BELDE CHIROPRACTIC & body shop

New Patient Intake Form

Patient LEGAL Name: _____ Date:_____

Birth Date: _____ Age: _____

Marital Status: ○ Married ○ Separated ○ Widowed ○ Single

Name of Spouse:_____ Spouse's Date of Birth: _____

Address: _____City:_____Zip Code _____

Phone Number: Cell_____ Other_____

Email Address: _____

Would you like to receive text reminders for upcoming appointments? ○ Yes ○ No

Legal Guardian (If under 18)

Name: _____ Date of Birth: _____

Phone: _____

Emergency Contact: ○ Same as Spouse or Guardian

○ Other. Name: _____ Relationship: _____

Phone: _____

How did you learn about Belde Chiropractic?_____

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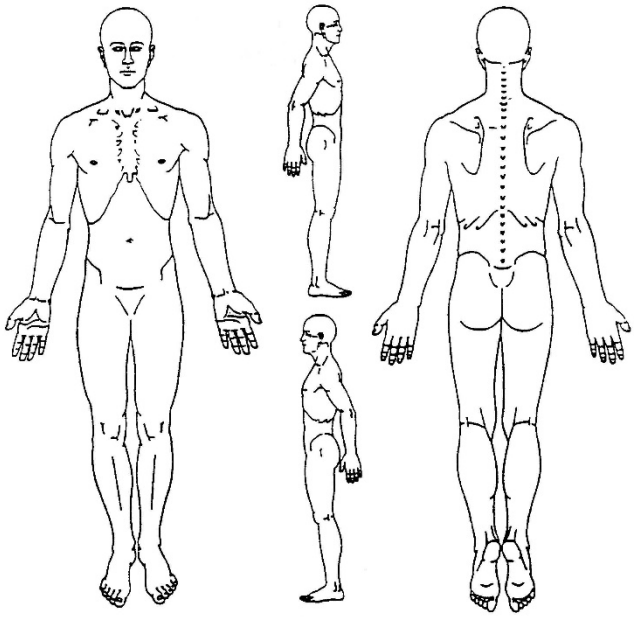
1. Is today's visit due to an active Auto Accident or Worker's Comp Case? ○ Yes, **please see the front desk staff.**
   ○ No, **CONTINUE BELOW.**

2. How did your complaint begin? (What activity brought on your pain?)_____

_____

3. When did your complaint begin?_____

4. On the diagram, please indicate the location of your complaint by marking with an X.



5. How would you describe your symptoms?

○ Aching	○ Burning	○ Dull	○ Numbness
○ Sharp	○ Shooting	○ Sore	○ Stabbing
○ Tight/Stiff	○ Tingling	○ Radiating into an arm/leg	

6. Are you experiencing headaches? ○ Yes ○ No

7. How would you rate your pain 0-10? (Circle, 0= No pain)
   0 1 2 3 4 5 6 7 8 9 10

8. What activities make your symptoms better or worse?

_____

_____

Please Continue to page 2 of 3

9. Have you ever had the same or similar condition? ○ Yes ○ No

If yes, please describe._____

_____

10. Have you seen any other healthcare providers for this condition? ○ Yes ○ No

If yes, Provider Name_____ Date _____

11. Have you had any surgeries or procedures? ○ Yes ○ No

If yes, please describe._____

_____

_____

12. Have you been hospitalized for any other conditions in the past year? ○ Yes ○ No

If yes, please describe._____

_____

13. Do have a history of Stroke? ○ Yes ○ No

14. Do you have a Pacemaker? ○ Yes ○ No

15. What over-the-counter or prescription medications are you currently taking? _____

_____

16. Are you pregnant or is there a chance you may be pregnant? ○ Yes ○ No ○ Uncertain

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Family History. In your family (siblings, parents, grandparents), has anyone had a history of the following conditions? If yes, please list who and age of onset.

Cancer	○ Yes ○ No	_____
Heart Disease	○ Yes ○ No	_____
Diabetes	○ Yes ○ No	_____
High Blood Pressure	○ Yes ○ No	_____
Arthritis	○ Yes ○ No	_____
Osteoporosis	○ Yes ○ No	_____

Social History.

About how many hours of sleep do you get per night? _____
About how many alcoholic beverages do you have per week?_____
About how many days a week do you exercise?_____

What is your occupation?_____

Do you smoke or live in a home that exposes you to second-hand smoke? ○ Yes ○ No

Please Continue to page 3 of 3

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself. Not between my insurance company and this office. I agree to pay my patient responsibility. In the event that my insurance company does not pay, upon request of this office, I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office all costs of such collection efforts, including but not limited to all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits on my behalf and to any attorney who may be representing me due to my condition and to complete any usual and customary reports and forms at no charge to assist in the collection from my insurance companies, attorneys, or other payers.

I have read, understood, and agreed to the fore going. The information which I have provided is true and complete to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

HIPAA Compliance Patient Consent. Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:_____

Patient/Guardian PRINTED NAME:_____

Patient/Guardian Signature:_____Date:_____

Clinic Witness:_____Date:_____