Chiropractor Intake Form

Title: (Circle one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____

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

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Cell Phone (____) _____-_____ **Email** _____

Date of Birth ____/____/_____ **Sex:** Male Female

Social Security Number: _____-____-_____ **Marital Status:** Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other____

Employer Data _____

Employer _____

Your Occupation _____

Spouse Data _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Spouse Date of Birth ____/____/_____

Emergency Contact _____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____-_____ **Cell Phone** (____) _____-_____

Doctor's Signature _____

How did you hear about our office? _____

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar Spine	Gall Bladder
Brain	Shoulder	Thoracic Spine	Knee
Carpal Tunnel	Gastrointestinal	Urogenital	Hernia
Breast Augmentation	Other _____		

Allergies: (Circle all that apply to you)

Mold	Seasonal	Milk or Lactose	Animal
Chemical _____	Sulfites	Wheat/Glutens	Other _____

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Drink Water:	<64 oz/day	>64 oz/day	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Sleep:	<8 hours/night	>=8 hours/night	Insomnia

Other _____

Family History: (Circle all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling

Other _____

Occupational Activities: (Circle one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper
Other _____			

Doctor's Signature _____

Patient Name _____ Date _____

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pacemaker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

Please list all current medications being taken _____

_____

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

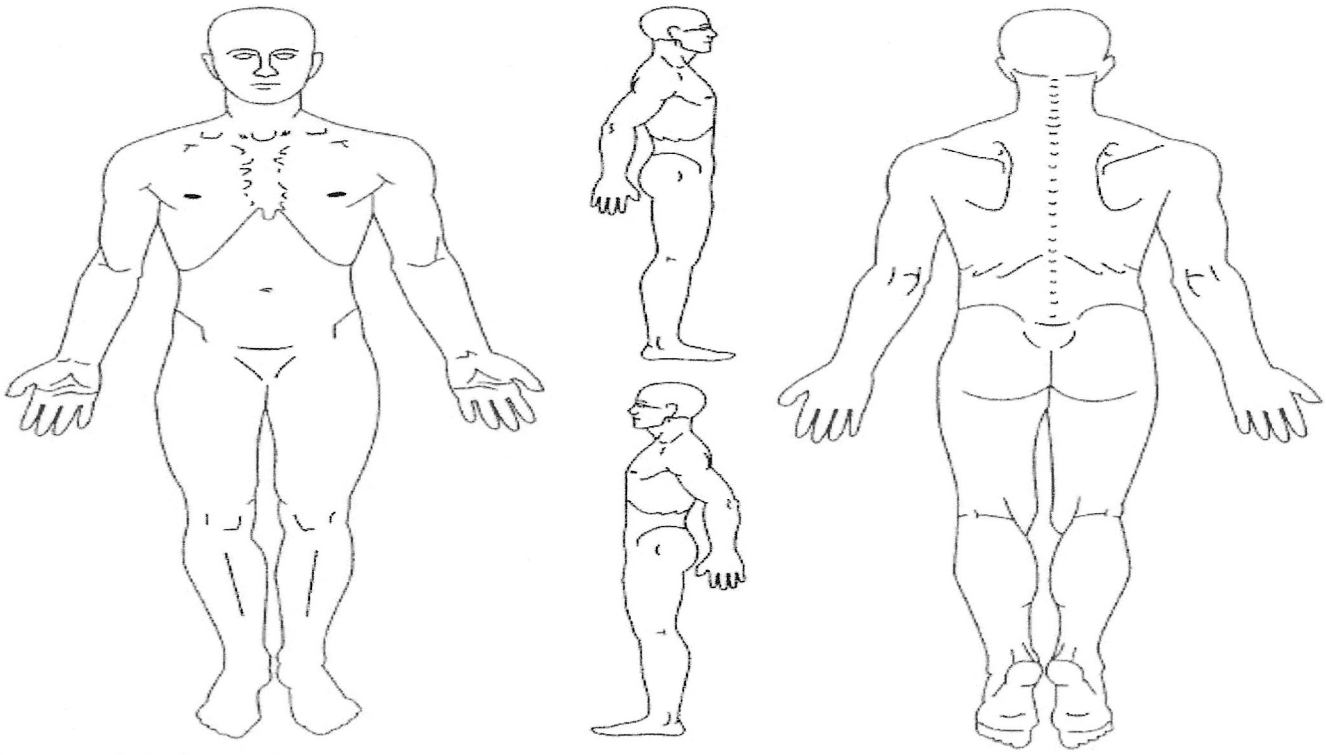
Are You Pregnant? (Check) ☐ **Yes** ☐ **No**

Doctor's Signature _____

Patient Name _____ **Date** _____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No **If Yes, please list:**

When did your symptoms begin? _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What describes the nature of your symptoms?

Sharp	Ache	Numb	Shooting
Burning	Tingling	Throbbing	Other _____

Doctor's Signature _____

Patient Name_____ Date_____

PAYMENT POLICY

Thank you for choosing Dr. Jen Al Ghuraibawi as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral, it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. CO-PAYMENT AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. PROOF OF INSURANCE. All patients must complete outpatient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. CONVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. MISSED APPOINTMENT. Our policy is to charge $0.00 after **one** missed appointment not cancelled 24 hours in advance. The charges will be your responsibility and billed directly to you. **Please help us to serve you better by keeping your regular scheduled appointment**.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines

_____ _____

Patient Signature **Date**

Informed Consent for Chiropractic Spinal Manipulation and Treatment, Authorization and Release

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below for whom I am legally responsible) by the licensed Doctor of Chiropractic of Above and Beyond Chiropractic Center PLLC, Southern Chiropractic PLLC or any doctor, who now or in the future, works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments, Y strap and other procedures and understand that spinal manipulation involved the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks

and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment of insurance benefits directly to Above and Beyond Chiropractic Center PLLC, Southern Chiropractic or Dr. Jennifer Al Ghuraibawi DC. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize Above and Beyond Chiropractic Center PLLC to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I understand the Federal Government has deemed it mandatory to notify my doctor of any other part of insurance company who may be responsible for reimbursement for my treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

I have also read or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask all questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

Patient Signature: _____ Date: ____/____/_____

Printed Name: _____

Pain Disability Index (Revised Oswestry)

Patient Name: _____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

SECTION 1—PAIN INTENSITY
- ☐ The pain comes and goes & is very mild
- ☐ The pain is mild & does not vary much
- ☐ The pain comes and goes & is moderate
- ☐ The pain is moderate and does not vary much
- ☐ The pain comes and goes and is very severe
- ☐ The pain is severe and does not vary much

SECTION 2—PERSONAL CARE
- ☐ I would not have to change my way of washing or dressing in order to avoid pain
- ☐ I do not normally change my way of washing or dressing even though it causes some pain
- ☐ Washing & dressing increase the pain but I manage not to change my way of doing it
- ☐ Washing & dressing increase the pain & I find it necessary to change my way of doing it
- ☐ Because of the pain I am unable to do some washing & dressing without help
- ☐ Because of the pain I an unable to do any washing & dressing without help

SECTION 3—LIFTING
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it causes extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, I can manage if they are conveniently positioned ie: on a table
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

SECTION 4—WALKING
- ☐ I have no pain when I walk
- ☐ I have some pain on walking but it doesn't increase with distance
- ☐ I cannot walk more than one mile without increasing pain
- ☐ I cannot walk more than ½ mile without increasing pain
- ☐ I cannot walk more than ¼ mile without increasing pain
- ☐ I cannot walk at all without increasing pain

SECTION 5—SITTING
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ I avoid sitting because it increases pain straight away

SECTION 6—STANDING
- ☐ I can stand as long as I want without pain
- ☐ I have some pain on standing but it does not increase with time
- ☐ I cannot stand for longer than one hour without increasing pain
- ☐ I cannot stand for longer than ½ hour without increasing pain
- ☐ I cannot stand for longer than 10 minutes without increasing pain
- ☐ I avoid standing because it increases the pain straight away

SECTION 7—SLEEPING
- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless)
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless)
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless)
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless)
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless

SECTION 8—SOCIAL LIFE
- ☐ My social life is normal & gives me no pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. dancing
- ☐ Pain has restricted my social life & I don't go out very often
- ☐ Pain has restricted my social life to my home
- ☐ I have hardly any social life because of the pain

SECTION 9—TRAVELLING
- ☐ I get no pain while travelling
- ☐ I get some pain while travelling, but none of my usual forms of travel make it worse
- ☐ I get extra pain while travelling, but it doesn't compel me to seek alternative forms of travel
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel
- ☐ Pain restricts all forms of travel
- ☐ Pain prevents all forms of travel except that done lying down

SECTION 10—CHANGING DEGREE OF PAIN
- ☐ My pain is rapidly getting better
- ☐ My pain fluctuates but overall is definitely getting better
- ☐ My pain seems to be getting better but improvement is slow at present
- ☐ My pain is neither getting better nor worse
- ☐ My pain is gradually worsening
- ☐ My pain is rapidly worsening

Pain Severity Scale: Rate the severity of your pain by circling one box of the following scale.

No Pain

0	1	2	3	4	5	6	7	8	9	10

Excruciating Pain

Authorization and HIPAA Compliance Patient Consent Form

I have reviewed the information provided for the chiropractor and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and helpful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor. I authorize my insurance company, lawyer, or representative to pay the chiropractor or chiropractic group all benefits for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that: • Protected health information may be disclosed or used for treatment, payment, or healthcare operations. • The practice reserves the right to change the privacy policy as allowed by law. • The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions. • The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. • The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:_____

This consent was signed by (PRINT NAME HERE): _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT