Bakeris Family Chiropractic Patient Intake Form

Please print and complete form, and bring to your first appointment.

Full Name: _____ Birth Date: ___/___/___ Age: ___ Today's Date: ___/___/___
Address: _____
City: _____ State: _____ Zip: _____
Home #: (____) _____ Mobile #: (____) _____ Soc. Sec. # _____
Email: _____
Male ____ Female ____ Women only: Are you Pregnant? Y N Marital Status: S M W D
# of Children: _____ What are their ages? _____
Your occupation: _____ Place of Employment: _____
Name of spouse (parent if under 18) _____ D.O.B of spouse (parent) ___/___/___
How did you hear about our office? _____
Method of Payment please circle those that apply: Cash Check Credit Card Insurance

Patient History

Reason for seeking chiropractic care:

_____

How long have you had this problem?

_____

Do you have any other problems that you would like the doctor to evaluate?

_____

Have you ever had chiropractic care? Y N When was your last treatment? _____

Other doctors/chiropractors you've utilized: _____

Are you under a doctor's care presently for any type of health condition?

_____

The health of your family is important for a complete evaluation of your health. Please list any health conditions/concerns you have about your:

Children: _____ Spouse: _____
Parents: _____ Siblings: _____
Grandparents: _____ Familial diseases: _____

Have you had any broken bones? Y N Which bones? When? _____

_____

Have you undergone any type of surgery? Y N What kind of surgery? Where? When? _____

_____

Have you had any soft tissue injuries (sprains/strains)? Y N What type of injury? Where? When? _____

_____

Have you ever been in any past auto accidents, work injuries, or falls? Y N Where? When? _____

_____

By my signature, I hereby certify that the statement/s and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

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Please answer or fill in some information below for your health history:
Do you have any allergies? Y N What are you allergic to? _____
Have you ever smoked? Y N Do you currently smoke? Y N
Are you taking any medications? Y N Please list: _____
Are you taking any supplements? Y N Please list: _____
Please list any childhood illnesses you've had: _____
_____
Please list any adult illnesses you've had: _____
_____
Do you think you are getting enough sleep? Y N
Do you think you are getting enough physical activity? Y N
Do you think your diet is fairly healthy? Y N
Have you had any unexplained weight loss or gain? Y N
Do you think your stress level is high? Y N

Please indicate if you have any of the following by checking the box.

Constitutional	□ None □ daytime drowsiness □ fever □ night sweats □ chills □ fatigue □ loss of appetite
Eyes/Vision	□ None □ cataracts □ itching □ wear contacts/glasses □ blindness □ double vision □ photophobia □ blind spots □ eye problems □ tearing
Ears, Nose, & Throat	□ None □ history of head injury □ runny nose □ dizziness □ sore throat □ loss of sense of smell □ sinus infection □ ear discharge □ headaches □ ear pain □ hearing loss □ congestion
Respiration	□ None □ cough □ shortness of breath □ wheezing □ asthma □ coughing up blood □ sputum
Cardiovascular	□ None □ high blood pressure □ low blood pressure □ paroxysmal nocturnal dyspnea □ ulcers □ varicose veins □ claudication (leg pain and ache) □ orthopnea (difficulty breathing lying down) □ shortness of breath with exertion □ heart problem □ heart murmur □ palpitations
Gastrointestinal	□ None □ belching □ difficulty swallowing □ jaundice □ abdominal pain □ black/tarry stool □ heartburn □ ulcers □ abnormal stool (color/consistency) □ constipation □ hemorrhoids □ rectal bleeding □ diarrhea □ indigestion □ loss of bowel control
Female	□ None □ birth control □ frequent urination □ vaginal discharge □ abnormal vaginal bleeding □ breast lump/pain □ hormone therapy □ urine retention/incontinence □ burning urination □ irregular menstruation □ cramps My menses… □ are regular □ are NOT regular If you have been pregnant in the past, please fill in the appropriate information below: _____Number of C-sections _____Number of vaginal deliveries _____Number of miscarriages _____Number of complicated pregnancies
Male	□ None □ burning urination □ frequent urination □ prostate problems □ erectile dysfunction □ hesitancy/dribbling □ urine retention/incontinence
Skin	□ None □ change in skin color □ history of skin disorders □ rash □ change in nail texture □ hair loss □ itching □ skin lesions/ulcers □ hives □ numbness □ varicosities
Nervous System	□ None □ limb weakness □ seizures □ stroke □ dizziness □ loss of consciousness □ headache □ sleep disturbance □ unsteadiness of gait/loss of balance □ facial weakness □ loss of memory □ slurred speech □ numbness
Psychological	□ None □ bi-polar disorder □ depression □ memory loss □ anxiety □ confusion □ insomnia □ mood change □ behavioral change □ convulsions
Hematologic	□ None □ blood transfusion □ anemia □ blood clotting □ bruise easily □ lymph node swelling

Describe any health additional problems, and include duration:
_____

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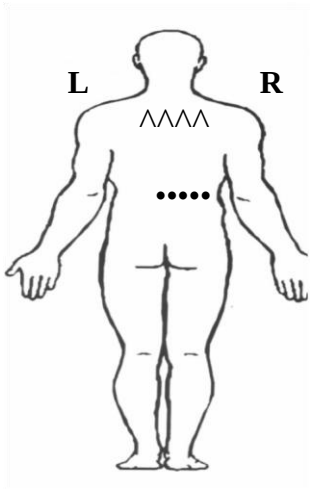
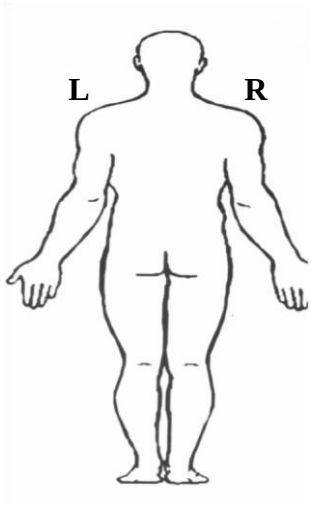
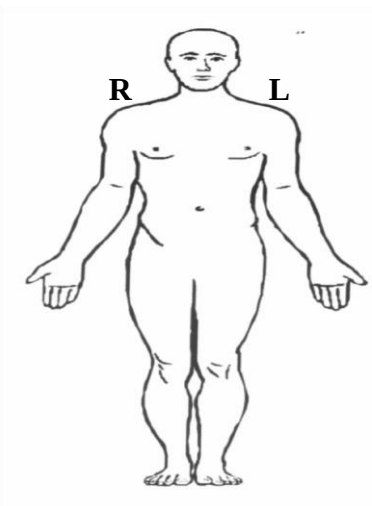


Example



Back



Front

Please mark the bodies above with these symbols to describe the sensation in the affected area(s):

Numbness:	Pins & Needles:	Burning:	Aching:	Stabbing:
- - - - -	OOOOOO	^^^^	xxxx	••••••••

Type of Condition:
Please check one
__ New Acute (pain)
__ Chronic
__ Recurrence (Acute)
__ New Injury
__ Exacerbation
(Increase in severity)

What makes symptoms better?
Please check all that apply
__ Sitting
__ Standing
__ Walking
__ Exercises
__ Lying down
__ Bending over
__ Rest

What makes symptoms worse?
Please check all that apply
__ Sitting
__ Standing
__ Lying Down
__ Lifting
__ Exercise
__ Getting up/down
__ Walking
__ Bending
__ Rest
__ Running

Onset: Please check all that apply
__ Gradual
__ Car Accident
__ Slip and Fall
__ Lifting Injury
__ Unknown
__ Work Injury
__ Sports Injury
__ Other: _____

Pain Scale: Please check the severity of your main complaints
__ 1 out of 10
__ 2 out of 10
__ 3 out of 10
__ 4 out of 10
__ 5 out of 10
__ 6 out of 10
__ 7 out of 10
__ 8 out of 10
__ 9 out of 10
__ 10 out of 10

Description: Please check all that apply
__ Aching
__ Burning
__ Numbness
__ Sharp
__ Shooting
__ Stabbing
__ Stiffness
__ Throbbing
__ Tingling

Frequency: Please check all that apply
__ Occasional: 25% of the time
__ Intermittent: 50% of the day
__ Frequent: 75% of the day
__ Constant: 100% of the day

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Daily Activities: Please check (x) all that are limited or painful:

__ No limitations are being experienced

__ Sitting

__ Sitting for more than 15 minutes

__ Sitting for more than one hour

__ Sitting all day

__ Standing

__ Standing for more than 15 minutes

__ Standing for more than one hour

__ Standing all day

__ Walking

__ Walking for more than 10 minutes

__ Walking for more than one half mile

__ Walking for more than one mile

__ Household Chores

__ Lift more than 10 pounds

__ Lifting 25+ pounds

__ Lifting more than 50 pounds

__ Caring for family member

__ Reading (concentration)

__ Going up/down stairs

__ Getting out of bed

__ Getting on/off the toilet

__ Self-care, bathing

__ Self-care, shaving

__ Self-care, dressing

__ Bending to tie/put on shoe

__ Kneeling e.g. weeding garden

__ Squatting

__ Reaching overhead

__ Driving Car

__ Getting into/out of car

__ Yard work

__ Pet care

__ Carry Groceries

__ Extended Computer Use

__ Feeding/Eating

__ Lifting Child

__ Sleeping

Difficulty with activity, with 10 being most difficult: 0 1 2 3 4 5 6 7 8 9 10

Pain with activity, with 10 being most pain: 0 1 2 3 4 5 6 7 8 9 10

Prescription Pain Medication, Dose/Frequency: _____

Over the counter pain medication, Dose/ Frequency: _____

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Assignment and Release

I, the undersigned certify that I (or my dependent) have (health or accident) insurance coverage with _____ and assign directly to Bakeris Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Any charges that are not covered by insurance will be immediately due and payable. Failure to pay by the final notice will result in a 40% late fee to cover the collections fee. (Payment is expected at the time of treatment. There is a 24 hour notice to cancel appointments, and you may be responsible for payment of a missed appointment.) I hereby authorize the doctors to release information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Relationship: _____ Date: _____

Informed Consent and Authorization for Chiropractic Treatment

You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo such care after being advised of the known risks. This disclosure is not meant to frighten or alarm you. It is simply to make you better informed in order that you may give or withhold your consent.

The profession of chiropractic (along with dentistry, medicine and surgery, nursing, optometry, osteopathic medicine and surgery, pharmacy, physical therapy, psychology, and others) are regulated in the state of Iowa under Iowa Code Chapter 147. Patient care and treatment provided by those above listed professions have known risks, which may include death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or scars.

Chiropractic is a science which concerns itself with the relationship between structure and function of the body, since it may affect the restoration and preservation of health. Adjustments are made by chiropractors to correct spinal and extremity joint misalignments. Adjustments are performed following an examination which may include, but not limited to spinal and physical examination, orthopedic and neurologic testing, palpation, and radiology examination.

An adjustment is the application of a quick, precise movement over a very short distance to the spine or extremity. There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. In addition, physiotherapy and/or rehabilitative procedures may be included in the management protocol.

Not only should you understand the benefits of chiropractic care and treatment in restoring and maintain good health, but you also should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to received chiropractic care. All health care procedures, including those used in carrying degrees, have some risks correlated with them. Risks correlated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological injury, fracture, vertebral artery syndrome including stroke and perhaps, death through complicating factors. Risks correlated with physiotherapy may include not only the foregoing but also allergic reaction, muscle and/or joint pain.

I have been informed of the nature and purpose of chiropractic care, possible consequences and risks of care, including risk that care may not accomplish the desired objective. Reasonable alternative treatment has been explained, including risks, consequences, and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of treatment and care.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED AND IT HAS BEEN EXPLAINED TO ME. ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE BAKERIS FAMILY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Date: _____

Patient's Name (Print) : _____ Patient's (Signature): _____

If patient is a minor, give relationship: _____

BAKERIS FAMILY CHIROPRACTIC

2411 Coral Court Suite 3
Coralville, IA 52241

Notice of Privacy Policy

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

This summary discloses how health information about you may be used. A full notice of your privacy rights is posted in the waiting area. You may also request to see a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

Bakeris Family Chiropractic uses Protected Health Information about you for the purposes of treatment, to obtain payment for treatment, administrative purposes, and to evaluate the quality of care that you receive. Understand this office will not condition your treatment or payment on whether you provide authorization for the requested use or disclosure.

Bakeris Family Chiropractic must retain the privacy of Protected Health Information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law. Private areas are available upon request in the office.

Bakeris Family Chiropractic will not disclose your information to provide appointment reminders, information about treatment alternatives or other health-related issues. Bakeris Family Chiropractic may disclose your information for health and safety of governmental functions in order to comply with workers compensation laws and regulations, and right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. Please let us know if there is any information you want to restrict or from anyone you want it restricted. You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing.

If there is anyone (spouse, parent, etc) that you want to have access to your Protected Health Information, please write down their information below. Otherwise, leave it blank.

Name	Date of Birth	Phone Number	Relationship	Date

If you are a **UNIVERSITY OF IOWA ATHLETE**, initial here _____, so Bakeris Family Chiropractic has permission to release or receive your medical information to/from the University of Iowa Sports Medicine team and/or coaches.

You may complain to the privacy/compliance officer, Dr. Kari Bakeris (319-545-4444), and to the Department of Health and Human Services if you believe your rights have been violated. You will not be retaliated against for filing a complaint.

By my signature below I give my permission to use and disclose my health information.

_____ _____

Patient or Legally Authorized Individual Signature Date

_____ _____

Print Patient's Full Name Time