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Louisville, KY 40223
(502) 785-4641

Welcome to Total Body Chiropractic!

Thank you for completing our New Patient Intake Forms. Your detailed and accurate information will assist us in understanding your condition which will allow us to provide the best treatment possible.

Patient and Payment Information

Patient Name: _____ Birthday: _____ SSN: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home#: _____ Cell#: _____ Email: _____

Height: _____ Weight: _____ Emergency Contact: _____ Emergency Phone: _____

Occupation: _____ Employer: _____ Work Duties: _____

Primary Care Phys.:_____ Sex: ☐ M ☐ F Married: ☐ Yes ☐ No # of Children: _____

Payment: ☐ Personal Insurance ☐ Self Pay ☐ Third Party Insurance Co.: _____

Are you the Policy Holder? ☐ Yes ☐ No if not: Primary Name: _____ Primary DOB: _____

Do you have a secondary policy? ☐ Yes ☐ No Do you have a Health Savings Account? ☐ Yes ☐ No

***Please be advised that payment is due at the time of service.**

Health History

Current Medications and Supplements: _____

Please list Allergies: _____

Broken Bones: ☐ Yes ☐ No Explain: _____ When?: _____

Sprains or Strains: ☐ Yes ☐ No Explain: _____ When?: _____

Surgeries: ☐ Yes ☐ No Explain: _____ When?: _____

Hospitalized: ☐ Yes ☐ No Explain: _____ When?: _____

Auto Accident: ☐ Yes ☐ No Explain: _____ When?: _____

Please select any conditions you have:

☐ Recent Fever/Rheumatic Fever
☐ Diabetes
☐ High/Low Blood Pressure (circle)
☐ Stroke or Blood Clots
☐ Corticosteroid Use (prednisone, etc.)
☐ Taking Birth Control
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain: _____)
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Prostate Problems
☐ Menstrual Problems
☐ Hormones/Thyroid Issues
☐ Urinary Problems/Kidneys/Bladder

☐ Abnormal Weight Gain/Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Cold Extremities
☐ Alcohol/Drug Dependence
☐ Concussion
☐ Sinus Trouble
☐ Anemia
☐ Back Pain/Sciatica
☐ Neck Pain or Spasms
☐ Digestion Problems/Constipation
☐ Heart Complications
☐ Currently Pregnant (# Weeks: _____)

☐ Arteriosclerosis
☐ Gout
☐ Lung Condition (asthma, bronchitis, etc.)
☐ Bruise Easily
☐ Fibromyalgia
☐ Hand or Wrist Pain
☐ Headaches
☐ HIV/Aids/Blood Infections
☐ Skin Infections
☐ Bleeding Disorders
☐ Psychological Problems
☐ Neuritis/Numbness/Neuro disorders
☐ MS/Muscular Dystrophy
☐ Deep Vein Thrombosis
☐ Other: _____

Family History:
☐ Cancer
☐ Heart Problems/Heart Disease
☐ Other: _____

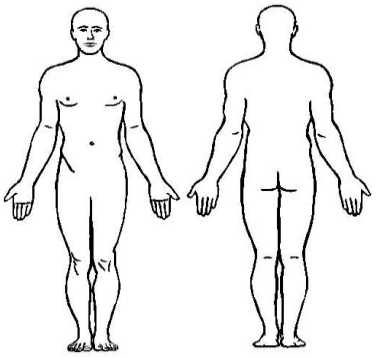
☐ Neurological Disorders
☐ Circulation Problems

☐ Alzheimer's Disease
☐ Rheumatoid Arthritis/Arthritis

Primary Complaint

Please circle ONLY ONE area of complaint on the body below then <u>answer all questions</u> for that area.

☐ Wellness ☐ Acute Complaint (less than 30 days) ☐ Sub-Acute Complaint (30 - 90 days) ☐ Chronic Discomfort (more than 90 days) ☐ Injury (Auto/Work/Fall) ☐ Other



(circle area of complaint)

Choose all that apply: ☐ Sharp ☐ Aching ☐ Burning ☐ Numbing ☐ Shooting ☐ Dull ☐ Throbbing ☐ Diffuse ☐ Tingling ☐ Tightness

Average Pain intensity in last 24 hours: 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable pain

Average Pain intensity in last week: 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable pain

Is the discomfort: ☐ Constant (76-100%) ☐ Frequent (75-51%) ☐ Intermittent (26-50%) ☐ Occasional (0-25%)

Date problem began: _____ Have you had this problem before? ☐ Yes ☐ No

Describe how it began: _____

Do your symptoms interfere with your daily activities? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Aggravates the condition?: _____ Improves the condition?: _____

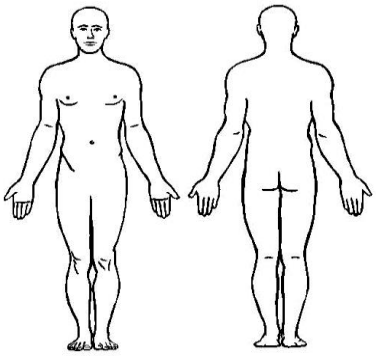
Have you received professional treatment for this issue? ☐ Yes ☐ No explain: _____

Have you had x-rays taken of the area of complaint? ☐ Yes ☐ No if yes, when and where?: _____

Secondary Complaint (if applicable)

Please circle ONLY ONE area of complaint on the body below then <u>answer all questions</u> for that area.

☐ Wellness ☐ Acute Complaint (less than 30 days) ☐ Sub-Acute Complaint (30 - 90 days) ☐ Chronic Discomfort (more than 90 days) ☐ Injury (Auto/Work/Fall) ☐ Other



(circle area of complaint)

Choose all that apply: ☐ Sharp ☐ Aching ☐ Burning ☐ Numbing ☐ Shooting ☐ Dull ☐ Throbbing ☐ Diffuse ☐ Tingling ☐ Tightness

Average Pain intensity in last 24 hours: 0 1 2 3 4 5 6 7 8 9 10
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Aggravates the condition?: _____ Improves the condition?: _____

Have you received professional treatment for this issue? ☐ Yes ☐ No explain: _____

Have you had x-rays taken of the area of complaint? ☐ Yes ☐ No if yes, when and where?: _____

Chiropractic Experience and Goals for Care

Who may we thank for referring you to our office?: _____

Have you been adjusted by a chiropractor before?: ☐ Yes ☐ No By Who?: _____

What was the reason for those visits?: _____ Date of last adjustment: _____

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ I want the doctor to select the type of care appropriate for my condition

☐ Relief Care: Symptomatic relief of pain or discomfort

☐ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

☐ Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care

Consents and Privacy

Consent to Treatment

I hereby request and consent to the performance of chiropractic and other procedures, including but not limited to x-rays and various modes of rehabilitative therapies on me/child (or the patient named below, for whom I am legally responsible) by the licensed physician and/or other healthcare providers who now or in the future work at our office listed above. I understand that results are not guaranteed. I understand that in the practice of chiropractic and other applicable methods of treatment, there are risks to treatment, including but not limited to fracture, disc injuries, stroke, dislocation, and sprains. I do not expect the physician to be able to anticipate and explain all the risks and complications. I wish to rely upon the physician to exercise judgment during the course of treatment, which the physician feels at the time, based on the facts known and information provided to her, is in my best interest. I have read, or have had read to me, the consent. By signing below, I state that I give consent to be treated and understand the risks and possible complications. I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I see treatment.

_____ Initials

Right to Submit Billing

Total Body Chiropractic will file your claims with your insurance company as a courtesy to you. You will be responsible for your deductible and/or copayments at the time of treatment. If your insurance company does not pay for something anticipated, you will be responsible for that amount as soon as we/you are aware of the denial. We offer affordable payment plans for each patient who has a care plan based on the individual condition. This allows patients to receive proper care while minimizing costs.

_____ Initials

Acknowledgement of Receipt of Notice or Privacy Practices

I acknowledge I have been offered a copy of Total Body Chiropractic's Notice of Privacy Practices. This notice discloses how Total Chiropractic may use and disclose my health information, the restrictions of use and my rights of privacy.

_____ Initials

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian (If patient is under 18 years of age) Date

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

Name _____ Date _____
Print Patient's Name

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.

Name _____ Date _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By _____
Signature of Parent/Guardian (circle one)