ashburn family chiropractic CENTER

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CHIROPRACTIC INTAKE & HISTORY

Today's date _____

PATIENT INFORMATION

Last name _____ **First name / MI** _____

Date of birth _____ **Age** _____ **Sex** ☐ M ☐ F

Address _____

City _____ **State** _____ **Zip** _____

Cell phone _____ **Home phone** _____

Email _____ **Best way to reach you** ☐ Text ☐ Call ☐ Email

Status ☐ Married ☐ Single ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Employer / School _____ **Occupation** _____

Spouse / partner _____ **Their employer / occupation** _____

Emergency contact _____ **Relationship** _____ **Phone** _____

Insurance carrier _____ **Member ID** _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

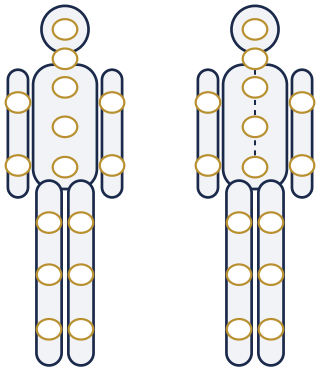
_____

Main symptom _____

When did it start? _____ ☐ Injury / accident ☐ Gradual ☐ Not sure

How intense are your symptoms? (circle one)

NONE (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) INTENSE



FRONT BACK

Where? (check, or click the circles on the figures where it hurts)

☐ Head ☐ Neck ☐ Upper back ☐ Mid back
☐ Low back ☐ Shoulder ☐ Arm / hand ☐ Hip
☐ Leg / knee ☐ Foot / ankle ☐ Left · Right ☐ Both sides

What does it feel like?

☐ Numbness ☐ Tingling ☐ Stiffness ☐ Dull ☐ Aching
☐ Cramping ☐ Nagging ☐ Sharp ☐ Shooting ☐ Burning
☐ Throbbing ☐ Stabbing ☐ Swelling ☐ Other _____

Ashburn Family Chiropractic Patient name _____

IMPACT OF YOUR SYMPTOMS

How is this interfering with your life?

	NONE	MILD	MODERATE	SEVERE		NONE	MILD	MODERATE	SEVERE
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude / mood	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Self-care	☐	☐	☐	☐

How committed are you to correcting this? NOT 0 1 2 3 4 5 6 7 8 9 10 VERY

WELLNESS ASSESSMENT

The Illness–Wellness Continuum

0 1 2 3 4 5 6 7 8 9 10

DISEASE
Multiple medications, poor quality of life, limited function

POOR HEALTH
Symptoms, drug therapy, surgery, losing normal function

COMFORT ZONE
No symptoms but "false wellness": sporadic nutrition and exercise

GOOD HEALTH
Regular exercise, good nutrition, minimal nerve interference

OPTIMAL HEALTH
Full function, continuous growth, a wellness lifestyle

My health today is a _____ **It's headed** ☐ Up ☐ Staying the same ☐ Down

Immediate goal _____ **Short-term goal** _____ **Long-term goal** _____

HEALTH & ILLNESS HISTORY

Check any you have or have had

- ☐ AIDS / HIV
- ☐ Alcohol / substance use
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma / allergies
- ☐ Back pain
- ☐ Blood thinners
- ☐ Cardiovascular issues
- ☐ Urinary issues
- ☐ Cancer
- ☐ Circulation issues
- ☐ Childhood illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive (GERD / IBS)
- ☐ Elbow / wrist / hand
- ☐ Thyroid / endocrine
- ☐ Foot / ankle
- ☐ Surgeries _____
- ☐ Gout
- ☐ Headaches / migraines
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Hip issues
- ☐ Immune issues
- ☐ Lymphatic issues
- ☐ Prior accident / injury
- ☐ Multiple sclerosis
- ☐ Neck pain
- ☐ Osteoporosis
- ☐ Reproductive issues
- ☐ Ringing in ears
- ☐ Scoliosis
- ☐ Shoulder issues
- ☐ Stroke
- ☐ TMJ
- ☐ Other _____

CHILDREN & PREGNANCY

Number of children / ages _____ **Currently pregnant?** ☐ No ☐ Yes, due _____

Children's health concerns _____ **Past pregnancies / concerns** _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES	MEDICATIONS	SUPPLEMENTS

OFFICE POLICIES & YOUR PRIVACY

YOUR CARE

Our care focuses on reducing subluxations, interference that keeps your nervous system and body from healing as they should. Your doctor may use adjustments and other techniques such as cervical traction, wobble disc and spinal exercises. Care usually moves through two phases: relief first, then structural correction.

FIRST VISIT & REPORT OF FINDINGS

Before care begins we complete your history, an exam and any imaging needed. Right after your first adjustment, you'll be scheduled for a Report of Findings, where your doctor reviews your x-ray and exam results and recommends a care plan. Attendance is required to become a patient.

BRING YOUR FAMILY

Please bring your spouse or significant other to the Report of Findings. Families who understand the goals of care become a real support in treatment decisions.

OPEN TREATMENT AREA

Most care happens in an open bay, so conversations may be overheard. For anything private, ask the front desk to schedule time in a consultation room.

PAYMENT & APPOINTMENTS

We are an out-of-network practice and do not bill insurance. Payment is due in full at each visit; we accept cash, credit/debit cards, HSA/FSA cards and CareCredit. On request we give you a superbill to submit to your insurer for out-of-network reimbursement; coverage depends on your plan and is not guaranteed. Please give 24 hours' notice to cancel or reschedule; missed appointments may be charged a $70 fee.

HOW WE USE YOUR INFORMATION (HIPAA)

We use your health information for treatment, payment and office operations, and may send appointment reminders by phone, text or email. We share it without your permission only where the law allows: workers' compensation claims, public health and safety, law enforcement and government agencies, military and national security purposes, coroners and medical examiners, an emergency (we may notify a family member), or a sale of the practice.

YOUR RIGHTS

- A copy of your records, x-ray images included, within 30 days of a written request (NY limit: $0.75/page for paper)
- Ask us to correct your records or limit how they are shared (we may decline, except as below)
- Keep a service from your insurer when you pay for it in full yourself
- Choose how and where we contact you
- A list of certain disclosures, our full Privacy Notice, and notice of any breach

QUESTIONS OR COMPLAINTS

Call our Privacy Officer at (845) 896-1200, or file with the U.S. Dept. of Health & Human Services, Office for Civil Rights, at hhs.gov/ocr/complaints. We will never retaliate for a complaint. We may update this notice at any time, and changes apply to all records we hold; the current full notice is always at the front desk.

INFORMED CONSENT

CHIROPRACTIC TREATMENT

Chiropractic care, like all health care, carries some risk. Most effects are mild and short-lived, such as soreness or stiffness. Rare risks include sprain or strain, disc irritation and minor fractures; stroke has very rarely been associated with neck adjustments. My doctor has explained the benefits, risks and alternatives of the care recommended. I may ask questions, decline any procedure, or withdraw consent at any time.

X-RAY · IF YOU COULD BE PREGNANT First day of last period _____ ☐ To my knowledge, I am not pregnant

Staff has explained the risk that x-ray exposure poses to an unborn child, and I consent to the x-rays my doctor finds necessary.

ACKNOWLEDGMENT & SIGNATURE

By signing, I confirm I have read and received a copy of these Office Policies and the Notice of Privacy Practices, my questions have been answered, the information I provided is accurate, and I consent to examination, any x-rays my doctor finds necessary, and chiropractic care as described above.

Patient name (print) _____ **Date of birth** _____

Patient or guardian signature _____ **Date** _____

Guardian's relationship _____ **Staff witness** _____

OFFICE USE HR# _____ Entered by _____ ☐ Copy of policies given ☐ Superbill requested