MARATHON CHIROPRACTIC CLINIC

Presenting Problem

Patient Name_____ Date_____/_____/_____

What is the **presenting problem/chief complaint** and when did it begin? _____

_____

What was the **mechanism/cause of injury**? _____

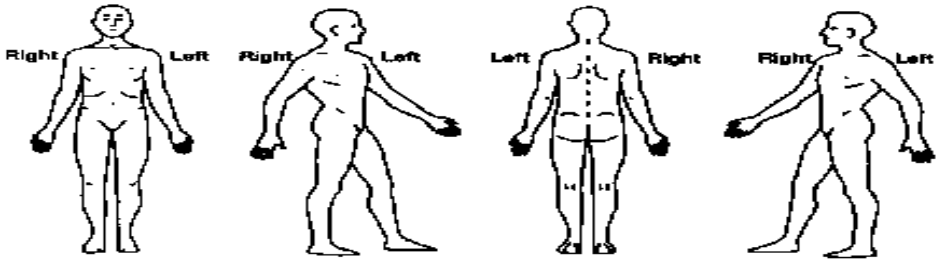
_____

Where is the pain **located**? _____

Describe the pain (ie burning, sharp, shooting, aching, boring, etc): _____

_____

Mark on the diagram the locations of your complaints:



Rate your pain, 0-10 with 0 being no pain and 10 being most excruciating:

Your Pain Right Now: _____

Your Pain at its Worst: _____

Your Pain at its Best: _____

Does anything **alleviate** the pain? YES ◊ NO ◊ If yes, what? _____

Does anything **exacerbate** the pain? YES ◊ NO ◊ If so, what? _____

Does the pain **radiate** into the extremities? YES ◊ NO ◊ _____

Is the pain worse or better at any time of the day? YES ◊ NO ◊ If so, when? _____

Are there any other associated **symptoms**? YES ◊ NO ◊ List them:_____

_____

Does the pain affect any of your normal daily activities? YES ◊ NO ◊ If yes, how? _____

_____

Have you sought any medical attention/treatment for this complaint yet? YES ◊ NO ◊ If so, who did you see and what was the therapy? _____

_____

Have you had any **imaging** for this problem (Xray, MRI, CT, etc.)? YES ◊ NO ◊ _____

_____

Describe below any other **problems** you have been experiencing related or unrelated to the **chief complaint**: _____

_____

_____

Physician Signature : _____ Date: _____/_____/_____

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History

Patient Name: _____

List any **past diseases** including those from childhood: _____

_____

_____

List any **surgeries**, major **traumas** (including concussions and broken bones), illnesses, recent immunizations, or other hospitalizations: _____

_____

_____

Have you ever been diagnosed w/ spondylolisthesis, a compression fracture, or other spinal fractures? YES ◊ NO ◊

_____

List any medical **allergies**: _____

_____

List your **medications**: _____

_____

_____

Have any of your **family** members suffered from diseases such as heart disease, diabetes, cancer, or any other inherited disease? YES ◊ NO ◊ If so, which one(s): _____

_____

Check those that apply:

YES ◊ NO ◊ Are you currently taking NSAIDS (Ibuprofen, Acetaminophen, etc) If so, how often? _____

Y**ES ◊ NO ◊** Do you drink alcohol? If yes, how many drinks and how often? _____

YES ◊ NO ◊ Do you smoke? If yes, how many packs a day? _____ How many years? _____

YES ◊ NO ◊ Do you drink water on a regular basis? How many glasses a day? _____

YES ◊ NO ◊ Do you have difficulties sleeping through the night? _____

YES ◊ NO ◊ Do you feel fatigued on a regular basis? _____

HIGH ◊ MED ◊ LOW ◊ What is your level of stress? Explain: _____

YES ◊ NO ◊ Have you been to a chiropractor before? If so, why and when? _____

MARATHON CHIROPRACTIC CLINIC

New Patient Intake Form

PATIENT INFORMATION

First Name:_____ Middle Initial ____ Last Name: _____

Date of Birth:_____/_____/_____ Sex: M ◊ F ◊ Married ◊ Single ◊ Other ◊

Address: _____ Email: _____

City_____ State_____ Zip_____

Cell: (_____)_____-_____ Home: (_____)_____-_____

Occupation:_____ Employer's Name:_____

Emergency Contact_____ Phone (_____)_____-_____

INSURANCE INFORMATION

Insurance Company:_____

Plan ID #_____Group #_____

Primary insured same as patient? YES ◊ NO ◊ (If yes then skip the rest of this section)

Patient Relationship to Insured: Self ◊ Spouse ◊ Child ◊ Other ◊

Insured Name_____

Insured Address (If different than yours):_____

Insured D.O.B._____/_____/_____ Sex: M ◊ F ◊ Insured Phone (_____)_____-_____

ACCIDENT/ILLNESS INFORMATION

Is this condition related to (check those that apply):

- □ Employment

HR Contact Name: _____

- □ Auto Accident

Auto Accident Number: _____

- □ Other Accident

Date of Accident _____/_____/_____ Dates missed from work_____

MARATHON CHIROPRACTIC CLINIC

Informed Consent for Chiropractic Treatment and HIPAA

Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician Marathon Chiropractic Clinic and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Ryan Woods and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

For Use of Disclosure of Private Health Information (PHI)

Trust is the foundation of a doctor/patient relationship and the information that you provide us will be kept in the strictest of confidence. There may be certain situations that may require us to use or disclose your healthcare information:

- It may be necessary to use or disclose your **PHI** to another healthcare provider in coordination of your care
- It may be necessary to use or disclose your **PHI** and billing records to another party if they are responsible for the payment of your services.
- It may be necessary to use or disclose your **PHI** within our practice for quality control and operational purposes.

If you would like to have your personal health information disclosed to anyone other than yourself, please fill in the following information. Keep in mind,

ADDITIONAL FAMILY MEMBER(S) ADDITIONAL FAMILY MEMBER(S)

_____ _____

To be completed by the patient or to be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

_____ _____

Print Patient's Name Print Name of Representative

_____ _____ _____/_____/_____

Signature of Patient Signature of Representative Date

Witness Signature (office staff only): _____ Date _____/_____/_____

MARATHON CHIROPRACTIC CLINIC

AUTHORIZATION TO SEND TEXT MESSAGES OR EMAILS

By signing this form, I authorize Marathon Chiropractic Clinic to send text messages OR emails with upcoming appointment information. I understand that stand text messaging rates may apply to any messages received from Marathon Chiropractic Clinic. I also understand that I myself or Marathon Chiropractic Clinic may revoke this permission in writing at any time. I agree not to hold Marathon Chiropractic Clinic liable for any electronic messaging charges or fees generated by this service. I further agree that if my cell phone number or email changes, I will inform the staff at Marathon Chiropractic Clinic.

To ensure you safety and protect you Private Health Information, no private health information will ever be shared via the above stated communication methods. We do not share patient names, phone numbers, or email with any other company or with any other patients.

Choose ***ONE*** of the following options for your communication preferences below:

◊ YES, I would like to receive email confirmations. EMAIL ADDRESS: _____

- OR –

◊ YES, I would like to receive text message confirmations. CELL PHONE NUMBER: _____

CELL PHONE PROVIDER: ◊ AT&T ◊ VERIZON OTHER:_____

Patient's Signature: _____ Date: _____/____/_____

Witness Signature (office staff only):_____ Date: _____/____/_____