BAREFOOT REHABILITATION CLINIC
WE FIX YOUR FRUSTRATING PAIN

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: _____/_____/_____

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: _____

Whom may we thank for referring you? _____

IF YOU HAD A MAGIC WAND, WHICH PAIN AREA WOULD YOU GET RID OF?

(Please don't circle your neck and lower back, we won't be able to help you with both AT THIS TIME)

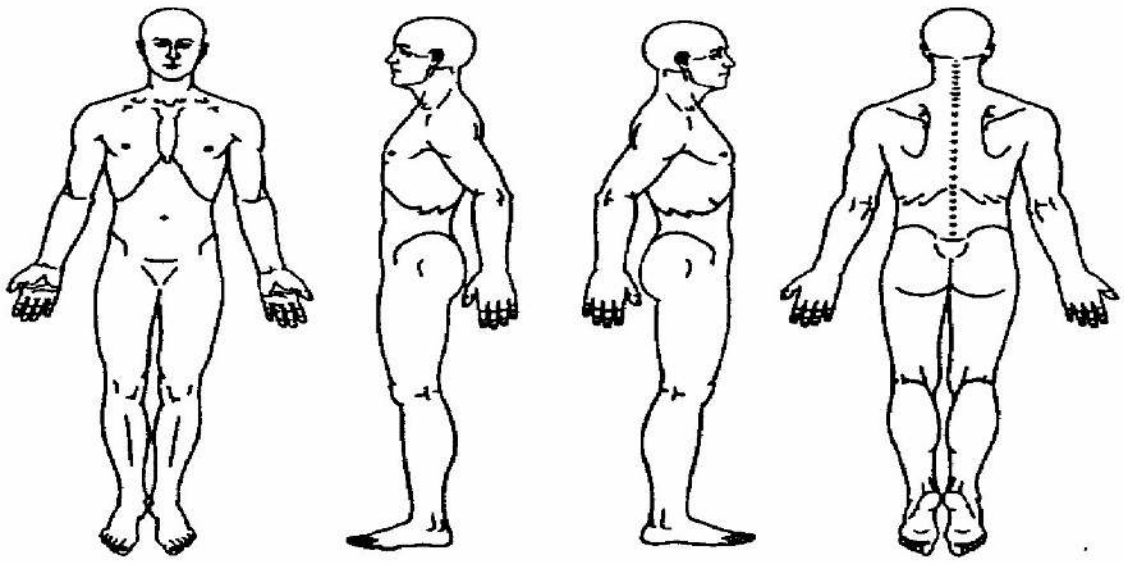
What ONE AREA hurts? _____

Use the following letters to indicate the TYPE and LOCATION of discomfort:

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

How bad is the pain on a scale from 0-10 (0 = no pain | 10 = worst pain ever)

_____



Do you feel pain sitting here, RIGHT NOW, WITHOUT MOVING, **at REST**? □Yes □No If yes, how intense is it from 0-10? _____

What makes the pain **WORSE**? _____

How long (in mins or hours) do you have to do the above activity before it gets **WORSE**? _____

The symptoms are:

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

Does it interfere with your daily activities:

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

If you feel it more in the morning, **how many minutes** does it take until it gets better? _____

What activities? _____

What makes the pain **feel BETTER**? _____

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

What is your BIGGEST concern about your pain?

_____

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

Is there anything else I should know? _____

When did this pain episode **BEGIN** ? _____ Was the **Onset**: □Gradual □Sudden

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

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

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

What type of physical activity do you do? □Weights □CrossFit □Walking □Running □Spinning □Yoga

□Other _____ How many days per week do you exercise? _____

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

Secondary or related complaint(s) if any: _____

PAST INJURY/DISEASE HISTORY

Have you been treated for your **CURRENT** problem in the past? □Yes □No

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

Outcome: □No effect □Somewhat better □Resolved

Have you been treated for **OTHER** problems in the past? □Yes □No

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

Outcome: □No effect □Somewhat better □Resolved

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.

Hypertension		Prostate Disease		M.S	
Heart Disease		Ulcer		Headaches	
Stroke		Allergies		Cancer	
Diabetes		Scoliosis		Seizures	
Kidney Disease		Mental/Emotional		Auto Accident	
Fevers		Upset Stomach		Other	

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

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

LIFESTYLE

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**? _____

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

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

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

HIPAA 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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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 will consist of a precise form of manual therapy to soft tissues. I acknowledge that all health care procedures have some risks and complications, and that treatment has 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.

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

EXPECTATIONS FOR YOUR INVESTMENT

Most of our patients invest in their pain relief through our Case Fee Model. This has 4 benefits. 1) **It's Transparent** - You'll receive upfront pricing where you know exactly how much you're investing in your healthcare with no hidden costs. 2) **It's Aligned** - We both want you to be pain-free as fast and permanently as possible. 3) **It's Complete** - In this model, you'll finish care instead of getting 50% better like our patients used to, then quit, and come back in 12 months and they're worse so we have to start from scratch. We want to prevent that. 4) We want you to be HAPPY with our care. There is a **Refund Policy** if you should move, aren't satisfied, or can't comply with the treatment plan.

If we decide to take you on as a patient after the Consultation and we diagnose you after the Exam, you'll be presented with a Case Fee Agreement ranging from $1,800 - $2,600 depending on the complexity of your problem. We have payment plans in place should you need one.

We do accept Out-of-Network benefits if your plan reimburses more than $70/visit. If you'd like us to check your benefits, send us a photocopy of the front and back of your insurance card, your date of birth, and the primary insurance holder's name and date of birth, and we'll verify for you.