Electronic Health Records Intake Form

Due to changes in government health care, providers are required to report on the following information.

First Name: _____ **Last Name**: _____

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Everyday Smoker / Occasional Smoker / Former Smoker / Never Smoked

The government requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage & Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date

□ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Signature: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure: _____ /_____

Application For Care

Welcome _____ **to our place of hope!**
Last First MI

Today _____ you have entered a journey of optimum health...
Date

I was referred to Fontana Family Chiropractic by: _____

I understand that Fontana Family Chiropractic is built by referrals. **I Do or Do Not (*circle one*)** give permission to use my name and/or picture in giving thanks for my future referrals and in any "in house" marketing.

I prefer to be called _____. I am (☐ male ☐ female) and was born into this amazing world on:_____/_____/_____ making me _____ years young. I was assigned the SS#: _____
Month Date Year Age

but understand that I am not a number, but a member of a family that looks for the underlying cause of DIS-EASE
My mailing address is: _____
Address City/State Zip

If needed, I can be reached at the following:

Cell # _____ Home #_____ Work # _____

Email _____

Emergency Contact _____ Relationship _____ Phone # _____

I give permission to receive emails and text messages for appointments, events, notifications, etc. **Yes or No**

My employer is _____ and I have worked there for _____ years.

I am a_____ by trade and I am currently ☐ Married ☐ Single ☐ Minor ☐ Divorced ☐ Separated ☐ Widowed
Occupation

The following is a list of my family members:

Spouse	**DOB**	**Age**
Children	**DOB**	**Age**
Children	**DOB**	**Age**
Children	**DOB**	**Age**

I am _____tall and my weight is _____. My shoe size is _____and I wear a (**narrow, medium, wide**) shoe.

1. Science tells us your spine should be cared for regularly. How often do you or have you been adjusted by a Chiropractor?

   Frequently When I Hurt 1x Month Never

2. Research shows poor posture leads to an early death. How do you rate your posture?

   Poor 1 2 3 4 5 6 7 8 9 10 Excellent

3. ***Subluxations*** **(**spinal misalignment) over time will cause degeneration (arthritis) to the spine. The major cause to these subluxations is stress. Stress accelerates spinal damage. What is your stress level over the last 3 months?

Calm/Relaxed 1 2 3 4 5 6 7 8 9 10 Very Tense/Tight

Please turn over

4. While we realize prescription medications are sometimes necessary they are also one of the leading causes of death in the U.S. and may hinder your body's ability to heal. Please list any medications you are taking: _____
_____

5. Subluxations often result from daily trauma, auto accidents, work trauma, etc., and can all lead to serious spinal problems. When was your most recent injury? Home _____ Car Accident _____ Slip or Fall _____

6. Subluxations often go unrecognized until they lead to a state of disease, medical conditions/complaints or sometimes unnecessary procedures. Please circle **Y or N** to any of the following that may relate to you.

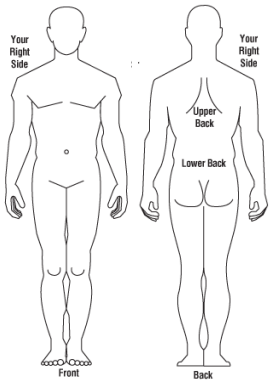
Y N	Heart Attack/Stroke	**Y N**	Heart Surg/Pacemaker	**Y N**	Heart Murmur	**Y N**	Congenital Heart Defect	**Y N**	Mitral Valve Prolapse
Y N	Artificial Valves	**Y N**	Difficulty Breathing	**Y N**	Venereal Disease	**Y N**	Hepatitis	**Y N**	HIV+/AIDS/ARC
Y N	Shingles	**Y N**	Cancer	**Y N**	Frequent Neck Pain	**Y N**	Glaucoma	**Y N**	Anemia/Diabetes
Y N	High blood Pressure	**Y N**	Psychiatric Problems	**Y N**	Rheumatic Fever	**Y N**	Severe/Frequent Headaches	**Y N**	Kidney Problems
Y N	Ulcers/Colitis	**Y N**	Fainting/Seizures/Epilepsy	**Y N**	Sinus Problems	**Y N**	Emphysema/Asthma	**Y N**	Tuberculosis
Y N	Digestive Problems	**Y N**	Alcohol/Drug Abuse	**Y N**	Lower Back Problems	**Y N**	Artificial Bones/Joints/Implants	**Y N**	Arthritis

7. Please list any surgeries with dates and/or other medical condition(s) not listed above:
_____
_____

8. ***Women Only*:** Spinal Health is vitally important to ensure a healthy pregnancy and birth of a miracle. Is there a chance that you are pregnant? **Y or N** Are you currently taking birth control to make your body act as if it is pregnant? **Y or N**

9. Please list any nutritional supplements you are currently taking: _____
_____

10. How do you rate your eating habits? **Unhealthy 1 2 3 4 5 6 7 8 9 10 Healthy**
11. Are you interested in learning more about how your eating habits and supplementation can improve your health? **Y or N**
12. Understanding the importance of regular exercise, how often do you exercise? _____ Hrs./Wk.
13. In 1958 the CDC stated smoking does not cause cancer. Today we know this is not true. Do you smoke? **Y or N**
14. If yes, how much? _____ For how long? _____
15. **Briefly describe your symptoms:** _____
_____
16. **How did your symptoms start?** _____
_____



Pain Diagram

Please complete the following "Pain diagram" by using letters to indicate your areas of pain.

P - Pain
T - Tingling
N - Numbness
B - Burning
S - Stiffness

17. **Average Pain Intensity:**
Last 24 hours: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain**
Past Week: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain**

18. How often do you experience your symptoms?
1 - Constantly (76%-100% of the time) 2 - Frequently (51%-75% of the time) 3 - Occasionally (26%-50%of the time) 4 - Intermittently (0%-25% of the time)

19. How much have your symptoms interfered with your usual daily activities? (Including both work outside the home and housework)
1 - Not at all 2 - A little bit 3 - Moderately 4 - Quite a bit 5 - Extremely

20. In general, would you say your overall health right now is…
1- Excellent 2 - Very good 3 - Good 4 - Fair 5 - Poor

I have read the HIPPA Guidelines and understand that my health information will not be shared with anyone without my consent.

_____ _____
Signature **Date**

Welcome to our place of HOPE!
We look forward to serving you along your journey to greater health…

Informed Consent for Chiropractic Care

Nature of Chiropractic Care: The doctor will use his/her hands or a mechanical device in order to adjust your joints, thus allowing the nerves to work without impairment. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked;" this noise is from gas bubbles stored within the joint. You may also feel the movement of the joint. Various ancillary procedures such as hot or cold pack, or electric muscle stimulation may also be used.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation complex; however, if during a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will inform you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Possible Risks and Occurrences: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include muscular strain, ligamentous sprain, fractures of bone, rib injury, soft tissue injury, dislocations of joints, or injury to intervertebral disc, nerve or spinal cord. The risk of these complications due to chiropractic care have been described as "rare," about as often as complications of taking a single tablet of aspirin. A minority of patients may notice stiffness or soreness after the first few days of care. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. This risk has been estimated between one in one million and one in ten million. The risk is even further reduced by screening procedures. The ancillary procedures could produce skin irritation, burns, or other minor complications. The probability of this happening is also considered "rare."

Other Treatment Options through Medical Means:

Over-the-Counter Analgesics: *The risks of these medications include irritation to the stomach, liver, and kidneys in a significant number of cases.*

Medical Care: *Typically, anti-inflammatory drugs, tranquillizers, and analgesics. Risks of these drugs include a multitude of undesirable effects and patient dependence in a significant number of cases.*

Hospitalization: *In conjunction with medical care adds the risk of exposure to virulent communicable disease in a significant number of cases.*

Surgery: *In conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as extended convalescent period in a significant number of cases.*

Remaining Untreated: *Delay in care 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 care will complicate the condition and make future rehabilitation more difficult or impossible.*

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

Printed Name	Signature	Date

Practice Member Financial Agreement

1. **Insurance**: I understand that Chiropractic will submit insurance claims as a courtesy to you, our practice member. We will call and verify your benefits, but please be advised…….

   Quotation of benefits **IS NOT** a guarantee of payment by an insurance company. You will be subject to the terms and limitations of your policy and any exclusion that may apply at the time.
   It is your responsibility to pay all deductible amounts, co-pays, co-insurance and any other amounts left uncovered by insurance.

   Co-pays and co-insurance will be expected to be paid **AT TIME OF SERVICE**.

   In the event that an insurance company would reject or deny your claim, it will be the practice member's responsibility to pay any remaining balances and pursue re-imbursement from the insurance company.

2. **Non-Insurance Dependent**: I understand that I am financially responsible for all services rendered and that all charges are to be paid **AT TIME OF SERVICE**.

3. **Credit and Collection:** I understand that any balance left outstanding is expected to be paid within **10 days**. If the balance becomes past due, you will receive a letter stating that you have 20 days to pay the outstanding balance in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency and will incur a $400 administration fee. If legal action should become necessary to enforce payment of any charges, I agree to be responsible for and pay all attorney's fees and court costs incurred.

I HAVE READ THE ABOVE FINANCIAL AGREEMENT POLICIES AND AGREE TO THE TERMS OF THESE POLICIES.

_____ _____

I hereby agree to abide by the above provisions: Date
Practice Member signature