FISHER CHIROPRACTIC

SPORTS PERFORMANCE & FAMILY WELLNESS

New Patient Intake Form

Date _____

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

First Name _____ Middle Initial ____ Last Name_____

I prefer to be called by_____

Address Line _____

City _____ State _____ Zip Code _____

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____

Emergency Contact

Name _____ Relationship to Patient _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

How did you hear about our office?_____

Medical Conditions: *(Check all that apply)*
Arthritis Cancer Diabetes Heart Disease Hypertension Psychiatric Illness Skin Disorder
Stroke Other _____

Are you pregnant? Yes No N/A

Surgeries: *(Check all that apply)*

Appendectomy	Joint Replacement	Brain	Carpal Tunnel
Cardiovascular	Cervical spine	Hysterectomy	Prostate
Shoulder	Lumbar spine	Gall Bladder	Gastro-intestinal
Thoracic spine	Uro-genital	Knee	Hernia

Allergies: *(List any allergies):*

Social History: *(Check all that apply)*

Caffeine use:	often	occasional	never
Drink Alcohol:	often	occasional	never
Exercise:	often	occasional	never

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Tobacco Use: often occasional never
Sleep: Hours per night= _____
Stress Level: High Moderate Low None

Family History: *(Check 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 _____

Review of Systems:
(Check if you have had trouble with any of the following within the last 3 months)

General:	Weight change	Fever Chills	Night Sweats	Weakness Fatigue	
Eyes:	Vision	Pain	Discharge		
Ears:	Hearing	Ringing	Pain Discharge		
Nose:	Pain	Bleeding	Taste		
Mouth/Throat:	Sores	Bleeding	Taste		
Skin:	Rash	Itching	Hair Changes	Nail Changes	
Neurologic:	Headache	Dizziness	Fainting	Convulsions	
G-I:	Appetite	Abdominal Pain	Vomiting	Diarrhea	Constipation
G-U:	Frequent Urination	Painful Urination		Incontinence	
Cardio:	Murmur	Chest Pain	Palpitations	Difficulty Breathing	Cough
	Wheezing	Blue Extremities		Swollen Extremities	
Breasts:	Mass	Pain	Discharge	Self-exam	
Psychologic:	Anxiety	Depression	Moods	Memory	
Musculoskeletal:	Neck	Upper Extremities			
	Upper Back	Lower Extremities			
	Lower Back				

Please list ALL current medications and/or supplements being taken:

_____

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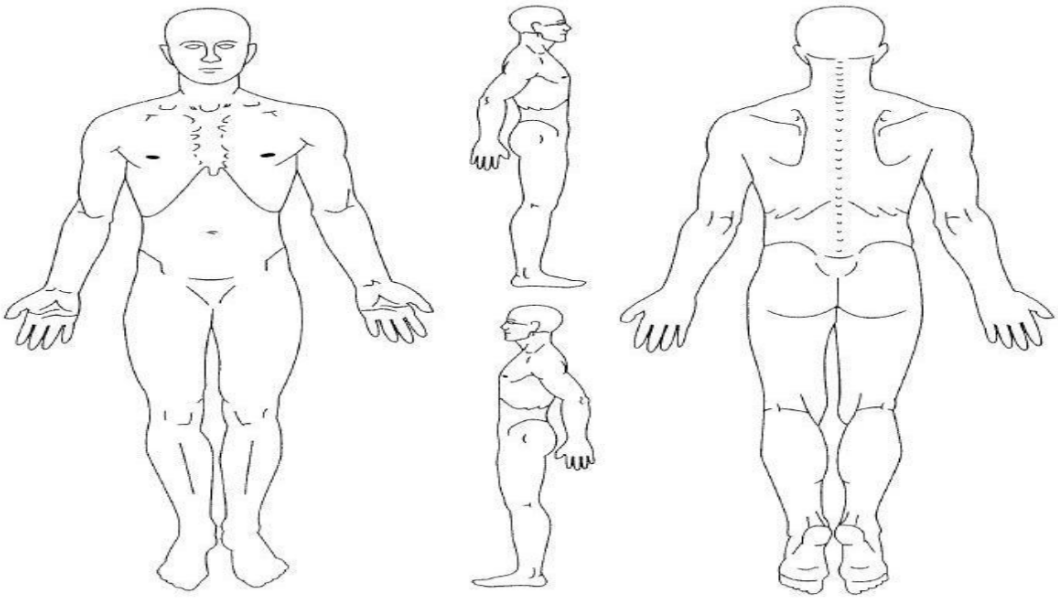
By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing?

[0 = no pain and 10 = the worst pain imaginable]

Please circle: 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms in order of severity, with worse symptom being #1:

_____

_____

_____

_____

_____

_____

Are your symptoms a result of:

Motor Vehicle Accident Work related Accident Other_____

How are your symptoms changing?

Getting better Not changing Getting worse

Activities of Daily Living:

Please check if you have pain or difficulty performing the following:

Bending Carrying Groceries Change Posn–Sit-Stand

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Driving	Extended Computer Use	Lift Children
Climb Stairs	Feeding	Household Chores
Kneeling	Lifting	Self Care–Dressing
Sexual Activities	Walking Yard	Work
Pet Care	Sleep	Reading (Concentration)
Static Sitting	Self Care–Bathing	Static Standing

Other_____

What type of treatment are you looking for?

I am looking for the most minimal amount of care to "patch up the symptoms" of my problem I am looking to resolve my symptoms and then go on to "fix the cause" of my problem

I am looking to take care of my problem and then go on to "achieve optimal health and wellness"

Cancellation Policy

We are very pleased to participate in your healthcare, and have set aside time for your appointment. We understand that sometimes it is necessary to cancel or change an appointment. In consideration of the others who need care, we ask that if you are unable to keep an appointment with our office, that you please observe our cancellation policy, which follows:

Our office requires at least 24-hour notice for all appointment cancelations.

If you are unable to provide **24 hour** notice, you will be billed a **$25.00** charge to your credit card on file.

Same day cancellations or re-schedules will be billed **50% of full rate of the appointment.**

No call / no show appointments or cancellations/reschedules made within 4 hours will be charged the **full amount.**

Your credit card will not be charged without notification. It is kept on file only to enforce the cancellation policy. Please sign stating you agree to the terms and conditions.

Signature _____ Date: _____

Visa Discover MasterCard

Card Number: _____ Expiration Date: _____ CVD_____

Cardholder: _____ Signature: _____

Patient's Signature _____Date_____

Guardian / Spouse's Signature Authorizing Care _____

SIGNATURE OF PHYSICIAN: _____ Date: _____

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THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

In the course of your care as a patient of Fisher Chiropractic, we may use or disclose personal and health related information about you in the following ways:

. 1) Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

. 2) Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or maybe responsible for the payment of services provided to you.

. 3) Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that maybe of interest to you.

. 4) You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of the office.

. 5) Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, to your present care, or other health related information that may be of interest to you.

. 6) If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

. A) If we provide health care services to you in an emergency.

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. B) If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

. C) If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.

. D) If we are ordered by the courts or another appropriate agency.

. E) You have a right to receive an accounting of any such disclosures made by this office.

. F) Any use of disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or it you would like the information in a specific form please advise us in writing as to your preferences. You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

FISHER CHIROPRACTIC, Chiropractic Privacy Notice

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply to all of your health information in our files. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Charlotte Fisher. You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which it was created. My signature acknowledges that I have read and received a copy of this notice.

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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, o me by the doctor of chiropractic named above and/or anyone working in this clinic authorized by the doctor of chiropractic listed above. I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including but not limited to, muscle strains and sprains, disc injuries, fractures, dislocations, and strokes. I do not expect the doctor to anticipate and explain all risks, and I wish to rely on the doctor to exercise good judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and in my best interests.

I have read the above consent. I have also had an opportunity to ask 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 any future condition(s) for which I seek treatment.

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

. 1) The Health Information Portability and Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further been explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.

. 2) The Practice reserves the right to change its privacy practices that are described in the Privacy Notice, in accordance with applicable law.

. 3) I understand that, and consent to, the following: appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me: and b)

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telephoning my home and leaving a message on my answering machine or with the individual answering the phone. I also understand that, and consent to being sent birthday and holiday cards and newsletters, and my name appearing on various boards in the office.

. 4) The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct specific health care operations.

. 5) I understand that I have the right to request that the doctor restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the doctor is not required to agree to any restrictions that I have requested. If the doctor agrees to a requested restriction, then the restriction is binding on the doctor.

. 6) I understand that this Consent is valid for seven years. I further understand that I have the right to revoke the Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.

. 7) I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

. 8) I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the doctor will not treat me.

. 9) I understand, and consent to, an open door / open wall environment for adjusting and therapy, and conversations with doctors, staff, or others may be overheard. I also consent to my name appearing on the sign-in sheets and appointment book which will be visible to others.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____

Date: _____

Patient Name: _____

Patient's Signature: _____

Guardian / Spouse's Signature Authorizing Care: _____