BAREFOOT REHABILITATION CLINIC
SPORTS THERAPY & CHRONIC PAIN RESOLUTION

NEW PATIENT INTAKE FORM

Please fill out all information. We cannot begin the consultation until this form is fully completed.

Date:_____

Patient's Full Name: _____ How would you like to be addressed by our staff? _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

☐Male ☐Female Age: _____ Date of Birth: _____/_____/_____ Social Security #: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

☐Married ☐Single ☐Widowed ☐Separated ☐Divorced Number of Children: _____ Ages: _____

Occupation: _____ Employer: _____ Business Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ City: _____ State: _____ Zip: _____

Family Physician: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

**May our office inform your physician of our exam findings, diagnosis, and treatment plan? ☐Yes ☐No

Whom may we thank for referring you? _____

CHIEF COMPLAINT

(No, you can't just say your "husband" or "wife")

Chief complaint: _____

Secondary or related complaint(s) if any: _____

When did this bout **begin**? _____ Was the **Onset**: ☐Gradual ☐Sudden

Since the onset, has it gotten: ☐Worse ☐Stayed same ☐Better

Has this occurred before: ☐Yes ☐No How long ago since first occurrence? _____ months / years ago

What **caused** the pain: ☐no apparent cause ☐one incident _____

What makes the pain **worse**? _____

How long do you have to do the above activity before you experience symptoms? _____

How **intense** is the pain: ☐Minimal ☐Mild ☐Moderate ☐Severe / Excruciating

Have you had any changes in bowel or bladder functioning? ☐Yes ☐No

Have you been treated for your present problem in the past? ☐Yes ☐No

If yes, when: _____ If yes, by whom: _____

Outcome: ☐No effect ☐Somewhat better ☐Resolved

What does your condition prevent you from normally doing? ☐sitting/driving ☐walking ☐running ☐golfing ☐swimming ☐work ☐weight lifting ☐playing with children ☐sleeping ☐normal activities of daily living

☐other: _____

What is your long-term goal from treatment (e.g. play a round of golf without pain)? _____

Do you want this pain gone? ☐Just now ☐Forever

Is there anything else I should know? _____

Describe the quality of the complaint/pain:

- ☐ sharp/ stabbing
- ☐ dull/ache
- ☐ pulling/tight
- ☐ tingling/numbness
- ☐ burning/throbbing
- ☐ other: _____

Does any of the following make the pain worse:

- ☐ lifting/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ bending forward/leaning back
- ☐ other: _____

Describe the location of the symptoms:

- ☐ generalized dull, deep ache
- ☐ pin point
- ☐ pain starts localized, but then radiates
  Describe: _____
- ☐ other: _____

Does any of the following make the pain better:

- ☐ rest/laying down ☐ walking/exercise
- ☐ sitting ☐ standing
- ☐ ice ☐ heat ☐ aspirin
- ☐ other: _____

The symptoms are:

- ☐ more prevalent in the morning
- ☐ more prevalent at night
- ☐ better as the day goes on
- ☐ worse as the day goes

The symptoms feel:

- ☐ better with exercise/activity
- ☐ worse with exercise/activity
- ☐ no change with exercise/activity

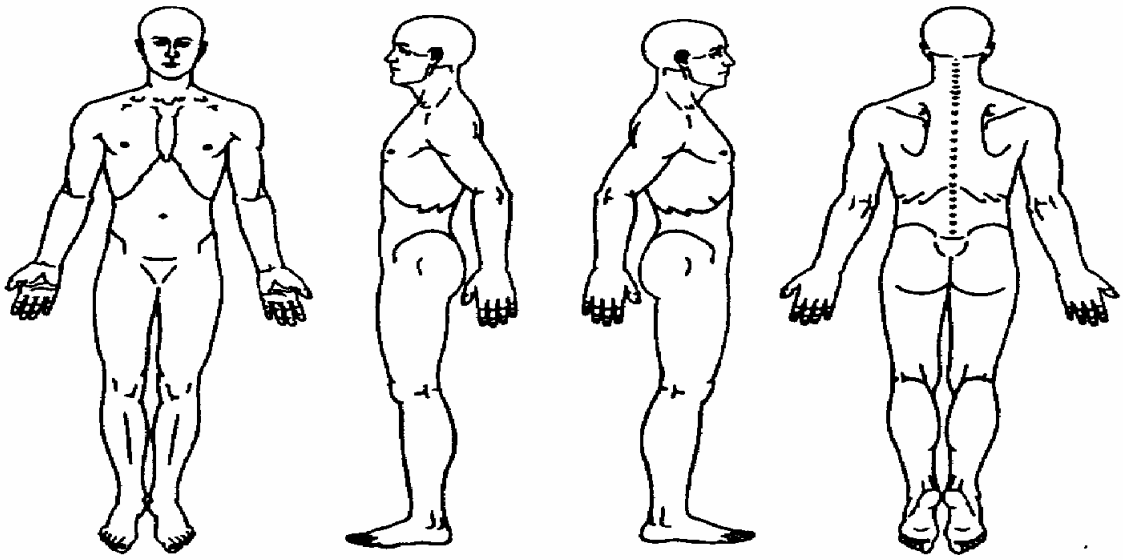
How often daily are you aware of the symptoms:

- ☐ intermittent (less than 25% of time)
- ☐ occasional (25-50% of time)
- ☐ frequent (50-75% of time)
- ☐ constant (75-100% of time)

Does it interfere with your daily activities:

- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)

If your shoulder is being treated, please bring a tank top/loose shirt. If it's your hip/knee bring a pair of shorts



Pain Scale

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate Severe

Please Circle Current Level of Pain

Use the following letters to indicate the type and location of discomfort:

A - Aching
B - Burning
N - Numbness/Tingling
P - Pins and Needles
S - Stabbing/Sharp
T - Throbbing
O - Other

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LIFESTYLE

What **medications** are you currently taking? _____

What **vitamins/supplements** are you currently taking? _____

How many nights per week do you drink **alcohol**? _____ On those nights, how many drinks do you have? _____

Do you smoke **cigarettes**? ☐Yes ☐No How much **mental stress** do you experience? ☐Mild ☐Moderate ☐Severe

How many hours of **sleep** do you get/night? _____ What time do you go to bed? _____

Do you eat the following with every meal? **Vegetables**: ☐Always ☐Sometimes ☐Never

Animal Protein: ☐Always ☐Sometimes ☐Never

What did you have for **breakfast**? _____

What **general physical** activity do you do? ☐No regular exercise ☐Light exercise ☐Strenuous exercise

What type of physical activity do you do? ☐Cardiovascular ☐Resistance ☐Walking ☐Other _____

What is your **athletic history** (middle, high school, college, post-college)? _____

Females only: Are you currently pregnant? ☐Yes ☐No

In general, would you say your health is (check one): ☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

PAST HEALTH HISTORY

Previous Chiropractic Care: ☐Yes ☐No If Yes, for what Problem: _____

What treatment(s) were received: _____ Were they helpful? ☐Yes ☐No

Doctor's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Please list any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries:

Date	Injury / Fracture / Illness / Surgeries / Falls	Treatment	Results

Please indicate any of the following illnesses you have had or currently have with approximate dates.

High Blood Pressure		Prostate Disease		Multiple Sclerosis	
Heart Disease		Ulcer		Headaches	
Stroke		Allergies		Cancer	
Diabetes		Scoliosis		Seizures	
Kidney Disease		Mental/Emotional		Auto Accident	
Fevers		Upset Stomach		Other	

Signature of Patient: _____ ***Date***: _____

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HIPPA NOTICE OF PRIVACY PRACTICES

YOUR HEALTH INFORMATION RIGHTS:
Unless otherwise required by law, your record is the physical property of the healthcare practitioner or facility that compiled it, but the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information and request amendments to your health records. You may also request a copy of your medical records at any time. This organization is required to maintain the privacy of your health information.

By signing this document, I (**PRINT NAME**) _____, acknowledge that I waive my right to privacy regarding the below individuals.

In order to give you the best care possible, we've found it helpful to connect with and send reports to other individuals close to you or healthcare providers who are serving you.

**I want you to send a report of my condition to the following people/providers: ☐Yes ☐No

I authorize my care/condition to be discussed with the following:

Name	Relationship	Phone Number
Physician's Name	Field	Phone Number
Physician's Name	Field	Phone Number

Patient/Guardian Name Printed	**Patient/Guardian Signature**	**Date**
Witness Name Printed	Witness Signature	Date

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BILLING POLICIES AND PATIENT RESPONSIBILITY

Dear Patient:

We will attempt to provide you with the information necessary to determine the type of care you will require and the financial information you may need to determine how you wish to handle your financial obligation to our office.

We wish to make it very clear that your health is the sole responsibility of you, the patient, or your guardian. **It is our policy to collect the below fees at the time of service**. However, Barefoot Rehab Manhattan does accept insurance plans that have *out-of-network* benefits. Should your insurance company cover any of your care, you will be refunded based on how much they cover.

These policies apply only to the services actually performed and in no way obligates the patient to continue the course of treatment recommended.

Our office fees are **$150** for an initial exam and **$80** for subsequent visits.

Our office fee for Heroes Journey Fitness members and referrals is **$125** for an initial exam and **$65** for subsequent visits.

If you are unable to keep an appointment, please give us a minimum of 24-hour notice. We do not want to charge for missed appointments, but it is an inconvenience because that time block could have been booked by someone else. After **three** missed visits without 24-hour notice, you will be billed our office fee of **$65** per missed visit*. _____ **(Initials)**

I have elected to use the following payment method to finance my care at the Barefoot Rehab Manhattan.

NOTE: The Barefoot Rehabilitation Clinic will refund any overpayments made to us upon completion of care.

☐ 1. CASH – Payment is due at the time of service.
☐ 2. PERSONAL CHECK – Payment is due at the time of service.
☐ 3. CREDIT CARD – Payment is due at the time of service.

Patient's Signature: _____ **Date**:_____ Witness: _____

* We will request for your credit card information to be placed on file for this purpose.

Authorization for Credit Card Use ☐ treatment visits ☐ missed visit

Name on Card: _____ ☐ Visa ☐ MasterCard ☐ Discover ☐ Amex

Billing Address: _____

Credit Card Number: _____ Expiration Date: _____

Card Identification Number: _____ (last 3 digits on back) Amount to Charge: $_____ for treatment.

I authorize Barefoot Rehabilitation Clinic to charge the amount listed above (or $_____ for a missed visit) to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder signature _____ Date: _____

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INFORMED CONSENT

Health care professionals are required to obtain your informed consent prior to treatment. Informed consent is the patient's legal right to know all the risks and benefits inherent to a medical procedure prior to agreeing to treatment.

I (**PRINT NAME**) _____, do hereby give my consent to have chiropractic care procedures performed. I understand that the procedures may consist of chiropractic manipulations/adjustments involving joints and soft tissues. I acknowledge that all health care procedures have some risks and complications, and that chiropractic spinal and extremity manipulations/adjustments have some limited, inherent risks that seldom occur. I have considered the following risks and complications regarding chiropractic care:

- **Soreness/Bruising**: It is common to experience localized muscle soreness and occasionally minor bruising in the treatment area.
- **Fractures**: In isolated cases, fractures may result from treatment.
- **Stroke**: Although there has never been a direct link between chiropractic manipulation/adjustment and stroke, I am aware that stroke is reported to occur once in one million to once in ten million treatments.

I also understand that the beneficial effects associated with these procedures including decreased pain, improved mobility and function, and increased quality of life. Reasonable alternatives have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises, and surgery.

By signing below, I now voluntarily and freely agree to have the chiropractic care procedures recommended and performed. I have had the opportunity to ask questions regarding the above information and possible consequences and risks. I have no further questions and I acknowledge that no guarantee of cure has been made to me concerning results and treatment.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent or Guardian (if patient is a minor) Date

_____ _____

Signature of Witness Date