BACK TO HEALTH CHIROPRACTIC

2504 Monroe Street, LaPorte, IN 46350
PH: (219) 326-5100 FX: (219) 326-0180

Confidential Patient Intake Form

WELCOME TO OUR OFFICE! Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent medical records and will help us get a better understanding of your overall health. Please ask if you have any questions or concerns while completing this form. THANK YOU!

PERSONAL INFORMATION

Patient Legal Name: ______________________________ **Date:** ______/______/______

Date of Birth: ______/______/______ **Age:** ______ **Sex:** ❑ Male ❑ Female **Marital Status:** S / M / D / W

SSN: ______/______/________ **Home Phone:** (_____) ______-________ **Cell Phone:** (_____) ______-________

Address: ______________________________ **City:** ____________________ **State:** _____ **Zip:** __________

Email: ______________________________ **Occupation:** ______________________________

Employer Name/City: ______________________________ **Work Phone:** (_____) ______-________

Spouse or Guardian's Name: ______________________________ **Spouse Date of Birth:** ______/______/______

Emergency Contact: ______________________________ **Phone:** (_____) ______-________

Whom May We Thank for Referring You to Us? ______________________________

How Else Did You Hear About Us? ______________________________

If Patient is School Age (15+), I Authorize Treatment in My Absence esp. In Case of Medical Emergency (GUARDIAN SIGN BELOW):

Legal Guardian Signature: ______________________ Patient Relation: ____________________ Date: ____________

PRIMARY COMPLAINT – HPI (HISTORY OF PRESENT ILLNESS)

What is Your MAIN SYMPTOM? ______________________________

Location (Where is your main pain/problem?): ______________________________

Quality (Describe this pain/problem): ______________________________

Duration (When did this pain/problem start?): ______________________________

Cause (What started this pain/problem?): ______________________________

Severity (How severe is this pain/problem?): ______________________________

Frequency (How often is this pain/problem?): ______________________________

Timing (Worse in morning, night, constant?): ______________________________

Change (Getting better, worse, same over time?): ______________________________

Relieving Factors (What activities make it better?): ______________________________

Aggravating Factors (What activities make it worse?): ______________________________

Radiation (Other body areas affected by this pain/problem?): ______________________________

OTHER HEALTH COMPLAINTS

Please list health complaints you are having currently and mark location(s) on the diagram using the "Key". Then indicate below the severity of the symptom(s) from 1 to 10 with 10 being worst.

Main Complaint: (No Pain → Worst Pain)

1)________________________ 1 2 3 4 5 6 7 8 9 10

Additional Health Complaints

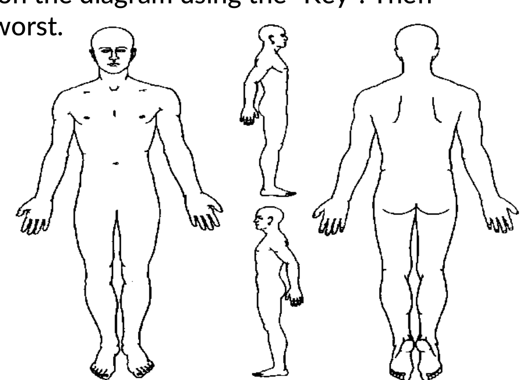
2)________________________ 1 2 3 4 5 6 7 8 9 10

3)________________________ 1 2 3 4 5 6 7 8 9 10

4)________________________ 1 2 3 4 5 6 7 8 9 10

5)________________________ 1 2 3 4 5 6 7 8 9 10

Diagram Key: A=Ache, B=Burning, N=Numbness, P=Pin & Needles, S=Sharp



Doctor Signature: Matthew C. Kirkham, DC, CCSP____________________ Date: _____/_____/20_____

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Patient Name: ____ Date: ______/______/ 20______

PAST MEDICAL HISTORY

Height: ______ft. ______in. **Current Weight:** _________lbs. **Recently Lost or Gained More Than 10 lbs?** ❑Yes ❑No
Family Medical Doctor: ________________________________ **Last Physical Exam Date?** __________________________
Have You Seen Other Physicians/Providers for THIS Main Primary Condition? ❑Yes ❑No
If Yes, List All Doctors or Therapists Consulted for THIS Condition (include approximate dates and diagnosis).
Provider Name: ______________________________ Date of Visit: __________ Diagnosis: ___________________________
Provider Name: ______________________________ Date of Visit: __________ Diagnosis: ___________________________
Describe Any Treatment You've Had for THIS Condition (include medications, testing, etc.): ______________________
____
Have You Ever Received Chiropractic Care? ❑No ❑Yes: When? _____________________ Satisfied with Care? ❑Yes ❑No
May We Communicate Our Findings on Your Current Health Condition to The Above Providers? ❑Yes ❑No

ACTIVITIES OF DAILY LIVING

Work Status: ❑Employed ❑Unemployed ❑Retired ❑Disabled ❑Student ❑Stay-at-home ❑Other: ______________
Usual Daily Activities: ❑Bend ❑Reach ❑Climb ❑Sit ❑Kneel ❑Stand ❑Pull ❑Twist ❑Push ❑Walk ❑Lift
Repetitive Activities: ❑Assembly/Fine Manipulation ❑Hand Tool Use ❑Computer Use/Typing ❑Operate Machinery
❑Grasping ❑Phone Use ❑Other: ____
How Has Primary Condition Affected Job Performance? ❑No Effect ❑Limited Ability ❑Can't Perform Normal Duties
How Has Primary Condition Affected Daily Activities?

Bending:	❑No Effect	❑Mild	❑Moderate	❑Severe	Lifting:	❑No Effect	❑Mild	❑Moderate	❑Severe
Changing Positions:	❑No Effect	❑Mild	❑Moderate	❑Severe	Sleeping:	❑No Effect	❑Mild	❑Moderate	❑Severe
Climbing Stairs:	❑No Effect	❑Mild	❑Moderate	❑Severe	Sitting:	❑No Effect	❑Mild	❑Moderate	❑Severe
Driving:	❑No Effect	❑Mild	❑Moderate	❑Severe	Standing:	❑No Effect	❑Mild	❑Moderate	❑Severe
Computer Use:	❑No Effect	❑Mild	❑Moderate	❑Severe	Walking:	❑No Effect	❑Mild	❑Moderate	❑Severe
Household Chores:	❑No Effect	❑Mild	❑Moderate	❑Severe	Yard Work:	❑No Effect	❑Mild	❑Moderate	❑Severe

How Has Primary Condition Affected Recreational Activities? ____
____

MEDICATIONS & ALLERGIES

List Any Prescription & Non-Prescription Medications, Vitamins You Are Currently Taking: ❑ Not Taking Any Meds

Medication	Dosage	For What Condition?	How Long Been Taking This?

List Any Allergies, Including Sulfa, Seasonal, Food and Medicinal Allergies: ❑ No Known Allergies

Allergen	Reaction to Allergen

PAST HOSPITALIZATIONS & SURGERIES

Please Indicate If You Have Had the Following Surgeries: ❑ No Prior Hospitalizations or Surgeries

❑ Carpal Tunnel Surgery Date: _______________ ❑ Rotator Cuff Repair Date: ________________
❑ Laminectomy Date: _______________ ❑ Knee Repair Date: ________________
❑ Joint Reconstruction Date: _______________ ❑ Spinal Fusion Date: ________________
❑ Joint Replacement Date: _______________ ❑ Spinal Disc Surgery Date: ________________

List Any Other Past Hospitalizations and Surgeries: ____

Doctor Signature: _Matthew C. Kirkham, DC, CCSP________________________ Date: _____/_____/20_______

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PAST INJURIES

Please Indicate If You Have Had the Following Injuries: ❑ No Past Injuries

❑ Back Injury	Date: _______________	❑ Severe Fall	Date: _______________
❑ Joint Injury	Date: _______________	❑ Auto Accident	Date: _______________
❑ Broken Bones	Date: _______________	❑ Sprain/Strain	Date: _______________
❑ Head Injury	Date: _______________	❑ Severe Laceration	Date: _______________

List Any Other Past Major Injuries: ____
____

PAST ILLNESSES/DISEASES

Please Indicate If You Have Ever Had the Following Illnesses: ❑ No Past Illnesses or Diseases

❑ Measles	❑ Pneumonia	❑ Asthma	❑ Hepatitis	❑ Anemia
❑ Mumps	❑ Rheumatic Fever	❑ Eczema Hives	❑ Ulcer	❑ Bladder Infection
❑ Chicken Pox	❑ Arthritis	❑ AIDS & HIV	❑ Kidney Disease	❑ Epilepsy
❑ Whooping Cough	❑ Venereal Disease	❑ Infectious Mon	❑ Thyroid Disease	❑ Migraine Headaches
❑ Scarlet Fever	❑ Polio	❑ Bronchitis	❑ Blood Clots	❑ Blood Pressure Issue
❑ Diphtheria	❑ Tuberculosis	❑ Mitral Valve Prolapse	❑ Cancer	❑ Glaucoma
❑ Small Pox	❑ Diabetes	❑ Stroke	❑ Bleeding Tendency	❑ Hemorrhoids

List Any Other Past Serious Illnesses or Disease: ____
____

REVIEW OF SYSTEMS

Please Indicate Any of the Following You Have Experienced in the Last 1-2 months.
Please Circle the Number According to Frequency: **1=Never, 2=Rarely, 3=Occasionally, 4=Frequently, 5=Constantly**

General & EENT		Musculoskeletal		Neurological	
Weakness	1 2 3 4 5	Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5
Fatigue	1 2 3 4 5	Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5
Fever	1 2 3 4 5	Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5
Chills	1 2 3 4 5	Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5
Night Sweats	1 2 3 4 5	Joint Stiffness	1 2 3 4 5	Tingling	1 2 3 4 5
Fainting	1 2 3 4 5	Low Back Pain	1 2 3 4 5	Seizures	1 2 3 4 5
Asthma	1 2 3 4 5	Neck Pain	1 2 3 4 5	Vertigo	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Mid Back Pain	1 2 3 4 5	Trembling	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5	Weak Grip	1 2 3 4 5
Earache/Infection	1 2 3 4 5	Elbow Pain	1 2 3 4 5	Incoordination	1 2 3 4 5
Shortness Breath	1 2 3 4 5	Shoulder Pain	1 2 3 4 5	Paralysis	1 2 3 4 5
Wheezing	1 2 3 4 5	Hip Pain	1 2 3 4 5	Memory Loss	1 2 3 4 5
Ear Ringing	1 2 3 4 5	Knee Pain	1 2 3 4 5	Speech Difficulty	1 2 3 4 5
Skin Changes	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5	Facial Loss	1 2 3 4 5

SIGNATURE OF RESPONSIBLE PARTY

The questions on this form have been completed by me and accurately answered to the best of my knowledge. It is my responsibility throughout the course of any future recommended treatment to inform this doctor's office of any changes in my medical status. I also authorize the healthcare staff of this office to perform any necessary services I may need today and in the future.

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

SIGNATURE of Patient, Parent or Guardian: X_________________________________ Date: _____/_____/______

Doctor Signature: Matthew C. Kirkham, DC, CCSP________________________ Date: ______/______/20______

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Patient Informed Consent to Examination & Treatment

To the Patient:
You understand that consultation, examination, and any diagnostic testing will help determine if you are candidate for treatment and what types of treatment, if any, are recommended. You understand that treatment will not begin until all your questions and concerns have been answered to your satisfaction. You have a right as a patient to be informed about your condition, the recommended treatment, and potential risks involved with the recommended treatment. This will allow you to make an informed decision whether to undergo the treatment or not. This information is not meant to scare or alarm you; it is simply an effort to make you better informed, so you may give or withhold your consent to the procedures and/or treatment.

Consent for Chiropractic Evaluation and Treatment:
I have been advised that chiropractic care, like all forms of health care, carries some risk. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which is suggested to occur at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Back to Health Wellness Center, have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to examination and treatment by any means, methods, and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Consent to Participate in Active Rehabilitation Therapy Exercises and Therapies:
The goals of the rehabilitation program are to provide a therapeutic exercise program to stretch, strengthen and correct posture, mobility, flexibility, balance and decrease pain. Participation in the rehabilitation program is voluntary and I understand that I can stop at any point in the program. I understand that there are no guarantees that my personal goals and/or those listed above will be met to my satisfaction. The success of any rehabilitation process lies in the combined efforts of myself and my Provider(s) and their team. I realize the best chance of achieving health goals is a team approach, so asking questions as necessary to gain maximum benefit from my rehabilitation program is encouraged. Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. I understand it is imperative that I communicate with the Provider(s) and their team of any aggravation or injury and consent fully to participating.

Patient Name Printed: ____ Date of Birth: _____/_____/_____

Patient, Parent or Guardian Signature: **X**_________________________________ Date: _____/_____/_____

Witness Initials: ___________

FEMALE PATIENTS ONLY:

Regarding X-Rays/Imaging Studies and Procedures: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions. Otherwise, see your case manager for further explanation.*

❑ I am aware of when I am most likely to become pregnant, and to the best of my knowledge, **I AM NOT PREGNANT**, nor is pregnancy suspected or confirmed at this time. I consent to X-rays if the doctor/nurse practitioner deems them necessary for evaluation of my condition.

The first day of my last menstrual cycle (period) was on: (date) ______/______/______

By my signature below, I am acknowledging that the doctor, nurse practitioner, and/or staff member discussed with me the potentially hazardous effects of certain in office procedures, such as X-rays, that may cause ionization to an unborn child. I have conveyed my understanding of these risks and documented above my non-pregnancy condition as it relates to X-ray examination the doctor/nurse practitioner may have deemed necessary in my case.

Patient Name: ____ Date of Birth: ______/______/______

Patient/Guardian Signature: ____ Date: ______/______/______

Witness Initials: ___________

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Acknowledgments, Agreements and Authorizations

Patient Acknowledgment of Receipt of HIPAA Notice of Privacy Practices and Consent for Use of PHI, Disclosure of Ownership Interest, and Statement of Patient Rights & Responsibilities

I acknowledge receipt of a copy of Back to Health Wellness Center Privacy Notice, last updated 3/1/2019, as well as a Disclosure of Ownership Interest and Statement of Patient Rights & Responsibilities.

___________________ initials

Consent to Health Care Services / Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf), hereby request and consent to patient health care services from Back to Health Wellness Center. The Patient health care services will be provided by and overseen by licensed, treating healthcare providers. Health care services will also be provided by non-physician health care professionals and assistants employed or otherwise retained by Back to Health Wellness Center. Ancillary staff, technicians, assistants, and other health care personnel who are in training may also participate in the Patient's care as part of their education.

___________________ initials

Payment Guarantee / Assignment of Benefits

In consideration of the services provided by Back to Health Wellness Center (hereafter, "the Clinic"), Provider to Patient, you agree to; 1) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); 2) irrevocably assign and transfer to the Clinic, all right, title and interest to medical insurance reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and 3) authorize payment of such benefits directly to the Clinic. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

___________________ initials

Notice of Non-Coverage

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. Your insurance likely does not pay for all of your healthcare costs. Your insurance policy will only cover services that it deems "Medically Necessary" according to their specific guidelines. When you receive a service or item that your insurance policy does not cover, then you are personally responsible for the non-covered services at the time they were rendered (unless prior arrangements have been made). Specifically, your insurance policy will not allow payment for the following non-covered services and you will have to pay out-of-pocket the normal fee as listed below because they are routinely deemed not-medically necessary according to insurance guidelines: maintenance/wellness chiropractic care ($65 per visit), nutritional supplements, therapeutic modalities used for maintenance ($30), rehabilitation therapy ($35 per unit), and any service beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

___________________ initials

Patient Right to Restrict Disclosure of Protected Health Information (PHI)

For any service in which you pay for 100% out-of-pocket, you have the right to restrict the disclosure of that healthcare information for that particular service to any health insurance entity. This is according to your HIPAA privacy rights established under the American Recovery and Reinvestment Act (ARRA) of 2009. For services that are non-covered under your insurance plan and that you pay for in-full out-of-pocket, you understand and request that Back to Health Wellness Center do not bill for any of these non-covered services or items on my behalf and that you wish to restrict the disclosure of PHI of these services from your insurance company.

___________________ initials

Responsibility for Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by to Health Wellness Center for safekeeping under its sole care and custody. Back to Health Wellness Center is not responsible for lost or stolen items.

Patient Name Printed: ____ Date of Birth: ______/______/_____

Signature of Patient, Parent or Guardian: ____ Date: ______/______/______

Witness Initials: ___________

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Consent to Call, Email or Text Message for Appointment Reminders and Other Communication

We have the ability to call, email or text you, reminding you of your scheduled appointments in our office. Patients in our practice may be contacted via phone, text message or email to be reminded of an appointment, to obtain feedback on an experience within our office, to view and obtain your personal health information in a secure way, test results, and to provide general health reminders and office information. **YOUR INFORMATION WILL NEVER BE SOLD AND WILL ONLY BE USED FOR DIRECT COMMUNICATION BETWEEN OUR OFFICE AND YOU.**

1) I consent to receiving appointment reminders and other healthcare communications and information via phone from Back to Health Chiropractic. By completing and providing the phone number information below, you consent to this phone call communication.

   Phone Number for VOICE COMMUNICATION: (________) _________ - _______________

2) I consent to receive text messages from Back to Health Chiropractic on my cell phone and any number you have set forwarding/transferring to that number. The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is. By completing and providing the phone number information below, you consent to this text communication.

   Phone Number for TEXT COMMUNICATION: (________) _________ - _______________

3) I consent to receive email messages from Back to Health Chiropractic for the reasons stated above. The email that I authorize to receive email messages for general health reminders, feedback, and office information is provided below. By providing the email information below, you consent to this email communication.

   E-mail for EMAIL COMMUNICATION: ____

I understand that this request to receive phone calls, emails and/or text messages from our office to you will apply to all future appointment reminders, feedback, health information unless I request a change in writing. By signing below, you consent to the above approved communication methods.

Patient/Guardian Signature: ____ Date: ______/______/______

Authorized Representatives

Your privacy is of utmost importance to us. If you are over age 18, you are the only one our office is authorized to communicate with regarding any aspect of your care, including appointments, finances, and billing. Please list anyone you are authorizing to obtain verbal medical information about you, including your spouse or anyone else you authorize. If you do not list anyone below, then you will remain the only one authorized for office to communicate.

Name of Authorized Representative	Initiated Date	Phone Number	Relationship to You	Discontinue Date
1.				
2.				
3.				
4.				