Patient Intake Form

Patient information contained within this form is considered strictly confidential

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

TWO RIVERS CHIROPRACTIC

"Add years to life and life to years"

Patient Information Date:_____

Last Name:_____ First Name:_____ M.I___

Address:_____

City:_____ State:_____ Zip:_____

Phone: Home:_____ Cell:_____ Work:_____

Email:_____

Age:_____ DOB:_____ Gender: ☐ M ☐ F

SS#: (OPTIONAL)_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouses Name:_____

Children: ☐ Yes ☐ No

Employer:_____ Occupation:_____

Additional Information

Emergency Contact:_____ Relationship:_____

Phone Number:_____

Who is your:

Primary Care Physician:_____ Location:_____

Date of last visit:_____

Do you have health Insurance: ☐ Yes ☐ No If yes, please provide card (put copy on file)

What made you choose Two Rivers Chiropractic: ☐ Friend or Family Member?_____

☐ Sign ☐ Phone Book ☐ Internet ☐ Radio ☐ TV ☐ Referral ☐ Print

Have you ever received chiropractic care? ☐ Yes ☐ No

If yes, when and where?_____

What type of treatment did you receive?_____

_____

_____

Health Complaints:

☐ I have no health complaints, I am interested in prevention and supportive care (skip to next section)

What is your **Primary** complaint?_____

_____

Other Complaints:_____

Location of Complaint:_____

What was the initial cause of the complaint:_____

When did your symptoms appear?_____

What makes it feel better?_____ Worse_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Discomfort ☐ Other

Do your symptoms radiate (shoot) anywhere? ☐ Yes ☐ No If yes, where_____

Do you have any numbness or tingling?_____

How often do you experience the pain?_____

Is the pain? ☐ Constant(76-100%) ☐ Frequently(51-75%) ☐ Occasionally(26-50%) ☐ Intermittent(0-25%)

Is this complaint getting progressively worse? ☐ Yes ☐ No

Is the complaint worse in the..... ☐ Morning ☐ Evenings

Is it affecting activities of daily living? ☐ Yes ☐ No If yes, how?_____

Additional Notes:_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you presently under a doctor's care for this complaint? ☐ Yes ☐ No

List all doctors you have seen as result of your complaint:

Date: Doctor: Treatment:

1._____

2._____

3._____

Did you go to the emergency room? ☐ Yes ☐ No If yes, when?_____

Are you experiencing any of the following since your complaint started?

☐ Unexplained weightloss or malaise ☐ Recent fever/infection ☐ Neurological Deficit

☐ "Worst Headache Ever" ☐ Visual disturbances, difficulties in speech/swallowing, or alteration consciousness

☐ Nausea ☐ Dizziness ☐ Bowel/Bladder incontinence

If your injury is NOT due to an Automobile Collision, Please skip this section

Were you stopped? ☐ Yes ☐ No If no, approximate speed:_____mph

Was the other vehicle stopped? ☐ Yes ☐ No If no, approximate speed:_____mph

At impact, was your body straight in your seat? ☐ Yes ☐ No If no, turned to the ☐ left ☐ right

At impact, were you looking straight ahead? ☐ Yes ☐ No If no, was your head turned to the ☐ left ☐ right

Were you aware that you were about to be hit? ☐ Yes ☐ No

Were you wearing a seatbelt at the time of the accident? ☐ Yes ☐ No

Did your (chest/head) hit the steering wheel? ☐ Yes ☐ No

Did an airbag Deploy? ☐ Yes ☐ No

Did your head hit the (windshield/side window)? ☐ Yes ☐ No

Did your knees hit the dashboard? ☐ Yes ☐ No Did the seat break? ☐ Yes ☐ No

Do you have any (cuts/bruises) from the accident? ☐ Yes ☐ No If yes, where?_____

Was your car equipped with headrests? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

Pain Rating Scale:

What is your pain RIGHT NOW?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Unbearable

What is your TYPICAL or AVERAGE pain?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Unbearable

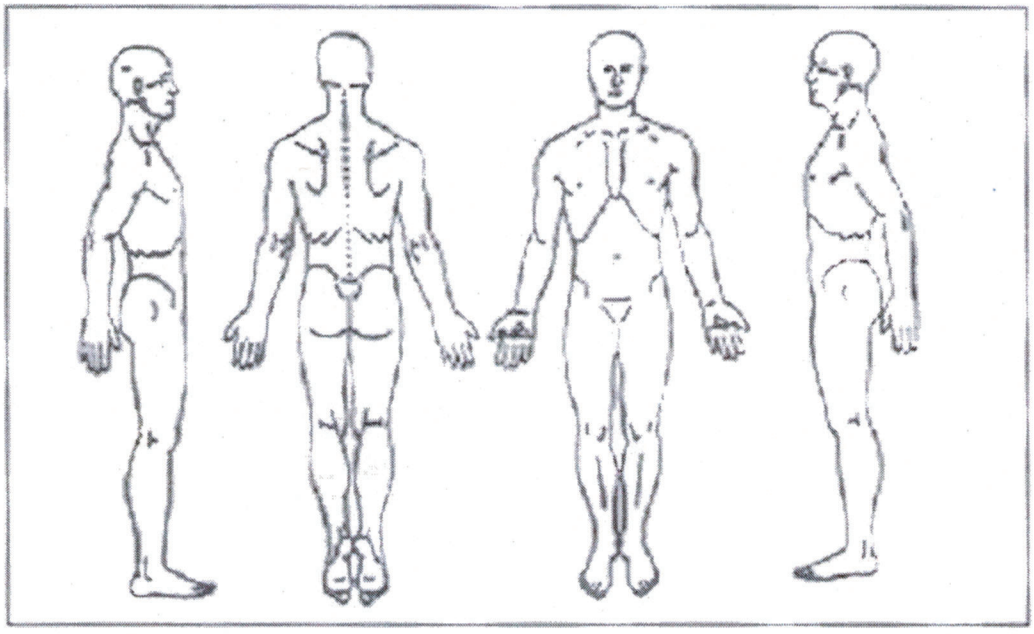
What is your pain AT ITS WORST?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Unbearable

Please mark your area(s) of pain on the figure below

A=ache N=numbness B=burning T=tingling S=stiffness O=other



Health History/Medical Conditions: Have you had any of the following

☐ Alcoholism	☐ Emphysema	☐ High Cholesterol	☐ Prostate Problems	☐ Anemia
☐ Epilepsy	☐ Kidney Disease	☐ Prosthesis	☐ Anorexia/Bulimia	☐ Eye Condition
☐ Liver Disease	☐ Psychiatric Illness	☐ Arthritis	☐ Fibromyalgia	☐ Lupus
☐ Scoliosis	☐ Asthma	☐ Fractures	☐ Lyme disease	☐ Skin Disorders
☐ Back/Neck Cond.	☐ Gall Bladder Disease	☐ Miscarriage	☐ Stroke	☐ Bleeding Disorder
☐ Gout	☐ Multiple Sclerosis	☐ Thyroid Problems	☐ Breast Lump	☐ Headache
☐ Neurological Cond .	☐ Tuberculosis	☐ Cancer	☐ Heart/Vascular Disease	☐ Osteoporosis
☐ Ulcers	☐ Hepatitis	☐ Pacemaker	☐ Urinary Tract Infection	☐ Chicken Pox
☐ Hernia	☐ Parkinsons Disease	☐ Venereal Disease	☐ Depression/Anxiety	☐ Herniated Disk

Past Health History

	Yes	No
Are you Pregnant?	☐	☐
If pregnant how many weeks?_____		
Date of last menstrual period?_____		
Have you....		
Been hospitalized in the last 5 years?	☐	☐
Had any mental disorders?	☐	☐
Had any broken bones?	☐	☐
Had knee or hip replacement surgery?	☐	☐
Do you have a pacemaker?	☐	☐

Please list any other surgeries, hospitalizations, or injuries

_____

_____

Habits:

Do you use tobacco? ☐ Yes ☐ No If yes, how long?_____

How often do you use tobacco daily? ☐ 0 ☐ 1-2 ☐ 3-15 ☐ 6-9 ☐ 10-20 ☐ 21+ ☐ social

How many servings of alcohol do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ 10-20 ☐ 21+ ☐ social

How many servings of coffee do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ 10-20 ☐ 21+ ☐ social

Do you use recreational drugs? ☐ Yes ☐ No

How often do you exercise each week? ☐ Daily ☐ 5x ☐ 3x ☐ 2x ☐ 1x ☐ none

How long do you workouts last? ☐ <30 minutes ☐ 30 minutes ☐ 1 hour ☐ >1 hour

What are your exercise activities?

☐ walking ☐ swimming ☐ weightlifting ☐ stretching/flexibility ☐ resistance bands ☐ running/treadmill/rowing ☐ yoga/palates ☐ other

Family History: If any blood relative has had any of the following conditions, please check and indicate which relative

☐ Alcoholism	☐ Cancer	☐ High blood pressure
☐ Anemia	☐ Diabetes	☐ High cholesterol
☐ Arteriosclerosis	☐ Emphysema	☐ Multiple sclerosis
☐ Arthritis	☐ Osteoporosis	☐ Asthma
☐ Stroke	☐ Heart disease	☐ Thyroid disease

Medications and Supplements:

Are medications (prescription or over-the-counter) necessary for you to have relief and/or to function? ☐ Yes ☐ No

Please list any supplement and/or medications you are currently taking and why?

_____

_____

By signing below, I verify that the above information is correct to the best of my knowledge

Patient Signature:_____ Date:_____

TWO RIVERS CHIROPRACTIC P.C.

1121 Upper Front Street
Binghamton, New York 13905

Phone: 607-744-6500
Fax: 607-744-6550
E-mail: TwoRiversChiropractic@gmail.com
www.TwoRiversChiro.com

PATIENT CONSENT FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION AND ACKNOWLEDMENT OF RECEIPT OF TWO RIVERS CHIROPRACTIC P.C. NOTICE OF PRIVACY PRACTICES

I hereby give my consent for Two Rivers Chiropractic, P.C. to use and disclose protected health information (PHI)

About me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Two Rivers Chiropractic, P.C. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Two Rivers Chiropractic, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Two Rivers Chiropractic, P.C.

With this consent, Two Rivers Chiropractic, P.C. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Two Rivers Chiropractic, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "personal and confidential".

With this consent, Two Rivers Chiropractic, P.C. may e-mail to my home or other location any items that assist the practice in carrying out TPO, such as appoint reminder cards and patient statements. I have the right to request that Two River Chiropractic, P.C. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Two Rivers Chiropractic, P.C. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Two Rivers Chiropractic, P.C. may decline to provide treatment.

Signature: _____ _____ _____

Signature of Patient/Legal Guardian | Date | Relation to Patient

_____ _____

Print Patients Name | Print Name of Legal Guardian, if applicable

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CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with **Chad Hansen, DC** (health care providers name).

Patient signature :_____ Date:_____

Print Name:_____