Patient Intake Form (PIF)

PATIENT INFORMATION

Date:___________________________________

First Name: _____________________________

_____________ ______________ _____________

Last Name Middle Name Nickname

Mailing Address:__________________________

City:____________ State:___ Zip:__________

SS#:______-______-________ Sex □ Male □Female

Date of Birth:_____/_____/______ Age: _______

□Married □Single □Widowed

□Separated □Divorced □Minor

Number of children:_______________________

Race: □American Indian or Alaska Native

□Black or African American □Other

□White □Native Hawaiian or Pacific Islander

□Asian □I decline to answer

Ethnicity:□Hispanic or Latino

□Not Hispanic or Latino □I decline to answer

Note: CMS requires providers to report both race and ethnicity

Preferred Language: _____________________

Employer:_________________________________

Employer Address:_________________________

Occupation:______________________________

If minor, Parent's Name:__________________

If minor, Parent's SS #:____________________

Whom may we thank for referring you to us?

____

IN CASE OF EMERGENCY, PLEASE CONTACT

Name: ___________ Relationship:_____________

Home Phone: (_________) ________-__________

Mobile Phone: (_________) ________-__________

INSURANCE INFORMATION

Policy Holder's Name:______________________

Relationship to Patient: ____________________

Insurance Company:_______________________

Person responsible for account if other than self?

Name: ______________ Phone:_______________

Address:___________________________________

PHONE NUMBERS/EMAIL

Home: (________) ___________-_____________

Work: (________) ___________-_____________

Mobile: (________) ___________-_____________

Email Address:_____________________________

Contact Preference(s): □Mobile □Home □Any
□Work □Email □All

CHIEF COMPLAINT(S)

Main reason that brought you in:

____

Symptoms are worse in the:

□Morning □Afternoon □Evening □Night

When and how did it occur?_________________

____

Symptoms developed from:

□Job-related injury □Auto Accident

□Unknown cause □Other accident □Gradual

Date occurred:_____________________________

Treatments that you have received for this condition:___________________________________

What activities **aggravate** your condition:

____

____

What activities **relieve** your condition:

____

____

Patient Intake Form (PIF)

Any other symptoms or problems that you suffer from: ______________________________

____

What would you like to achieve from care?

- □ **Relief Care**: Just eliminate or reduce your discomfort.
- □ **Corrective Care**: Correct any underlying injury or cause of discomfort and improve neuromuscular function.
- □ **Wellness Care**: Maintain improved neuromuscular function, prevent the return of the original condition and catch small problems before they become serious

Are you currently taking any supplements?
□Yes □No
What kind:______________________________

Are you pregnant or trying to get pregnant?
□Yes □No

Have you ever used tobacco?
□Never □Previously □Daily □Occasionally

Alcohol consumption
□Never □Previously □Daily □Occasionally

Height___’____” Weight _________lbs

MEDICAL HISTORY

Have you been treated by a physician for any health conditions in the last year? □Yes □No
Describe condition:

____

____

Primary Medical Doctor’s Name:

____

Phone:_________________________________

MEDICATIONS

Are you currently taking any medications?
□Yes □No

MEDICATION NAME	DOSE & FREQUENCY
____________________	_______________
____________________	_______________
____________________	_______________
____________________	_______________
____________________	_______________
____________________	_______________

Do you have any medication allergies?
□Yes □No

MEDICATION NAME	REACTION/ONSET DATE
_________________	___________________
_________________	___________________
_________________	___________________
_________________	___________________

SURGICAL HISTORY

1._________________ Date:______________

2._________________ Date:______________

3._________________ Date:______________

4:_________________Date:_______________

Patient Intake Form (PIF)

MEDICAL & FAMILY HISTORY

S=SELF M=MOTHER F=FATHER

Please indicate which **conditions** you have been experiencing (using key above) by marking appropriate boxes.

S	M	F	Condition	S	M	F	Condition	S	M	F	Condition
☐	☐	☐	AIDS	☐	☐	☐	Epilepsy	☐	☐	☐	Stroke
☐	☐	☐	Anemia	☐	☐	☐	Fatigue	☐	☐	☐	Thyroid Problem
☐	☐	☐	Ankle Swelling	☐	☐	☐	Headaches	☐	☐	☐	Weakness
☐	☐	☐	Arthritis	☐	☐	☐	Heart Trouble	☐	☐	☐	Weight Gain/Loss
☐	☐	☐	Asthma	☐	☐	☐	High Blood Pressure	☐	☐	☐	Problems Swallowing
☐	☐	☐	Back Pain	☐	☐	☐	HIV	☐	☐	☐	Problems Speaking
☐	☐	☐	Bladder Trouble	☐	☐	☐	Indigestion	☐	☐	☐	Double/Blurred Vision
☐	☐	☐	Bone Fracture	☐	☐	☐	Kidney Disorders	☐	☐	☐	Nausea
☐	☐	☐	Bowel Control Loss	☐	☐	☐	Loss of Smell	☐	☐	☐	Reproductive Trouble
☐	☐	☐	Cancer	☐	☐	☐	Loss of Taste	☐	☐	☐	Serious Injury
☐	☐	☐	Concentration Loss	☐	☐	☐	Menstrual Cramps	☐	☐	☐	Sinus Trouble
☐	☐	☐	Concussion	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	Dizziness/Loss of Balance
☐	☐	☐	Constipation	☐	☐	☐	Neck Pain	☐	☐	☐	Double Vision/Blurred
☐	☐	☐	Convulsions	☐	☐	☐	Nervousness	☐	☐	☐	Earache
☐	☐	☐	Depression	☐	☐	☐	Numbness/Pins & Needles	☐	☐	☐	Other__________________
☐	☐	☐	Diabetes	☐	☐	☐	Poor Circulation				

Please indicate which **symptoms** you have been experiencing by marking appropriate boxes.

- ☐ Chronic Indigestion
- ☐ Heart burn
- ☐ Bloating
- ☐ Muscle cramps
- ☐ Eye sensitive to light
- ☐ Trouble falling to sleep
- ☐ Dizziness / Fainting
- ☐ Tired after eating
- ☐ Night Sweats
- ☐ Trouble staying asleep
- ☐ Feel tired all the time
- ☐ Hormonal Imbalances
- ☐ Easy Bruising
- ☐ Bleeding Gums
- ☐ Irritability
- ☐ Skin Rashes

HIPAA NOTICE

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of our policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: (parent, if minor) ____ Date: _____________

Activities of Daily Living

Rate your current difficulties of performing daily living activities by placing the appropriate number in the box.

If an activity does not cause your pain or if pain does not affect an activity, leave the box blank.

[1] This activity cause some pain, but it is only a minor annoyance.
[2] This activity causes a significant amount of pain, but I can do it.
[3] I cannot perform this activity due to pain and disability.

Self Care and Personal Hygiene

[ ] bathing/showering [ ] brushing teeth [ ] putting on shoes [ ] eating [ ] doing laundry

[ ] grooming hair [ ] making the bed [ ] putting on pants [ ] washing dishes [ ] going to the toilet

[ ] washing face [ ] putting on shirt [ ] cooking [ ] taking out trash

Physical Activities

[ ] standing [ ] walking [ ] reaching [ ] bending right [ ] twisting right

[ ] sitting [ ] squatting [ ] bending forward [ ] bending left [ ] twisting left

[ ] reclining [ ] kneeling [ ] bending back [ ] looking left [ ] looking right

Functional Activities

[ ] carrying small objects [ ] lifting object off floor [ ] pushing/pulling while seated

[ ] carrying large objects [ ] lifting weights off table [ ] pushing/pulling while standing

[ ] carrying briefcase/purse [ ] climbing stairs/incline [ ] exercising upper body [ ] exercising lower body

Social/Recreational Activities

[ ] bowling [ ] jogging [ ] swimming [ ] gardening

[ ] biking [ ] hunting/fishing [ ] competitive sports

[ ] walking [ ] horseback riding [ ] golfing [ ]other:___________

Difficulties with Traveling

[ ] driving in car

[ ] riding as passenger

[ ] driving for long periods

[ ] riding as passenger for long periods

Other Activities

[ ] concentrating [ ] reading [ ] studying

[ ] writing [ ] sleeping [ ] sexual relations

[ ] listening [ ] using computer

Patient Name: ____ **DOB**:____________________

Doctor Signature: ____ Date:____________________

Patient Intake Form (PIF)

Informed Consent:

I hereby authorize physicians and staff at Naples Abundant Health Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Naples Abundant Health Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness-Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and an acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustments x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns- Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke- Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems-There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask the doctor or staff.

Having carefully read this above, I hereby give my informed consent to have chiropractic treatment administered.

Patient's Signature: (parent, if minor)____ Date:___________________

☐ I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Intake Form (PIF)

Assignment of Benefits

Form Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignments of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Jennifer Moses medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. Jennifer Moses to: (1) release any information necessary to insurance carries regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Jennifer Moses on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Naples Family Chiropractic Clinic Inc DBA Naples Abundant Health Chiropractic

Patient Signature (parent, if a minor) _______________________________________ Date: ____________________