Confidential Intake Form

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply will all federal privacy standards. Please print clearly in BLACK or BLUE **INK**.

Reason for visit (mark circle)

○ A worsening long-term problem

○ An interest in: ○ Wellness and prevention ○ Annual check-up ○ Other: _____

○ An accident or injury: ○ Work ○ Auto ○ Other:_____ Claim #:_____

_____ _____ _____

Today's Date (mm/dd/yy) Date of Injury (If applicable) Who referred you/how did you find out about us?

○ No ○ Yes _____ _____

Previous chiropractic, physical therapy or naturopathic care? Where? Date of last visit (approx)

_____ _____ ○ Male ○ Female

Your full name Preferred Name Gender

_____ _____ _____ ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Your Social Security Number Birth date (mm/dd/yy) Age Marital Status

_____ _____ _____

Mailing address Home phone Spouse's Name

_____ _____ _____ _____ _____

City State ZIP/Postal Code Cell phone Child's name and age

_____ _____

E-mail address Child's name and age

_____ _____ _____

Emergency contact Telephone Child's name and age

_____ _____ _____

Your occupation Your employer Telephone

_____

Work address City State ZIP/Postal Code

Family/Specialist Doctor (if applicable)

_____ _____ _____ _____

Primary care physician (Family doctor) Clinic Telephone Fax

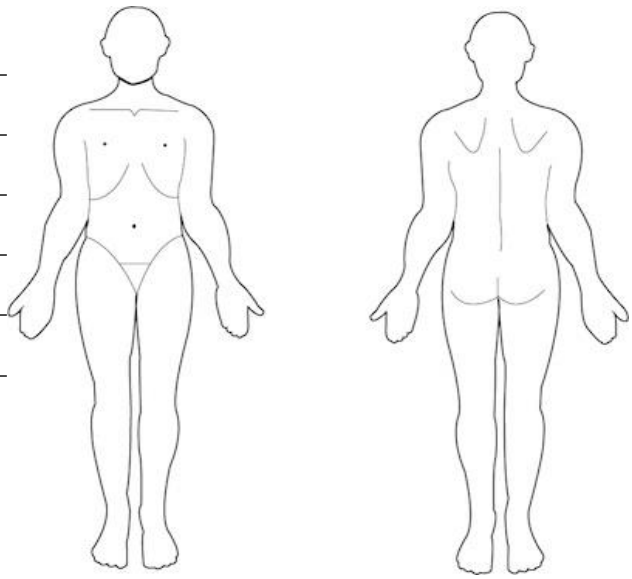
_____ _____ _____ _____

Specialist Clinic Telephone Fax

Patient name

●1. List your current conditions/complaints

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____



●2.Location (Where does it hurt?)
Mark the area(s) on the illustrations.

●3. Have you received any evaluation and/or treatment for your current condition(s)? ○Yes○ No If yes, explain:

Date: _____ Doctor or therapist name: _____

Testing done? ○ Yes ○ No Which?: _____

Diagnosis: _____

Treatment/recommendations: _____

Results of treatment?:_____

Date: _____ Doctor or therapist name: _____

Testing done? ○ Yes ○ No Which?: _____

Diagnosis: _____

Treatment/recommendations: _____

Results of treatment?: _____

4. Have you ever suffered from your current symptoms in the past? **○No○Yes** If yes, describe below:

Year	Cause	Tests done?	Problem resolved completely?
			○No ○Yes
			○No ○Yes
			○No ○Yes

5. Please list any other special diagnostic tests that you have had in the past with the year: _____

_____

●6. Activities of Daily Living How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect		No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	○	○	○	○	Grocery shopping	○	○	○	○
Rising out of chair	○	○	○	○	Household chores	○	○	○	○
Standing	○	○	○	○	Lifting objects	○	○	○	○
Walking	○	○	○	○	Reaching overhead	○	○	○	○
Lying down	○	○	○	○	Showering or bathing	○	○	○	○
Bending over	○	○	○	○	Dressing myself	○	○	○	○
Climbing stairs	○	○	○	○	Love life	○	○	○	○
Using a computer	○	○	○	○	Getting to sleep	○	○	○	○
Getting in/out of car	○	○	○	○	Staying asleep	○	○	○	○
Driving car	○	○	○	○	Concentrating	○	○	○	○
Looking over shoulder	○	○	○	○	Gardening/Yard work	○	○	○	○
Caring for family	○	○	○	○	Exercising/Recreation	○	○	○	○
Work duties	○	○	○	○	Athletics	○	○	○	○

Examination Note

Doctor's Initials

Josh Bailey, D.C.

Patient name

(Continued from previous page)

Past personal, family and social history Please identify your past health history, including accidents, injuries, illnesses and treatments.

7. Have you ever been hospitalized or had surgery? ○No ○Yes If yes, describe:

Year	Reason	Surgery	Outcome

8. Have you ever had any traumas or accidents? (Falls, car accidents, work injury, sports injury, fractures) ○No ○Yes If yes, describe:

Year	Trauma	Treatment	Outcome

9. Do you take any medications or supplements (including over the counter eg.Tylenol?) ○No ○Yes If yes, describe:

Name	Reason	x/day	Dose	Since when?

10. Do you have any allergies? ○No ○Yes If yes, list:

11. Family History

Some health issues are hereditary. Is there a history of illness (cancer, arthritis, heart disease, depression, diabetes, etc.) in your immediate family?

FAMILY

Relative	Age (If living)	State of Health: Good	State of Health: Poor	Illnesses	Age at death	Cause of death: Normal	Cause of death: Illness
Mother	_____	○	○	_____	_____	○	○
Father	_____	○	○	_____	_____	○	○
Sister 1	_____	○	○	_____	_____	○	○
Sister 2	_____	○	○	_____	_____	○	○
Brother 1	_____	○	○	_____	_____	○	○
Brother 2	_____	○	○	_____	_____	○	○
Other	_____	○	○	_____	_____	○	○

12. Social/Occupational History

SOCIAL

What is your current occupation? _____

Do you rest well at night? ○ Yes ○ No

Do you have trouble falling asleep? ○ Yes ○ No

Do you wake up frequently during the night? ○ Yes ○ No

Do you grind your teeth at night (bruxism)? ○ Yes ○ No

Approximate age of your mattress and pillow? _____

Do you snore heavily? ○ Yes ○ No

How many hours do you sleep at night? ○< 6h ○ 6-8h ○> 8h

Preferred sleep position? ○ Face up ○ Face down ○ Side

Rate your fatigue level (0-10) _____

How often do you exercise?: ○ Don't ○ Occasionally (<1x/week) ○ Frequently (2-3x/week) ○ Daily

Water intake: ○<33oz(1L) ○ 33-50oz (1-1.5l) ○>50oz(1.5L)

SOCIAL

Alcoholic Drinks ○ Never ○<1/day ○ Daily ○ 6-10/week ○>10/week

Caffeine use ○ Never ○<1/day ○ Daily ○ 6-10/week ○>10/week Source of caffeine:_____

Tobacco use ○ No ○<1x/day ○<½ pack/day ○>½ pack/day ○>1 pack/day Type of tobacco: _____

Soft drinks ○ Never a ○<1/day ○ Daily ○ 6-10/week ○>10/week

What vitamins/supplements do you take? ○ Not taking ○ Glucosamine ○ Chondroitin ○ Calcium ○ Multi-Vitamin ○ Fish Oils ○ Pro-biotics ○ Magnesium ○ Greens ○ B Complex ○ Vitamin C ○ Vitamin D ○ Vitamin E Others: _____

Describe your eating habits: ○ Skip breakfast ○ Two meals per day ○ Three meals per day ○ Snacking between meals

Diet restrictions/intolerances: _____

Rate your overall stress level (0-10): _____ What are your major causes of stress? ○ Work ○ Economic ○ Family/Kids/Relationships

Hobbies: _____

_____
Doctor's Initials

Josh Bailey, D.C.

(Continued from previous page)

Patient name

13. Review of systems
Our integrative care focuses on the integrity of all body systems. Please mark the circle beside any condition that you've **HAD** or currently **HAVE**:

a. HEENT	b. Integumentary	c. Respiratory	d. Neurological	e. Digestive	f. Endocrine	g. Genitourinary
○ Blurred Vision	○ Dry Skin	○ Asthma	○ Anxiety	○ Ulcer	○ Thyroid Issues	○Kidney Stones
○ Floaters in vision	○ Psoriasis	○ Apnea	○ Depression	○ Anorexia/Bulimia	○ Hypoglycemia	○Prostate Issues
○ Hearing Loss	○ Eczema	○ Shortness of breath	○ Pins and needles	○ Food Sensitivities	○ Immune Disorders	○Erectile Dysfunction
○ Ringing in ears	○ Acne	○ Emphysema	○ Dizziness	○ Heartburn	○ Low Energy	○Bedwetting
○ Loss of taste	○ Hair Loss	○ COPD	○ Headaches	○ Constipation	○ Swollen glands	○PMS Symptoms
○ Loss of smell	○ Rash	○ Allergies	○ Numbness	○ Diarrhea	○ Frequent Infection	○Infertility
○ Glaucoma	○ Melanoma	○ Pneumonia	○ Multiple Sclerosis	○ Crohn's Disease	○ Polycystic Ovarian Syndrome	○ Urinary Tract infections
○ Ear infections	○ **None**	○ Tuberculosis	○ Parkinson's	○ Irritable Bowel Syndrome	○ Diabetes	○ Yeast Infections
○ Sinusitis		○ **None**	○ Fibromyalgia	○ Ulcerative Colitis	○ Hepatitis	○ Abnormal PAP
○ Nasal Polyps			○ Chronic Pain	○ Celiac	○ Goiter	○ STD's
○ Strep Throat			○ Mood Disorders	○ diverticulitis/osis	○ **None**	○ Decreased Libido
○ Mononucleosis			○ **None**	○ Gas/Bloating		○**None**
○ **None**				○ Gall Bladder disease		
				○ **None**		

h. Constitutional	i. Cardiovascular	j. General
○ Fainting	○ Angina	○ Cancer
○ Low Libido	○ High-cholesterol	○ Epilepsy
○ Poor Appetite	○ High Blood Pressure	○ AIDS
○ Difficulty losing weight	○ Low Blood Pressure	○ Alcoholism/Drug dependence
○ Weakness	○ Excessive Bruising	○ Gout
○ Sudden Weight Change	○ Poor Circulation	○ Polio
○ Fever	○ Stroke	○ Rheumatic fever
○ Chills	○ Murmurs	○ Scarlet fever
○ Night Sweats	○ A-Fib	○ Typhoid
○ **None**	○ Heart Disease	○ Malaria
	○ **None**	○ Post-Nasal Drip

○ Other:
○ Other:
○ Other:

14. What would be the most significant thing that you could do to improve your health? _____

_____

15. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

FOR MEDICARE ONLY

1. At the present, would you describe your health as: ○ Excellent ○ Very good ○ Fair ○ Poor

2. Who do you currently live with? (or intend to live with at the conclusion of this therapy?)
○ Alone ○ w/Spouse or Partner ○ w/Children/Relative ○ w/Personal Care Attendant ○Other: _____

3. Where do you currently live (or intend to live) at the conculsion of this therapy?
○ Private home ○ Private apartment ○ Rented room ○ Group home ○ Board and care apartment ○ Assisted living ○ SNF

4. Were you discharged from an inpatient, SNF, or home health treatment within the last 30 days? ○ Yes ○ No

5. Do you need this plan of care/therapy to return to a previous, or move into a new, living environment? ○ Yes ○ No

6. What other condition are you currently being treated for? Do you requiere any durable medical equipment (bath bench, wheelchair, cane, etc.) for these conditions? _____

_____

7. "ADLs" are "activities of daily living" such as eating, bathing, dressing and toileting. What is your current level of independence with these activities?

○ Maximal assistance (you provide 50% of the effort)
○ Moderate assistance (you perform 50-75%)
○ Minimal assistance (require incidental hands-on help)
○ Supervision Only (require standby assistance only)
○ Modified Independence (require a device but no physical help)
○ Complete independence

_____
Doctor's Initials

8. "IADL's" are activities such as cooking, driving, using telephone and shopping. What is your current level of independence with these activities?

○ Maximal assistance (you provide 50% of the effort)
○ Moderate assistance (you perform 50-75%)
○ Minimal assistance (require incidental hands-on help)
○ Supervision Only (require standby assistance only)
○ Modified Independence (require a device but no physical help)
○ Complete independence

Josh Bailey, D.C.

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Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Informed Consent

I hereby request and consent to the performance of procedures, which may include, but is not limited to, various modes of physical therapy, massage therapy, diagnostic x-rays, diagnostic lab work including urine, blood, gynecological specimens and body cultures, medical doctor and/or chiropractic adjustments on me (or the patient named below, for whom I am legally responsible) by the doctor named below and/or licensed doctors who now or in the future treat me while employed by, work or are associated with, or are serving as back up, for Restart Chiropractic, LLC, including those working at the center or office listed below or any other office or center.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and/or other procedures.

I understand, and am informed that in the practice of medicine, and in the practice of chiropractic, naturopathy and physical therapy, there are some risks to treatments including, but not limited to fractures, disk injuries, strokes, dislocations, sprains and potential exacerbation of symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the same time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above-named procedure. 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.

To be completed by patient

Patient Name _____ Signature of Patient _____

Date Signed _____

To be completed by patient's representative if patient is a minor or physically or legally incapacitated

Representative Name _____ Signature of Representative _____

Date Signed _____

Notice of privacy practices acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name _____

Representative Name _____

Signature _____

Date_____

Office use only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so, as documented below:

Date:

Initials:

Reason:

Notice of privacy practices

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions on relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to the requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Patient Copy

Josh Bailey, D.C.