

MILTON CHIROPRACTIC CENTER PO BOX 125 MILTON, VT 05468 802-893-1070

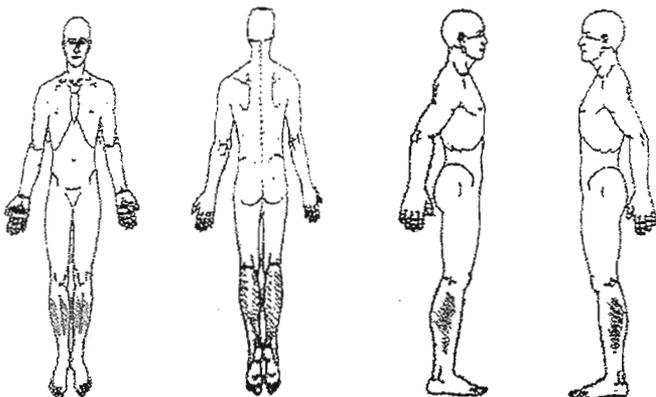
PATIENT INTAKE INFORMATION FORM

Appointment Date: _____

Full Name _____ DOB: _____
First MI Last
Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____ I am (circle): Minor/Single/Married
Employer: _____ Occupation: _____
Business Address: _____ City: _____ State: _____ Zip: _____
Emergency Contact: _____ Relationship to Patient: _____ Phone #: _____
Present Insurance: _____ Policy Holder Name: _____ DOB: _____

Please mark your areas of pain on the figure below

New Condition



My Present symptoms are: _____

This started: (how and when) _____

What functions are you **unable** to perform or induce pain upon performance?

Recent Health Condition

Recent falls, slips or injuries: _____

Recent Surgery: _____ Last Adjustment: _____ Allergies or sensitivities? Y N _____

Are you currently pregnant? Y N If yes, how far along? _____

Medications (prescriptions and OTC) _____

Is this visit an Auto Injury or a Worker's Comp. Injury? _____

Patient Comments: _____

CONSENT FOR TREATMENT: Authorization, Assignment & Release -

By signing below, I authorize Milton Chiropractic Center to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Milton Chiropractic Center 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 whom I am the guarantor, including any deductibles and co-payments and that payment is due at the time of services or at any time the insurance claims are denied. 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. I give my consent for examination and the performance any tests or prodecures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient. This "Authorization to pay physician" is valid even where insurance policy prohibits payment directly to the doctor.

I certify that I have read the above and fully understand it.

PATIENT SIGNATURE: _____

Milton Chiropractic Center

• 165 Route 7 South - PO BOX 125 • Milton, Vermont 05468 • 802-893-1070

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

Appointment Reminders and Health Care Information Authorization

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us permission to contact you.

Our Office may contact you by: Phone at Home, Work, or Cell, Email, Newsletter or Postcard
Messages may be left at: Phone at Home, Work, or Cell and with individuals answering my phone.

(Please place a line through and initial any of the above that you do not want us to use.)

Information that we use or disclose based on this authorization may be subject to re-disclosure by authorized person(s) and may no longer be protected by the federal privacy rules.

You may restrict the individuals or organizations to which your healthcare information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective on the date received. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information.

You have the right to refuse this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information. (8164.524)

I acknowledge that I have received a copy of the Milton Chiropractic Center *Notice of Privacy Practices of Protected Health Information*. I authorize the use or disclosure of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

Patient name printed

Date

Patient signature

Authorized provider representative

Personal representative printed

Personal representative signature

Description of personal representative's authority to act for the patient.

Milton Chiropractic Center Office Policy

• 165 Route 7 South-PO BOX 125 • Milton, Vermont 05468 • 802-893-1070

"Our emphasis is on restoration and maintenance of health. We believe in normal spinal biomechanics because spinal health is directly related to physical and emotional health. We strive to provide chiropractic services in an excellent and caring way while educating patients to establish knowledge and value so that they can take personal responsibility for their health."

When entering the office on any given visit, please go directly to the front desk and "sign in." We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. Upon leaving, always check with the chiropractic receptionist to schedule your *next appointment(s)* and *pay any fees owed on your account*.

APPOINTMENT POLICY: You may be given multiple appointments for convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine. Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts. Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. Please know that this time has been reserved for you. If unable to keep your appointment, kindly let us know within 24 hours. If ample notice is not given, you may be charged \$25.00 for the missed appointment. Repetitive missed appointments may result in dismissal from care.

TREATMENT PROGRAM: The Doctor will discuss your schedule of treatments and recommendations with you in detail. Recommendations, such as nutrition, exercises, and orthopedic appliances, may be used as deemed necessary in each phase of your care. Periodically during your care you may be re-examined to determine your progress. We do not base your treatment program on your insurance coverage and neither should you.

INSURANCE: All co-payments & deductibles are expected at the time of service. A surcharge of \$5.00 will be billed to the patient if payment is not made at time of service. The privilege of insurance assignment begins when your insurance coverage is verified. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and after 90 days you will be responsible for payment in full for any outstanding balance. Remember your insurance is a *contract between you and them*. This office *may* elect to bill your secondary insurance. We will refund any overpayment made to us upon completion of care. A \$25.00 late/service fee will be charged on any balance that is 60 days over due.

COVERED SERVICES: Most insurance companies will pay for **medically necessary** treatment for an *acute condition* or limited flare-ups of a chronic condition and also *supportive care*, defined as, care when a patient has reached maximum improvement, but fails to sustain this improvement and progressively deteriorates when treatment is withdrawn.

NON-COVERED SERVICES: Most insurance companies **will not pay** for maintenance or preventative/wellness care. Most **do not pay** for supplies, supplements, massage, acupuncture, or some modalities. These non-covered services will be at the patient's expense. This office does not promise that an insurance company will pay for the usual, reasonable and customary charges of this office. (See Self-Pay Agreement form). Ask us about **CHIROHEALTH**-aimed at reducing your out-of-pocket expenses.

HEALTH CARE CLASS: On occasion and on various topics, we have classes to enlighten you about your body, especially the spine and nervous system. We have found that patients attending these classes seem to respond faster because they can help us to help them. Some patients mistake relief for correction, and discontinue care when they begin to feel better. Keep in mind that you should follow through with your entire treatment program; otherwise you increase the tendency for the original condition to return, often worse than before.

Thank you! If at any time you have questions about our office policies, or require assistance in any related matter, just ask. We are working to serve you.

Patient: _____ Date: _____

INFORMED CONSENT

THE NATURE OF CHIROPRACTIC TREATMENT: The doctor will use their hands or a mechanical device in order to move your joints. You may or may not feel a "click" or "pop" such as the noise when a knuckle is "cracked" and you may or may not feel movement of the joint. Various ancillary procedures, such as but not limited to: hot or cold packs, electric muscle stimulation, therapeutic ultrasound, massage or various Myofascial Release Techniques may also be used.

POSSIBLE RISKS: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints or injury to intervertebral discs, nerves or the spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, bruising, burns or minor complications.

PROBABILITY OF RISKS OCCURRING: The risks of complications due to chiropractic treatment have been described as "rare" about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

OTHER TREATMENT OPTIONS WHICH COULD BE CONSIDERED MAY INCLUDE THE FOLLOWING:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects, including death, in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects, including death, and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, including death, as well as an extended convalescent period in a significant number of cases.

RISKS OF REMAINING UNTREATED: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

UNUSUAL RISKS: I have had any and all unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Printed Patient Name

Patient Signature (18 years or more)

Date _____

LEGAL GUARDIAN (if patient is a minor): I hereby authorize the doctors @ MCC and whomever they may designate as assistants to perform diagnostic tests and render chiropractic adjustments and other treatment to **MY MINOR CHILD** named above. As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Printed Guardian Name

Guardian Signature

WITNESS

Printed Witness Name

Witness Signature

Date _____

Patient Medical History & Health Questionnaire

Date: _____ PT ID# _____

Patient Name: _____ Date of Birth: _____

Language: English French Spanish German OTHER _____

RACE: White Hispanic or Latino Asian Black or African American

Ethnicity: Hispanic or Latino NOT Hispanic or Latino Decline to Answer

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

Date of last X-RAY? _____ Where? _____

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

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List all **Prescription medications and other vitamins, herbs, mineral & supplements** that you take-include Brand/Generic, strength, dosage, frequency, duration & quantity.

List any **Surgeries or Hospitalizations** you have had complete with the month and year for each:

Do you have **Allergies?** Food? Environmental? Medication? _____

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

Number of children? _____ Grandchildren? _____

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

Are you dieting? Yes No Since: _____ Do you smoke? Yes No _____ packs per day. How many years? _____

Coffee? _____ Soda? _____ Do you drink alcoholic beverages? Yes No _____ drinks per day.

Height: _____ Weight: _____

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

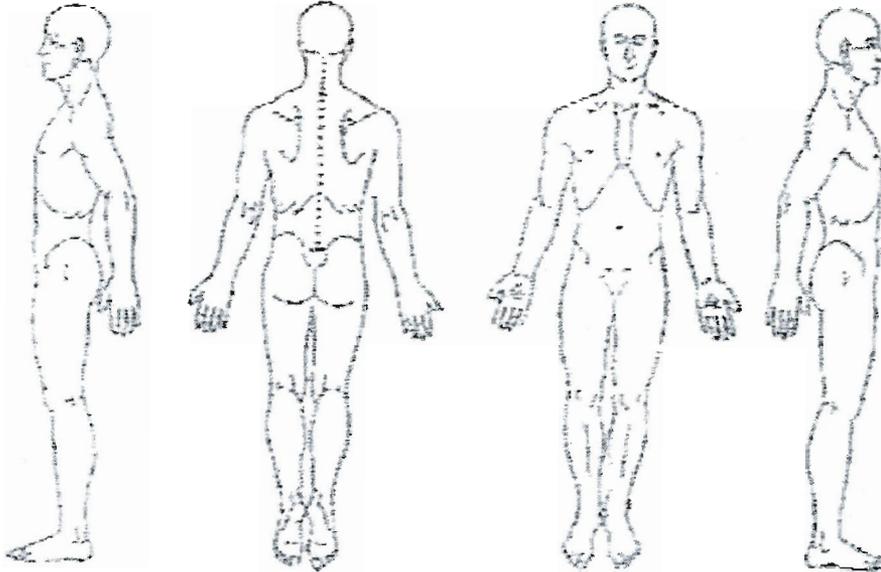
Date of last menstrual period: _____

Page 2 **Patient:** _____ **ID#** _____ **DOB:** _____

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 ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

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

Do you suffer from any condition other than that for which you are now consulting us? _____

What others factors or additional comments of your health would you like to have the doctor know? _____

Patient: _____ ID# _____ DOB: _____

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
<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Elbow/upper arm pain	<input type="radio"/>	<input type="radio"/>	Liver/Gall Bladder Disorder
<input type="radio"/>	<input type="radio"/>	Abnormal Weight gain/loss	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	Loss of Bladder Control
<input type="radio"/>	<input type="radio"/>	Allergies Headache	<input type="radio"/>	<input type="radio"/>	Excessive thirst	<input type="radio"/>	<input type="radio"/>	Low back pain
<input type="radio"/>	<input type="radio"/>	Angina	<input type="radio"/>	<input type="radio"/>	Frequent Urination	<input type="radio"/>	<input type="radio"/>	Mid back pain
<input type="radio"/>	<input type="radio"/>	Ankle/foot pain	<input type="radio"/>	<input type="radio"/>	General Fatigue	<input type="radio"/>	<input type="radio"/>	Neck pain
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Hand pain	<input type="radio"/>	<input type="radio"/>	Painful Urination
<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Heart Disease	<input type="radio"/>	<input type="radio"/>	Prostate Problems
<input type="radio"/>	<input type="radio"/>	Bladder Infection	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Shoulder pain
<input type="radio"/>	<input type="radio"/>	Birth Control Pills	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	STDs
<input type="radio"/>	<input type="radio"/>	Cancer-type _____	<input type="radio"/>	<input type="radio"/>	Hip/upper leg pain	<input type="radio"/>	<input type="radio"/>	Stroke
<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>	HIV/AIDS	<input type="radio"/>	<input type="radio"/>	Systematic Lupus
<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis	<input type="radio"/>	<input type="radio"/>	Hormone Therapy	<input type="radio"/>	<input type="radio"/>	Thoracic Outlet Syndrome
<input type="radio"/>	<input type="radio"/>	Depression/Mental Disorder	<input type="radio"/>	<input type="radio"/>	Jaw pain	<input type="radio"/>	<input type="radio"/>	Tumor
<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema	<input type="radio"/>	<input type="radio"/>	Joint swelling/stiffness	<input type="radio"/>	<input type="radio"/>	Ulcer
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>	Upper back pain
<input type="radio"/>	<input type="radio"/>	Drug/Alcohol Use	<input type="radio"/>	<input type="radio"/>	Knee/lower leg pain	<input type="radio"/>	<input type="radio"/>	Wrist pain
Diabetes -Type 1 Insulin _____			Diabetes- Type 2 _____					

Patient's signature: _____

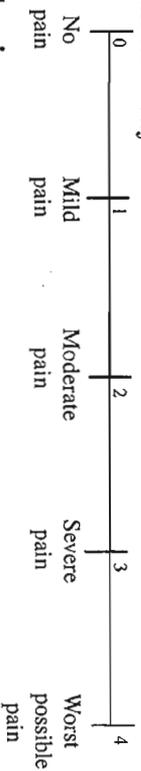
Patient: _____ **ID#** _____ **DOB:** _____

Functional Rating Index

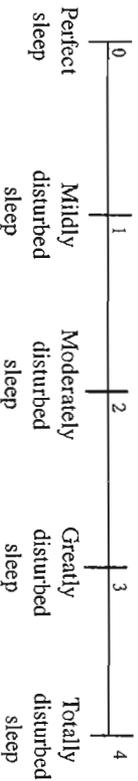
For use with Neck and/or Back Problems only.

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 below, please circle the number which most closely describes your condition right now.

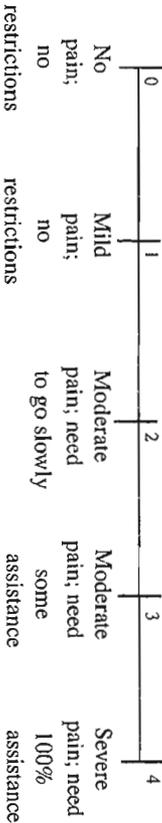
1. Pain Intensity



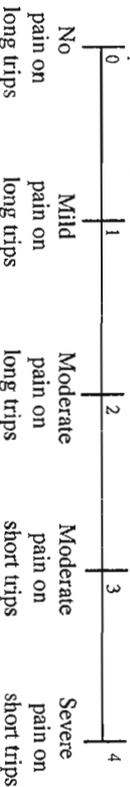
2. Sleeping



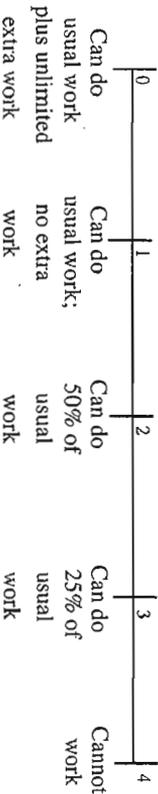
3. Personal Care (washing, dressing, etc.)



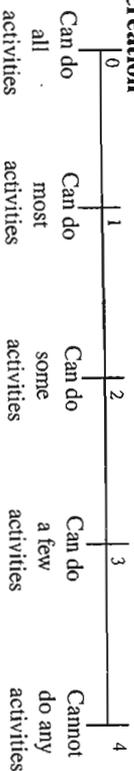
4. Travel (driving, etc.)



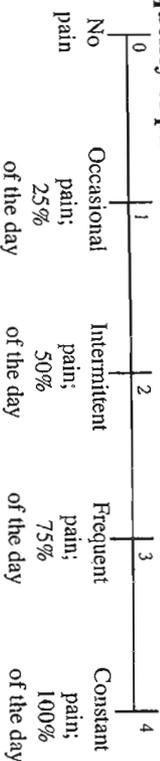
5. Work



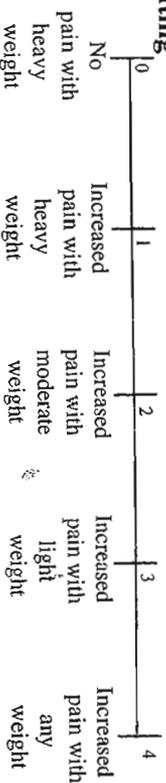
6. Recreation



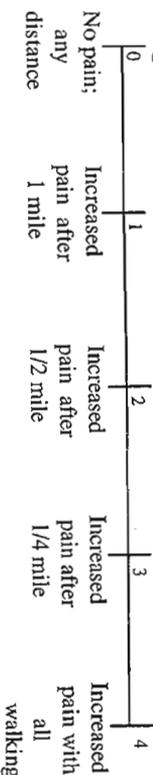
7. Frequency of pain



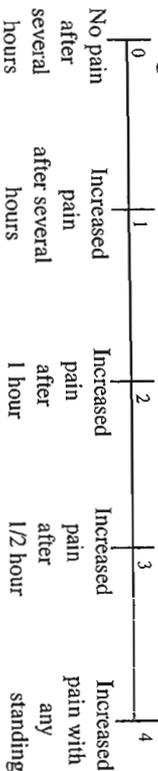
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Signature _____

Date _____

Total Score _____