Revision 10/12/2011

Patient Intake Form

Welcome to our office of chiropractic. Thank you for taking a moment to fill in our ***Patient Intake Form***. Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorization checked and appropriate signatures filled in.

Patient Information

SSN: _____ Birthday: _____

*First Name: _____ Middle Name: _____ *Last Name: _____

Sex: ◯M ◯F Height: _____ Weight: _____

Married/Civil Union: ◯Married ◯Single Spouse Name: _____ # of Children: _____

Home #: _____ Cell #: _____ Wireless provider) _____

Address: _____

City: _____ State: _____ Zip: _____

*Email: _____

Employer Information

Employed: ◯Full Time ◯Part Time ◯Homemaker ◯Unemployed Employer Name: _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Physical Work Duties: _____

Reason for this Visit

Describe the reason for this visit: _____

Impact on Life: _____

(Skip this section for wellness services)

◯Wellness ◯Sports ◯Auto ◯Fall ◯Home Injury ◯Job ◯Chronic Discomfort ◯Other

When did this concern begin? _____

Has this concern? ◯Gotten Worse ◯Stayed Constant ◯Come and Gone

Does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain: _____

Has this concern occurred before? ◯Yes ◯No Briefly Explain: _____

Have you seen other doctors for this concern? ◯Yes ◯No Doctor's Name: _____

Type of Treatment: _____

Results: ◯Good ◯Bad ◯Indifferent

Chiropractic Experience

Who referred you to our office? _____

How did you find our office? ☐ Newspaper ☐ Sign ☐ Yellow Pages ☐ Community Event ☐ Mailing

Have you been adjusted by a chiropractor before? ◯ Yes ◯ No

If yes, what was the reason ? _____

Doctor's Name: _____ Date of last visit _____

Has any member of your family ever seen a wellness chiropractor? ◯ Yes ◯ No

Women Only

Are you pregnant? ◯ Yes ◯ No **Are you taking birth control?** ◯ Yes ◯ No **Do you have irregular cycles?** ◯ Yes ◯ No

Are you nursing? ◯ Yes ◯ No **Do you experience painful periods?** ◯ Yes ◯ No **Do you have breast implants?** ◯ Yes ◯ No

(3)

PRE-OPERATIVE PHYSICAL / ASSESSMENT

Date: _____

Name: _____ Phone #: _____ Cell #: _____

Height: _____ Weight: _____ Age: _____ Language: ☐ English ☐ Other BP P

Medication Allergies: _____ Primary Care MD: _____

Do you have or have you ever had any of the following? Place a check in the box that applies:

Nervous System	Epilepsy/Seizures/Fainting spells	☐ Yes	☐ No	GI/GU	Hiatal Hernia	☐ Yes	☐ No
	Stroke	☐ Yes	☐ No		Stomach ulcer	☐ Yes	☐ No
	Loss of Consciousness	☐ Yes	☐ No		Kidney Disease	☐ Yes	☐ No
	ADHD/ADD	☐ Yes	☐ No		Unexplained Recent Weight Loss/Gain:	☐ Yes	☐ No
	Cerebral Palsy	☐ Yes	☐ No		Gastric Reflux	☐ Yes	☐ No
	Head Injury	☐ Yes	☐ No		Indigestion	☐ Yes	☐ No
	Headaches/Migraines	☐ Yes	☐ No		Motion Sickness	☐ Yes	☐ No
Psychosocial	Anxiety/Depression	☐ Yes	☐ No	Endocrine	Diabetes	☐ Yes	☐ No
	Counseling Service	☐ Yes	☐ No		Thyroid Disease	☐ Yes	☐ No
	Mental Illness	☐ Yes	☐ No		Insulin Dependent	☐ Yes	☐ No
					Hypoglycemia	☐ Yes	☐ No
Heart	High Blood Pressure	☐ Yes	☐ No	Musculo-Skeletal	Arthritis	☐ Yes	☐ No
	Chest Pain	☐ Yes	☐ No		Painful Stiff Joints	☐ Yes	☐ No
	Angina	☐ Yes	☐ No		Prosthesis: _____	☐ Yes	☐ No
	Heart Attack	☐ Yes	☐ No		Back Pain	☐ Yes	☐ No
	Pacemaker/AID	☐ Yes	☐ No		Metal Implants: _____	☐ Yes	☐ No
	Mitral Valve Prolapse	☐ Yes	☐ No		Physical Limitations:	☐ Yes	☐ No
	Heart Murmur	☐ Yes	☐ No	Blood	Bleeding Disorder	☐ Yes	☐ No
	Irregular Heartbeat/	☐ Yes	☐ No		Previous Blood Transfusions	☐ Yes	☐ No
	Palpitations/Skipped beats	☐ Yes	☐ No		Eye Glaucoma	☐ Yes	☐ No
	Heart surgery	☐ Yes	☐ No		Eye – Other	☐ Yes	☐ No
Lung	Asthma	☐ Yes	☐ No	Airway	Problem Opening Mouth Wide	☐ Yes	☐ No
	Hay fever/Sinus	☐ Yes	☐ No		Problem Turning Head in Any Direction	☐ Yes	☐ No
	Emphysema/COPD	☐ Yes	☐ No		Sleep Apnea / Snoring	☐ Yes	☐ No
	Shortness of Breath	☐ Yes	☐ No		Bridges, Partials, Dentures	☐ Yes	☐ No
	Croup	☐ Yes	☐ No	Dental	Loose or Missing Teeth	☐ Yes	☐ No
	Previous Smoke: Quit _____				TMJ	☐ Yes	☐ No
	Smoke: _____ Cigs per day	_____	Yrs		Any reactions to Latex?	☐ Yes	☐ No
	Bronchitis	☐ Yes	☐ No		Medications	☐ Yes	☐ No
	Recent Cold or Cough	☐ Yes	☐ No	Allergies	Dyes/Tape	☐ Yes	☐ No
	TB	☐ Yes	☐ No		Shellfish	☐ Yes	☐ No
	Pneumonia	☐ Yes	☐ No		Foods	☐ Yes	☐ No
	Chew Tobacco	☐ Yes	☐ No				
Anesthesia	Nausea/Vomiting After Anesthesia	☐ Yes	☐ No	Liver	Hepatits/Jaundice/Liver Disease	☐ Yes	☐ No
	Family history of Anesthesia Problems	☐ Yes	☐ No		Alcoholic beverages/day: ___	☐ Yes	☐ No
					Recreational drugs	☐ Yes	☐ No
GYN	Last Menstrual period: _____			Pregnancy Test: _____			

Skin: Have you ever had MRSA ☐Yes ☐No Treat by: _____
Open Lesions/Boils ☐Yes ☐No Description: _____
Physician Notified: ☐Yes ☐No

Above completed by patient: ☐Yes ☐No
Reviewed with patient by RN ☐Yes ☐No
Nurse signature _____ _____
Date

SURGERIES: tonsil, appendix , gallbladder , hysterectomy other _____

MEDICATIONS : _____

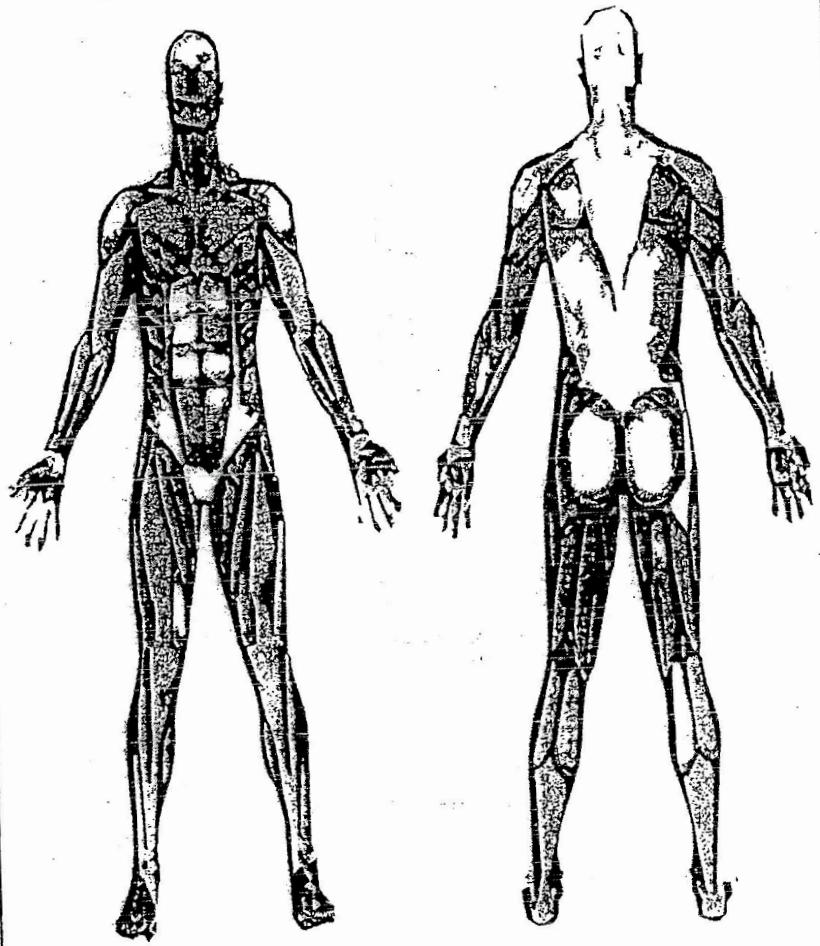
ILLNESS, ACCIDENT ,HOSPITALIZATIONS _____

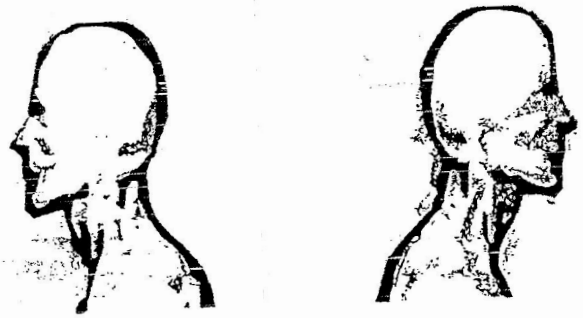
FAMILY HISTORY: Hypertension , Stroke , Thyroid, Heart Attack ,Diabetes _____

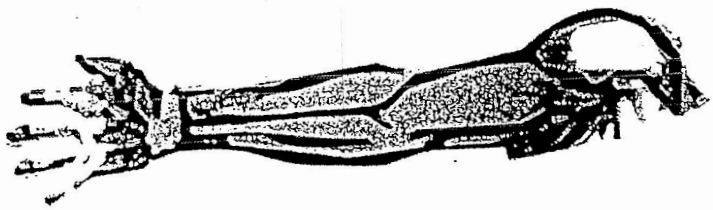
ALLERGIES: Y N _____ FRACTURES _____ BLOOD TRANSFUSIONS Y N
SMOKING: Y N PAST QUIT _____ PACKS /DAY ALCOHOL Y N Social
WORK HABITS: Y N Retired Full Part Time Disabled OCCUPATION _____
PREVIOUS CHIROPRACTOR Y N _____ EXERCISE : ___X per Week TYPE _____
DIET : Low sodium , diabetic , calorie restriction , unrestricted

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing







DELRAN CHIROPRACTIC, PA
CHIROPRACTIC PHYSICIANS

3001 Bridgeboro Road
Delran , NJ 08075
856-461-6262
fax 856-461-7798

Electronic Health Records Intake Form

In Compliance with Medicare requirements for the government EHR incentive program

First Name_____ Last Name_____ Zip Code_____

Email Address_____ Cell#_____ Cell Provider_____

Preferred method of Communication for patient reminders (Circle one): Text message / Phone Call

DOB: ____/____/_____ Gender(Circle One): Male / Female Preferred Language: _____

Smoking Status(Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race(Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity(Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

[ ] I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient signature:_____ **Date:**_____

For Office use only

Height:_____ **Weight:**_____ **Blood Pressure:**_____/_____

DELRAN CHIROPRACTIC, PA
CHIROPRACTIC PHYSICIANS

3001 Bridgeboro Road
Delran, NJ 08075
856-461-6262
fax 856-461-5644

DATE:

CASH ADJUSTMENT $45.00

CASH ADJUSTMENT PLUS 1 OR MORE MODALITIES = 50% DISCOUNT FOR EACH MODALITY i.e. $45.00 + 50% OFF EACH MODALITY.

NUTRITIONAL AND XRAYS ARE ADDITIONAL FEE

PATIENT NAME SIGN_____

DOCTOR_____

PRINT NAME_____

DATE_____

DELRAN CHIROPRACTIC PA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4-14-2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you. Treatment may be administered in an open room format.

Payment: We may use and disclose your health informat on to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare Operations: include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing health information that is directly relevant to the persons involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies; x-rays, or other similar forms of health information.

Marketing Health-Related services: We will not use your health information for marketing communications without your written authorization for example. (puzzle boards, thank you board)

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are.

a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as rescheduling missed appointments, phone calls, voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice; If you request copies, we will charge you $0.25 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we of our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14,2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you received this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. QUESTIONS AND COMPLAINTS. If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your, privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if, you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr Jason Polino DC
Office Telephone: 856-461 -6262
Billing Telephone: 8564616249 contact person: Jeni Polino
Fax 856-461-7798
Address: 3001 Bridgeboro Road
Delran ,NJ 08075

Patient's Signature & Date:_____