



# 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

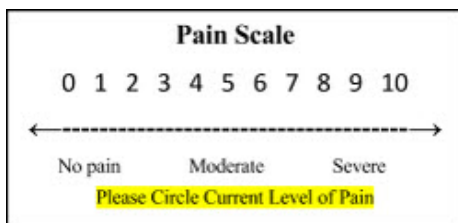
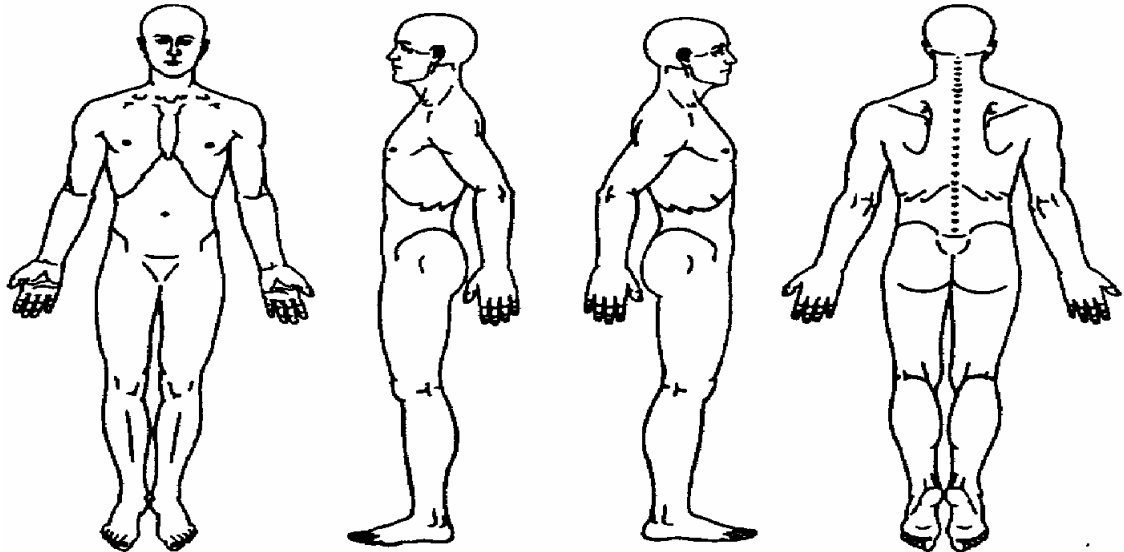
**How often daily are you aware of the symptoms:**

- 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



**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

## 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:** \_\_\_\_\_

## 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
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Physician's Name	Field	Phone Number
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Physician's Name	Field	Phone Number
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<b>Patient/Guardian Name Printed</b>	<b>Patient/Guardian Signature</b>	<b>Date</b>
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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: \_\_\_\_\_

## 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