

Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

We remind our patients after the initial visit of their upcoming appointments via text. Please let us know if this will be an issue for you, and please provide a cell phone number for us to utilize this!

Name: _____ Date: _____

Address: _____ Male Female

City/State/Zip: _____ Marital Status

Date of Birth: _____

M	S	D	W
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Phone: _____ Home: _____

E-Mail: _____

Occupation: _____ Employer: _____

Insurance Company: _____

How did you hear about us? _____

Check and indicate the age when you had any of the following:

General

- Allergies
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Headaches
- Loss of sleep
- Mental illness
- Nervousness
- Tremors
- Weight loss / gain

Muscle / Joint

- Arthritis / rheumatism
- Bursitis
- Foot trouble
- Muscle weakness
- Low back pain
- Neck pain
- Mid back pain
- Joint pain

Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergies
- Itching
- Rash
- Varicose veins

Eye, Ear, Nose & Throat

- Colds
- Deafness
- Ear ache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Ringing of the ears
- Sinus infection
- Sore throat
- Tonsillitis
- Vision problems

Gastrointestinal

- Abdominal pain
- Bloody or tarry stool
- Colitis / Crohn's
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Diverticulosis
- Bloating abdomen
- Excessive hunger
- Gallbladder trouble
- Hernia
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Painful defecation
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

Genitourinary

- Bed-wetting
- Bladder infection
- Blood in urine
- Kidney infection
- Kidney stones
- Prostate trouble
- Pus in urine
- Stress incontinence

Urination

- Overnight more than twice
- More than 8x in 24hrs
- Decreased flow/force
- Painful urination
- Urgency to urinate

Cardiovascular

- High blood pressure
- Low blood pressure
- Hardening of the arteries
- Irregular pulse
- Pain over heart
- Palpitation
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever
- Shortness of breath
- Spitting up phlegm / blood
- Wheezing

Women only

- Congested breasts
- Hot flashes
- Lumps in breast
- Menopause
- Vaginal discharge

Menstrual flow

- Reg. Irreg. Pain / cramps
- Days of flow: _____ Length of cycle: _____
- Date - 1st day last period: _____
- Are you pregnant? yes, no
- If yes, how many months? _____
- How many children do you have? _____
- Birth control method: _____
- Date of last PAP test: _____
- normal, abnormal
- Date of last mammogram: _____
- normal, abnormal

Check any of the conditions you have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chicken pox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart burn
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV/AIDS
- Influenza
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness/tingling
- Pace maker
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

Primary Care Physician: _____

Medications currently taking _____

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

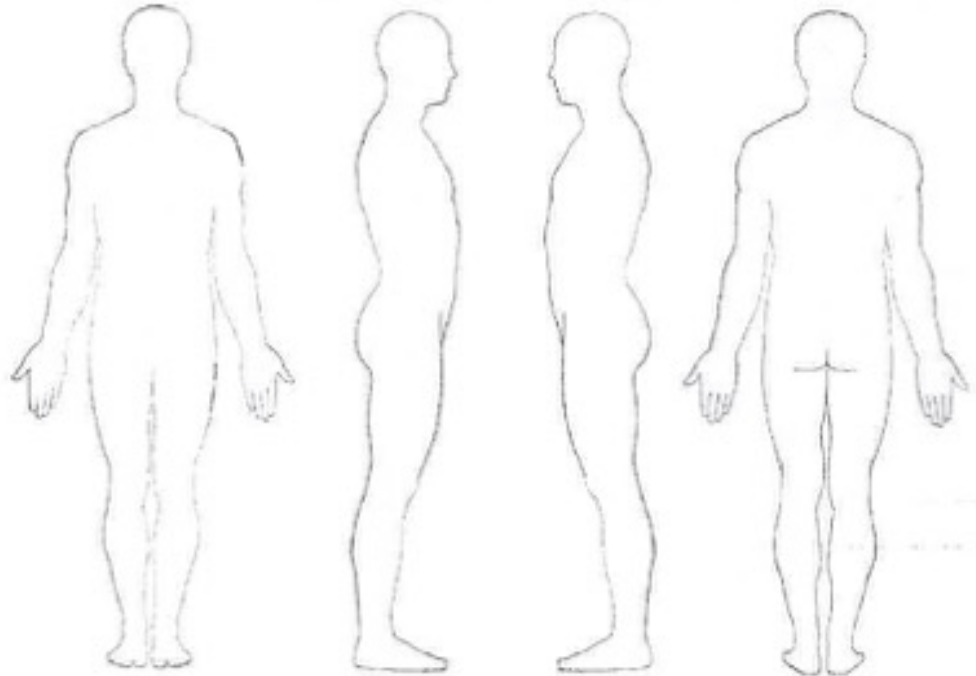
How long have you had this condition? _____ Is it getting worse? yes, no _____

Does it bother you (check appropriate box): work, sleep, other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... ever used orthotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How is most of your day spent?	<input type="checkbox"/> standing, <input type="checkbox"/> sitting, <input type="checkbox"/> other: _____		
How old is your mattress?	_____		
When was your last physical exam?	_____		

Habits	none	light	mod.	heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease |

Do you have any other health issues or concerns that our staff should be made aware of? _____

PROCEED TO FOLLOWING PAGE →

Notice of privacy practices

Effective date: 11/10/2015

Midland Chiropractic Sports Rehab

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information, beyond this form, upon your request.

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current notice in our offices in a visible location at all times, and you may request a copy of our most current notice at any time.

To acknowledge your receipt of this notice, please sign, print, and date below:

Print Name

Signature

____/____/____
Date

With rapid changes in the insurance industry, we do our best to keep up and to maintain fees that are as low as possible, while providing the best potential care options for our patients. There are services that are provided by our staff and practitioners that are not/may not be covered by your insurance provider. Consider the following your notification of our billing policy between patient & MCSR.

MCSR will bill your insurance (if applicable); there are services offered by our providers that will best contribute to your care that are not covered by all insurance plans. Any fees charged to your account here at MCSR are the sole responsibility of the patient to pay. If you are a non-insurance patient, you are responsible for any and all services rendered here at MCSR. Any changes to your treatment plan will be discussed between your provider and you, the patient.

Patient Signature acknowledging our policy

____/____/____
Date

Midland Chiropractic Sports Rehab - Primary Care Provider (PCP) Release Statement

At Midland Chiropractic Sports Rehab, our staff and Dr. Berard would appreciate the option to communicate openly with your Primary Care Provider (PCP) when we feel it warranted to do so, based on your treatment here with us. We feel that working in unison with Primary Care Providers benefits the patient(s) by keeping lines of contact open between practitioners.

By signing this form, you are giving us the option to release medical records obtained by our office to your Primary Care Physician only when they have requested such information. This is solely based on medical necessity. It will only be done under circumstances in which it is felt by our doctors, at Midland Chiropractic Sports Rehab, that it will benefit the patient’s well-being and/or progress. This release will be considered valid for seven (7 years) after signing.

Signature of Patient

Print Patient Name

Date

Primary Care Physician Name

Massage Cancellation Policy

If for any reason a massage is cancelled within a 24 hour window of its appointment or in the incident that you, the patient, do not show up for your scheduled appointment, you will be given one (1) free excused “miss”, without any fees charged. However, after your one (1) excused “miss”, you will receive a bill for 50 cents per minute scheduled (30 min = \$15.00 for example). Signing below acknowledges that you’ve read and seen this policy.

Signature of Patient

Print Patient Name

Personal Training Cancellation Policy

If for any reason a training session is cancelled within a 24 hour window of its appointment or in the incident that you, the patient, do not show up for your scheduled appointment, you will be given one (1) free excused “miss”, without any fees charged. However, after your one (1) excused “miss”, you will receive a fee of \$15.00 for a 30 minute session and \$25 fee for a 60 minute session.

Signature of Patient

Print Patient Name