TOV CHIROPRACTIC

Intake Paperwork

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced Do you have Insurance: ☐ Yes ☐ No Have you served in the military: ☐ Yes ☐ No

Employer: _____ Occupation: _____ Student: ☐ Yes ☐ No

Spouse's Name: _____ Spouse's Employer: _____

Do you have Children? ☐ Yes ☐ No | Ages: _____ Are you Pregnant? ☐ Yes ☐ No | Due Date _____

Name & Number of Emergency Contact: _____ Relationship: _____

How did you find out about TOV Chiropractic? _____

What is your main goal for coming here today: _____

_____

HISTORY OF CURRENT HEALTH CONCERNS

	List Concerns According to Severity	Rate of Severity 0 = No Pain 10 = Unbearable	When did this problem start?	Have you had this problem before?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary	_____	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____	_____
Fourth	_____	_____	_____	_____	_____	_____

Have you seen other doctors for these conditions? □ Yes □ No If Yes: □ Chiropractor □ Medical doctor □ Other_____

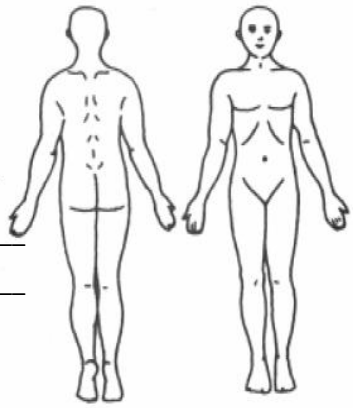
Name of Previous Chiropractor: _____ ☐ **N/A** Name of MD: _____ ☐ **N/A**

When?_____ Results?_____

When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

What relieves your symptoms? _____ What makes your symptoms feel worse? _____

PLEASE MARK the areas on the Diagram with the following **LETTERS** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling
Indicate where pain travels with arrows



List any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

List **PRESCRIPTION** & **NON-PRESCRIPTION DRUGS** you take, and provide a **REASON** for taking each one:

_____

_____

_____

Mark "**C**" For **Current** Health Concern or Mark "**P**" For **Past** Health Concern:

__Acid Reflux
__ADD/ADHD
__Allergies
__Anxiety
__Arthritis/Joint Pain
__Asthma
__Bed Wetting
__Bladder Issues
__Cancer
__Chronic Colds
__Constipation
__Depression
__Diabetes
__Diarrhea
__Difficulty Breathing
__Digestive Issues
__Disc Issues
__Dizziness
__Double/Blurry Vision
__Ear Infections
__Epilepsy/Convulsions
__Fatigue
__Fibromyalgia
__Food Sensitivity
__GERD/Gastric Reflux
__Headaches
__Hearing Loss
__Heart Attack
__Heart Issues
__High/Low Blood Pressure
__Infertility
__Irritability
__Kidney Issues
__Loss of Balance
__Loss of Energy
__Memory Loss
__Menstrual Issues
__Migraines
__Muscle Spasms
__Muscle Weakness
__Nausea
__Nervousness
__Numb/Tingling in Arms/Hands
__Numb/Tingling in Legs/Feet
__Plantar Fasciitis
__Poor Circulation
__Poor Posture
__Prostate Issues
__Ringing in the Ears
__Sciatica
__Scoliosis
__Seizures
__Sexual Dysfunction
__Shortness of Breath
__Sinus Issues
__Skin Problems
__Sleep Issues
__Spinal Bone Fracture
__Spinal Surgery
__Sports Injury
__Stiffness
__Stroke
__Thyroid Issues
__Tight/Sore Muscles
__Tremors
__Ulcers
__Weight Loss/Gain
__Vertigo

Pacemaker: Y N

PAIN
__Arm
__Chest
__Foot
__Hip/Leg
__Jaw/TMJ
__Knee
__Lower Back
__Mid Back
__Neck
__Shoulder
__Stomach
__Upper Back
Other_____
_____
_____
_____
_____

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS) / PAIN ASSESSMENT

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ Worst possible pain

Back pain **Headaches**

0 1 2 (3) 4 5 6 7 (8) 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your hours awake is your pain at its <u>best</u>? _____%

4. What is your pain level at its WORST?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your hours awake is your pain at its <u>worst</u>? _____%

PAST HISTORY

Have you ever been in an auto accident? ☐ Yes ☐ No List all accidents:_____

_____

Please list any **ADDITIONAL** Injuries and/or Health Concerns, that have **NOT** been previously mentioned:

_____

_____

SOCIAL HISTORY

1. Smoking: ☐ Cigars ☐ Pipe ☐ Cigarettes ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Exercise: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. Have you consumed any caffeine or products with caffeine in the past 48 hours? ☐ Yes ☐ No

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Heavy Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Showering/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit for Extended Time	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stand for Extended Time	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

What do your symptoms keep you from doing?

_____

_____

_____

FAMILY HISTORY

This form is to assist Dr. Ethan and TOV by providing past health history information for their review.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ADD/ADHD					
Allergies					
Alzheimer's					
Anxiety					
Arthritis/Joint Pain					
Asthma					
Back Pain					
Bed Wetting					
Blurred Vision/Double Vision					
Breathing Problems					
Cancer					
Depression					
Diabetes					
Dizziness					
Ear Infections					
Fibromyalgia					
Headaches					
Hearing Loss					
Heart Disease					
Heart Problems					
High Blood Pressure					
Hip/Leg Pain					
Infertility					
Jaw/TMJ Pain					
Loss of Energy					
Low Blood Pressure					
Neck Pain					
Nervousness					
Poor Posture					
Sciatica					
Shoulder Pain					
Sinus Issues					
Sleep Issues					
Stomach Problems					
Stroke					
Thyroid Problems					

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD or via e-mail will be available within 72 hours of request. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. I understand that even though x-rays are medically beneficial and will assist Dr Ethan in determining the severity of my case and my chiropractic recommendations, diagnostic x-rays are not always considered medically necessary under insurance guidelines and therefore, diagnostic x-rays will only be billed to insurance when deemed medically necessary under insurance guidelines. I will be responsible to cover the expense of my x-rays. The doctor of TOV Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

_____ _____ - _____ - _____

Printed Name **Date of Birth**

_____ _____ - _____ - _____

Signature **Date Completed**

FEMALES ONLY: *To the best of my knowledge,* ***I BELIEVE I AM NOT PREGNANT*** *at the time x-rays are taken at TOV Chiropractic.*

Signature: _____ **Date**: _____ - _____ - _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

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

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____ - _____ - _____

Signature **Date Completed**

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

- I authorize and request payment of insurance benefits directly to Ethan Germscheid, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

_____

Printed Name

_____ _____ - _____ - _____

Signature **Date Completed**

CHILD/MINOR INFORMED CONSENT FOR CHIROPRACTIC CARE

If This Health Profile Is For A Child/Minor, Please Fill Out And Sign Below
Written Consent For A Child

Name of practice member who is a minor/child: _____

I authorize Dr. Ethan Germscheid and any and all TOV Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my child/minor. As of this date, I have the legal right to select and authorize health care services for my child/minor. If my authority to select and authorize care is revoked or altered, I will immediately notify TOV Chiropractic.

Guardian Signature: _____ Date: _____ - _____ - _____

Relationship to Child/Minor: _____