Plaxco Chiropractic Associates, LLC

Patient Intake Form

Patient Information

Full Name: _____ Date: _____
Last First MI

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

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I prefer to receive calls at (circle) Home/Work/Cell Email Address: _____
Employer: _____ Occupation: _____
Business Address: _____ City: _____ State: _____ Zip: _____
Who Referred You? _____
Female: _____ Male: _____ Social Security Number: _____
I am (circle) Under Age18/Single/Married/Divorced/Widowed/Separated **Birth Date:** _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Payment Information

Person Responsible for Payment: _____
Social Security Number: _____ Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? ____ Yes ____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize Plaxco Chiropractic Associates, LLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Plaxco Chiropractic Associates, LLC and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations. Less than 24 hour cancellation notice will result in a $25.00 fee if not rescheduled within one week. This fee will be donated to a charity of the practice's choice.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____

Plaxco Chiropractic Associates, LLC

Health Questionnaire

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

List all prescription, non prescription medications and other supplements you take as well as the associated condition:

_____

_____

_____

List any surgeries or hospitalizations you have had complete with the month and year for each:

_____

_____

_____

List anything you are allergic to: _____

Family History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):

_____

_____

_____

Do you exercise? □ Yes □ No Hours per week _____ What activity(s)? _____

_____

Are you dieting? □ Yes □ No Since:_____ Do you smoke or dip/chew? □ Yes □ No __packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? □ Yes □ No ____drinks per day.

Do you wear? □ Heel lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, How many weeks? _____

Date of last menstrual period: _____

Medical History

Describe the reason(s) for your doctor visit today:

Are you here because of an accident? _____ What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (Circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities? _____

Have you experienced these symptoms in the past? _____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ____ No

Have you seen a chiropractor before? ____Yes ____ No Who referred you to us? _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____

Plaxco Chiropractic Associates, LLC

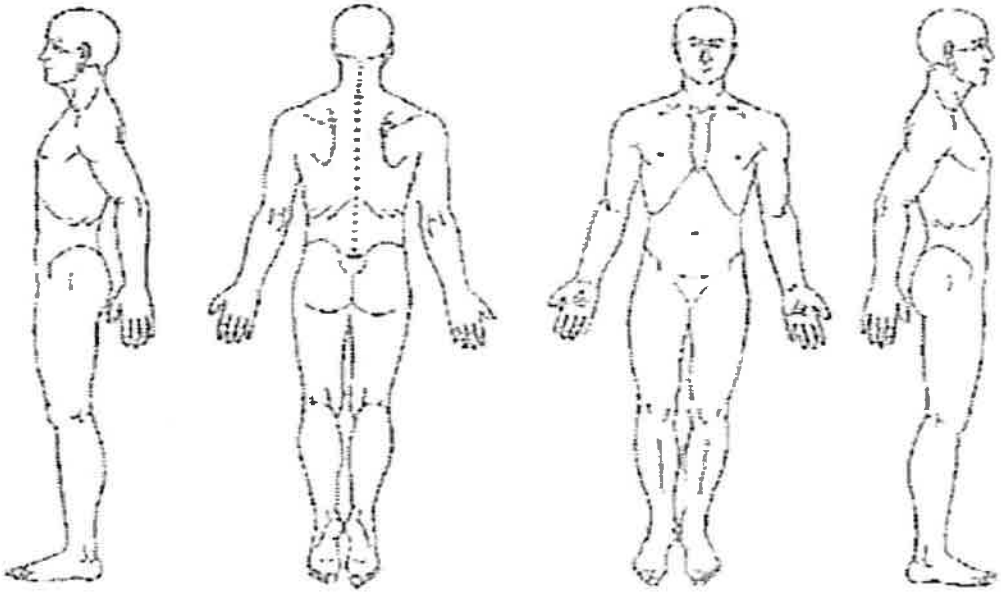
Name: _____

Date: _____

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Back Front Right

On a scale of one to ten how intense are your symptoms?

Not intense ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Unbearable

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
☐	☐	Abdominal Pain	☐	☐	Elbow/upper arm pain	☐	☐	Liver/Gall Bladder Disorder
☐	☐	Abnormal Weight gain/loss	☐	☐	Epilepsy	☐	☐	Loss of Bladder Control
☐	☐	Allergies Headache	☐	☐	Excessive thirst	☐	☐	Low back pain
☐	☐	Angina	☐	☐	Frequent Urination	☐	☐	Mid back pain
☐	☐	Ankle/foot pain	☐	☐	General Fatigue	☐	☐	Neck pain
☐	☐	Arthritis	☐	☐	Hand pain	☐	☐	Painful Urination
☐	☐	Asthma	☐	☐	Heart attack	☐	☐	Prostate Problems
☐	☐	Bladder Infection	☐	☐	Hepatitis	☐	☐	Shoulder pain
☐	☐	Birth Control Pills	☐	☐	High blood pressure	☐	☐	Smoking/tobacco Use
☐	☐	Cancer	☐	☐	Hip/upper leg pain	☐	☐	Stroke
☐	☐	Chest Pains	☐	☐	HIV/AIDS	☐	☐	Systematic Lupus
☐	☐	Chronic Sinusitis	☐	☐	Hormone Therapy	☐	☐	Thoracic Outlet Syndrome
☐	☐	Depression	☐	☐	Jaw pain	☐	☐	Tumor
☐	☐	Dermatitis/Eczema	☐	☐	Joint swelling/stiffness	☐	☐	Ulcer
☐	☐	Dizziness	☐	☐	Kidney Stones	☐	☐	Upper back pain
☐	☐	Drug/Alcohol Use	☐	☐	Knee/lower leg pain	☐	☐	Wrist pain

Additional comments you would like the doctor to know: _____

_____

_____

_____

Patient's signature: _____ **Doctor's signature:** _____

Functional Rating Index

For use with Neck and/or Back Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1. Pain Intensity

0--------1--------2--------3-------4

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0--------1--------2--------3-------4

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0--------1--------2--------3-------4

No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0--------1--------2--------3-------4

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0--------1--------2--------3-------4

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0--------1--------2--------3--------4

Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0--------1--------2--------3--------4

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain;100% of the day

8. Lifting

0--------1--------2--------3--------4

No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0--------1--------2--------3--------4

No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0--------1--------2--------3--------4

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Circle a number below to indicate your **usual/average** pain intensity

0	1	2	3	4	5	6	7	8	9	10

Name: _____(Printed) Total Score: _____

Signature: _____ Date: _____

PLAXCO CHIROPRACTIC ASSOCIATES, LLC * 814 SECOND ST * MUSCLE SHOALS, AL 35661

INFORMED CONSENT

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebral artery stroke is called the "extension-rotation-thrust atlas adjustment". We do not do this type adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA, Vol. 37 No2, June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may also become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscle move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine of middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their possibility.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

_____ _____

SIGNED DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice. I further authorize Plaxco Chiropractic Associates to use my Protected Health Information as allowed by HIPPA law to process insurance or other payments.

_____ _____

SIGNED DATE