# Patient Intake Form

Calhoun Chiropractic | 136 W Belmont Dr Suite 4, Calhoun GA 30701 | (706) 659-2122

| PATIENT INFORMATION | | | | |
|---|---|---|---|---|
| Today's date: | Primary Care Physician: | | | |
| Patient's last name: First: Middle Initial: | | | Marital status (circle one): Single Married Divorced Separated Widow Significant Other | |
| **Is this your legal name?** □ **Yes** □ **No** | If not, what is your legal name? | (Former name): | Birth date: / / | Age: Sex: □ M □ F |
| **Street Address:** | Social Security #: | | Home phone #: ( ) | |
| | Driver's License #: | | Cell phone #: ( ) | |
| **P.O. Box:** **City:** | | **State:** | **Zip Code:** | |
| Occupation: | Employer: | | Employer phone #: ( ) | |
| **I was referred to this clinic by (please check one box):** □Facebook □Television □Dinner Seminar □Event at your Work Place □Health Fair □Newspaper □Former Patient □Website □ Webinar □Referral □Other (Please Note_____) If you selected referral whom may we thank for referring you? | | | | |
| Email: | Spouse's Name: | | | |
| Emergency Contact: | Spouse's Employer: | | | |

| RESPONSIBLE PARTY (If Different from Patient) | | |
|---|---|---|
| Name: | Social Security #: | Date of Birth: |
| Address: | Employer: | Employer Address: |
| Phone #: | Relationship to Patient: | Employer Phone #: |

| INSURANCE | | | |
|---|---|---|---|
| Name of Insured: | Relationship to patient: | Birth Date: | SSN: |
| Insurance Company: | Policy #: | Group #: | |
| Name of Employer: | Employer Address: | Employer Phone #: | |

## Motor Vehicle Accident and Personal Injury

| If your injuries are the result of an Accident Please Fill out below | | |
|---|---|---|
| Are you being represented by an Attorney? Yes/No | Law Office Name: | Number: Email: |
| Attorney Name: | Case Manager: | Number: Email: |
| Police report Present: Yes/No | At-Fault Claim Number: | Medical Claim Number: |

## PAST MEDICAL HISTORY

**Check all conditions that apply to you:**

| | | | |
|---|---|---|---|
| □ Measles | □ Anemia | □ Back Trouble | □ Hepatitis |
| □ Mumps | □ Bladder Infection | □ High Blood Pressure | □ Ulcer |
| □ Chickenpox | □ Epilepsy | □ Low Blood Pressure | □ Kidney Disease |
| □ Whooping Cough | □ Migraine Headaches | □ Hemorrhoids | □ Thyroid Disease |
| □ Scarlett Fever | □ Tuberculosis | □ Asthma | □ Bleeding Tendency |
| □ Diphtheria | □ Diabetes | □ Hives or Eczema | □ Any Other Disease |
| □ Small Pox | □ Cancer | □ AIDS or HIV | _____ |
| □ Pneumonia | □ Polio | □ Infectious Mono | _____ |
| □ Rheumatic Fever | □ Glaucoma | □ Bronchitis | □ Date of Last Chest Xray: |
| □ Arthritis | □ Hernia | □ Mitral Valve Prolapse | |
| □ Venereal Disease | □ Blood or Plasma Transfusion | □ Stroke | |

***Gynecologic History***

Are you currently pregnant? Y / N Pregnancies#_____ Menstrual: Onset:_____ Duration:_____ Last menstrual period:_____

Natural Delivery or C-Section?_____Dates:__ Are they regular? Y / N Pain Associated? Y / N

### Please list all medications you are currently taking

| Name | Dosage | Name | Dosage | Name | Dosage |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

### Please list all surgeries and date of Surgery

| Name | Date | Name | Date | Name | Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

Signature of Patient, Parent or Guardian:_____

Date:_____

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## Activity Level

*Select one of the following*

| | |
|---|---|
| □ **Inactive:** no regular physical activity with a sit-down job | □ **Light Activity**: no organized physical activity during leisure |
| □ **Moderate Activity:** Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling. | □ **Heavy Activity:** consistent lifting, stair climbing, heavy construction, etc. or regular participation in jogging, swimming, cycling or active sports at least three times per week. |
| □ **Vigorous Activity:** Participation in extensive physical exercise for at least 60 minutes per session, 4 or more times per week. | |

## Chief Complaint

What problem are you seeing the doctor for? (Specific Complaint, date of injury, place of injury):

| | |
|---|---|
| Is it on the right or left side? **RIGHT / LEFT** | How long have you had this problem? |
| What treatment have you tried in the past? | What activities have you given up due to the problem? |
| How severe is the problem? 1 2 3 4 5 6 7 8 9 10 | Are you on any medications for the problem? |

## Family History

Previous Hospitalizations or Surgeries:

Allergies/Medication Allergies:

Do you have a Sulfa Allergy? Yes / No

**Family Medical History**

Mother Age:_ Disease:_____If Deceased, Cause of Death:_____

Father Age:_ Disease:_____If Deceased, Cause of Death:_____

Siblings Age:_ Disease:_____If Deceased, Cause of Death:_____

Siblings Age:_ Disease:_____If Deceased, Cause of Death:_____

Children Age:_Disease:_____If Deceased, Cause of Death:_____

Use of:

**Alcohol:** Never:____Rare:___Moderate:___Daily:___

**Tobacco:** Never:____Rare:___Moderate:___Daily:___

**Drugs:** Never:___Rare:___Moderate:___Daily:___

**Exposure to:** Fumes___Dust Solvents_____Noise___

**Hobbies and Activities:**

Exercise:____Family:____Golf:____Boating:____

Hiking:____Reading:____Sports:____

Church Groups:_____ Other: _____

## Do you experience any of the following Symptoms (rate on a scale of 1-5 *circle which is most appropriate*)

**1=Never, 2=Rare, 3=Occasionally, 4=Frequently, 5=All the Time**

| | | |
|---|---|---|
| I feel tired all the time: 1 2 3 4 5 | I feel foggy all the time: 1 2 3 4 5 | I'm getting sick more often: 1 2 3 4 5 |
| I get dizzy when I stand up: 1 2 3 4 5 | I get muscle twitches or cramps 1 2 3 4 5 | Don't heal like I used to: 1 2 3 4 5 |
| I have muscle weakness: 1 2 3 4 5 | Have trouble with my memory: 1 2 3 4 5 | My bones feel achy: 1 2 3 4 5 |
| I feel off balance or clumsy 1 2 3 4 5 | I feel unusually run-down: 1 2 3 4 5 | I'm always exhausted: 1 2 3 4 5 |
| I've been unable to sleep: 1 2 3 4 5 | I've been more irritable lately: 1 2 3 4 5 | My skin is dry or cracking: 1 2 3 4 5 |
| I wake up at night: 1 2 3 4 5 | I get headaches/migraines: 1 2 3 4 5 | My hair is falling out lately: 1 2 3 4 5 |

| | |
|---|---|
| My wounds are taking forever to heal 1 2 3 4 5 | I feel numbness or tingling in my fingers 1 2 3 4 5 |
| I feel pins and needles in my hands and feet 1 2 3 4 5 | I have trouble concentrating: 1 2 3 4 5 |
| I'm unusually tired: 1 2 3 4 5 | I get muscle cramps or spasms 1 2 3 4 5 |
| Have muscle soreness even when I haven't exercised 1 2 3 4 5 | My nails break easily and are brittle 1 2 3 4 5 |

## MEDICAL HISTORY

1. Are you diabetic? Yes/ No ---> Type 1 or Type 2 (please circle) Diagnosis Date: ____/____/_____
2. Last HA1C:_____ Date: ____/____/_____ Last Fasting Blood Sugar Level:_____Date: ____/____/_____
3. Do you have any implantable devices? Yes/ No If yes, please list:_____
4. Do you have a history of seizures? Yes/ No If Yes, list your last episode date:____/____/_____
5. History of cellulitis? Yes/ No
6. Any current wounds, rashes, or skin infection? Yes/ No If yes, please list:_____

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| SYMPTOM SURVEY | |
|---|---|
| **(Check the box if applicable and Circle if L or R):** | **Description (Please CIRCLE the term(s) that relates to your symptom)** |
| □ **Foot** Pain (Right/ Left)<br>When did this pain start? | Constant / Daily / On-and-Off / Dull / Ache / Burning / Pressure / Sharp / Stabbing / Tight / Cramping / Tingling / Numb / Radiating / Deep / Sore / Throbbing |
| □ **Hand** Pain (Right/ Left)<br>When did this pain start? | Constant / Daily / On-and-Off / Dull / Ache / Burning / Pressure / Sharp / Stabbing / Tight / Cramping / Tingling / Numb / Radiating / Deep / Sore / Throbbing |
| □ **Knee** Pain (Right/ Left)<br>When did this pain start? | Constant / Daily / On-and-Off / Dull / Ache / Burning / Pressure / Sharp / Stabbing / Tight / Cramping / Tingling / Numb / Radiating / Deep / Sore / Throbbing |
| □ **Hip** Pain (Right/ Left)<br>When did this pain start? | Constant / Daily / On-and-Off / Dull / Ache / Burning / Pressure / Sharp / Stabbing / Tight / Cramping / Tingling / Numb / Radiating / Deep / Sore / Throbbing |
| □ **Shoulder** Pain (Right/ Left)<br>When did this pain start? | Constant / Daily / On-and-Off / Dull / Ache / Burning / Pressure / Sharp / Stabbing / Tight / Cramping / Tingling / Numb / Radiating / Deep / Sore / Throbbing |
| □ **Elbow** Pain (Right/ Left)<br>When did this pain start? | Constant / Daily / On-and-Off / Dull / Ache / Burning / Pressure / Sharp / Stabbing / Tight / Cramping / Tingling / Numb / Radiating / Deep / Sore / Throbbing |
| □ **Wrist** Pain (Right/ Left)<br>When did this pain start? | Constant / Daily / On-and-Off / Dull / Ache / Burning / Pressure / Sharp / Stabbing / Tight / Cramping / Tingling / Numb / Radiating / Deep / Sore / Throbbing |
| □ **Neck** Pain<br>When did this pain start? | Constant / Daily / On-and-Off / Dull / Ache / Burning / Pressure / Sharp / Stabbing / Tight / Cramping / Tingling / Numb / Radiating / Deep / Sore / Throbbing |
| □ **Low Back** Pain<br>When did this pain start? | Constant / Daily / On-and-Off / Dull / Ache / Burning / Pressure / Sharp / Stabbing / Tight / Cramping / Tingling / Numb / Radiating / Deep / Sore / Throbbing |

1. Have you had any previous testing, workup, or imaging for the above selected conditions? Y / N

2. Loss of Function or Paralysis? Y / N 3. Bowel/Bladder incontinence? Y / N 4. Sleep issues? Y / N 5. Motor Weaken? Y / N

If Yes, then who did you see and what was done?_____

Have you tried TENS therapy? Y / N Do you Stumble? Y / N Fallen? Y / N Do you have to hold on to walls/furniture? Y / N

Failed treatments:_____

## ASSIGNMENT OF BENEFITS

**Assignment of Benefits & Payment Responsibility to Dr. Andre White DC, Dr. Glenn Robinson DC, Dr. Jeffery Getbehead DC, and Calhoun Chiropractic (referred to as "Providers")**

**Legal Assignment of Insurance Benefits: In exchange for and in connection with any and all of the service(s) provided to me ("Services") by Providers, I hereby Irrevocably assign to Providers all of my rights, benefits, privileges, protections, claims, and any interests of any kind whatsoever, without limitation, including, but without limitation, direct payment to Providers for the Services, appealing rights, rights to fiduciary duties, rights to sue, rights to payment, rights to penalties or interest, rights to plan documents, and rights to Information, notices, and disclosures from any source, (collectively "Rights") that I had, have or may have In the future pursuant to or in connection with any Insurance plan, health benefit plan; trust, fund, or any other source of payment, insurance, indemnity or health or medical coverage of any kind (collectively "Health Coverage"), such that I am hereby transferring all and retaining none of these Rights under any Health Coverage to which I am now, previously, or may be entitled to in the future. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, I Instruct my applicable Insurance plan, health benefit plan, trust, fund, or any other source of payment, insurance, Indemnity, or health or medical coverage of any kind to please advise and disclose to Providers In writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment Is waived on any pending claims for benefits under the respective policies. I agree that, should the amount received be insufficient to cover the entire claim I will be responsible for payment of any coinsurance and/or deductible that remains unpaid by my health Insurance company, workman's compensation plan, and/or auto accident insurance; I will be responsible to Providers for payment of the entire invoice. 2. Denial of Claim: I understand that Providers will make every effort to obtain payment of all health care services or products provided by providers from my Insurance company. I agree that I will be jointly and severally financially responsible for any portion of the Providers invoice that Is not paid; I understand that I am responsible for any health insurance deductibles and co-payments; 0 hereby irrevocably assign the benefits payable for any services rendered by Providers to me and authorize Providers to submit a claim to any medical Insurance company that I may have for payment to Providers. 3. One Time Claim Submission: I understand that Providers will make every effort to obtain payment for all services and or products provided by workman's compensation plan and/or auto accident Insurance, Providers will look to me for payment of any Providers services and/or products supplied to me. I agree that I will be jointly and severally financially responsible for any portion of the claim, in whole and in part, that is not paid. 4. I certify that the Information given by Patient to Providers In applying for payment to my workman's compensation plan and/or auto accident Insurance or any other medical Insurance that I may have, is correct. I agree that if assigned insurance benefits owed to Providers by me are paid to me, I shall Immediately notify Providers of such, and immediately endorse benefits check to Providers. 5. Appointment as Authorized Representative And Right to Sue: I hereby designate Provider's as my duly authorized representative In connection with all matters arising from or relating to Services, Rights and Health Coverage, such that Providers completely and without reservation stands in my shoes and takes my place for all purposes, and is granted absolute power and legal authority to do, seek, claim, appeal or obtain anything that I would have been entitled to do, seek, claim, appeal, or obtain In my own capacity pursuant to or in connection with the Services, Rights or Health Coverage, In any appeal, review, grievance, or any other process, procedure or entitlement under any Health Coverage. 6. Agreement to Cooperate: In addition, I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by, and Health Coverage, to effectuate, perfect, confirm or validate my assignment and/or authorization of Providers as my authorized representative, and I promise to assist and cooperate with Providers as a needed or reasonably requested by Providers In connection with any action In any forum, whether legal, formal or informal, without limitation, commenced or maintained by Providers in connection with the Services or relating to any Rights provided under Health Coverage. I understand that, In the event I don't fulfill any of the above obligations, I will remain personally liable for payment of the Services to the extent of the law.**

**By signing below, I acknowledge my authorization of treatment and receipt of all documentation in accordance with my treatment.**

Signature of Beneficiary/Participant/Parent/Legal Guardian Printed Name of Beneficiary/Participant/Parent/Legal Guardian Date

**PATIENT CONSENT FOR COMMUNICATION:**

We have the ability to call or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign. Patients in our practice may be contacted via phone/text message to be reminded of an appointment, to obtain feedback on an experience within our office, and to provide general health reminders/information.

1. I consent to receiving appointment reminders and other healthcare communications via telephone from Calhoun Chiropractic. _____(initial)
2. I consent to receive text messages from Calhoun Chiropractic at my cell phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is: (_____)-_____-_____
   Carrier:_____ _____(initial)
3. I consent to emails, to receive communications as stated above. The email that I authorize to receive email messages for general health reminders/feedback/information is:_____ _____(initial)

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. _____(initial)

Signature:_____ Date: _____

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

I acknowledge that I have received Calhoun Chiropractic's Notice of Privacy Practices for protected health information.

Date:_____ Name of Patient: _____ (DOB)_____

Signature of Patient/ Personal Representative:_____

Documentation of Good Faith Effort to Obtain Written Acknowledgment (Done By Office Staff):

I made a good faith effort to obtain the patient's written acknowledgment of our Notice of Privacy Practices for protected health information by (check all that apply):

- o Showing the patient the Notice of Privacy Practices posted in our office.
- o Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- o Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- o Asking the patient to sign this Acknowledgment form.
- o Other (explain in detail)_____

I was unable to obtain the patient's written Acknowledgment because (check all that apply):

- o The patient refused to sign this form.
- o The patient would not sign the form because the patient said he/she did not understand the Notice.
- o Other
  (explain in detail)_____

Date:_____ Name:_____

## Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) of chiropractic at this office and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor(s) of chiropractic at this office. I have had an opportunity to discuss with the doctor(s) of chiropractic at this office and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor(s) 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 time, based upon the facts then known is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and I have read, or have had read to me, 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.

Initial_____

## Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Initial_____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Calhoun Chiropractic will prepare any necessary reports and forms to assist me in making a collection from the insurance company. I authorize payment of insurance benefits directly to Calhoun Chiropractic. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date:_____