_____Relationship to Patient_____

THE FOLLOWING PERSON(S) ARE NOT ALLOWED TO RECEIVE MY PATIENT HEALTH INFORMATION:

Print Name:_____Print Name:_____

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the patient/parent/guardian. Uses and disclosures for treatment, payment and health care operations may be permitted without prior consent.

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OFFICE AND FINANCIAL POLICIES

Please read carefully. Listed below is the Office and Financial Policies of Reasor Chiropractic Center. This office will try to assist the patient whenever possible.

Reasor Chiropractic Center's Office and Finanacial Policies regarding payments is as follow:

1. Payment is due at the time of service. We will accept Cash, Credit Card (Visa, Master Card, and Discover), CareCredit, and Personal Finance.
2. Insurance billing is done as a courtesy to our patients. Waiting for insurance payment is a courtesy and may be withdrawn at any time. Your Insurance is a contract between you, your employer, and your insurance company. Reasor Chiropractic Center is not a party to that contract.
3. This office does not promise that an insurance company will pay. Nor does this office promise that an insurance company should pay the fees charged. **Any services not covered by insurance will be the responsibility of the patient.**
4. The patient must stay current with their percentage of responsibility (e.g. Insurance pays their percentage while patient pays copay, percentage, and/or deductible, plus any charges not covered by insurance). **Co-payments are expected to be paid at the time of service as well as deductibles.** Our office will contact your insurance company to verify your benefits. We encourage you to also call. Although those benefits cannot be guaranteed, amounts not covered by insurance will be the responsibility of the patient.
5. Reasor Chiropractic Center will not enter into a dispute with the insurance company over reimubrsement or the amount of reimbursement. That is the obligation of the patient.
6. When we receive an insurance check, your account will be credited. If there is any balance due at the time, the patient must pay the difference. If the insurance company pays more than the amount of your balance, we will issue a refund check to you-only after your balance is completely cleared in this office.
7. Any patient who has had active care in the past year and receives an insurance check must bring it to Reasor Chiropractic Center's office to check and see if it is money due on your account.

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8. **MEDICARE PATIENTS:** All Medicare patients are requested to pay for services at the time they are rendered. We will file your claim with Medicare and Medicare will pay you directly whatever they determine. If you receive a claim denial or have any questions on how Medicare handled your claim, please give them a call on their toll-free number, 1-800-622-4722.
9. If you receive correspondence or checks from your insurance company, or if you have any questions about your insurance, please contact our insurance department.
10. **FOR WORKER'S COMPENSATION:** We will file with your Employer's Insurance Company. Anything the Employer's Insurance Company will not pay, you will be responsible for.
11. All personal injury patients' accounts will be billed on their Health Insurance or their own Medical Pay Auto Insurance.
12. **MEDICAID IS AN EXCEPTION TO THE ABOVE.**

If you change Insurance Companies, please provide us with the current information immediately, as your coverage may have changed.

I understand and agree that health and accident insurance policies are an arrangement between insurance carriers and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also, understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I will also be responsible for any charges acquired in collection fees (small claims, attorney fees, search-locator fees). Interest accrues on unpaid accounts at a rate of 1.5% per month (18% APR) beginning 30 days after services.

By signing below you are agreeing to the Office and Financial Policies above for Reasor Chiropractic Center. If you should hae any questions please feel free to call us or stop by our office.

Patient Signature_____
(If patient is a minor, please have a parent or legal guardian sign below)
Parent or Legal Guardian Signature:_____
Date:_____