New Patient Intake Form

Patient Information

Full Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Gender: _____ Marital Status: _____

Email: _____ Phone Number: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us: _____

Major Complaint: _____

Have you seen another doctor for this condition: _____ Date seen: _____

Type of Treatment: _____ Results: _____

Are your symptoms: Improving ☐ Getting Worse ☐ Staying the Same ☐ Intermittent (Come and Go) ☐

Has this condition occurred before? Yes/No If yes, when did your symptoms begin? _____

Do you suffer from any conditions other than that which you are consulting us? Yes/No

If yes, please explain: _____

Consent for Treatment

Assignment & Release – By signing below, I authorize Wise Cracks, LLC to release medical record required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Wise Cracks LLC and I agree that a reproduced copy of this authorization will be valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If the patient is a minor, by signing, I give consent for examination, tests and procedures for the above minor patient.

Signed: _____ Date: _____

Joshua Tanner, D.C.
499 E. Central Pkwy, Suite 245
Altamonte Springs, FL 32701

Wise Cracks

INFORMED CONSENT

Please read the entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign it if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulation therapy. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment:

As part of the analysis, examination and treatment, you are consenting to the following procedures:

Spinal manipulation therapy, Orthopedic testing, Basica neurologic testing, palpation, EMS, Ultrasound, Hot/Cold therapy, traction and Decompression.

The material risk inherent in chiropractic adjustments:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to disc injuries, fractures and muscle strains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications including stroke. Some people will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The availability and nature of other treatment options:

Other treatment options for your condition may include: (1) self-administered, OTC analgesics and rest, (2) Medical care and prescription drugs, (3) Hospitalization, (4) Surgery, if you choose to use one of these options you should be aware that there are risks and benefits of such options and you may wish to discuss those with your primary medical physician.

I have read ___ or have had read to me ___ the above explanation of the chiropractic adjustment and related treatment. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Wise Cracks, LLC responsible for any errors or omissions that I may have made in the completion of this form. By signing this form, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent for treatment.

I understand that I am liable for the charges for services rendered and I agree to notify the practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician if necessary.

_____ _____

Print Name of Patient Date

_____

Signature of patient/Guardian

Complaint #1: Check 1: Headache ____ Neck Pain ____ Mid-Back Pain ____ Low Back Pain ____ Other _____

Date problem began:_____ What caused it?_____

Please grade your pain level: (no pain) 0——1——2——3——4——5——6——7——8——9——10 (Worst pain imaginable)

How often are your symptoms present: 25% of the day ____ ; 50% of the day ____ ; 75% of the day ____ ; 100% of the day ____

What other treatment have you had for this complaint? _____

What makes it feel worse? _____

What makes it feel better? _____

Complaint #2: Check 1: Headache ____ Neck Pain ____ Mid-Back Pain ____ Low Back Pain ____ Other _____

Date problem began:_____ What caused it?_____

Please grade your pain level: (no pain) 0——1——2——3——4——5——6——7——8——9——10 (Worst pain imaginable)

How often are your symptoms present: 25% of the day ____ ; 50% of the day ____ ; 75% of the day ____ ; 100% of the day ____

What other treatment have you had for this complaint? _____

What makes it feel worse? _____

What makes it feel better? _____

Complaint #3: Check 1: Headache ____ Neck Pain ____ Mid-Back Pain ____ Low Back Pain ____ Other _____

Date problem began:_____ What caused it?_____

Please grade your pain level: (no pain) 0——1——2——3——4——5——6——7——8——9——10 (Worst pain imaginable)

How often are your symptoms present: 25% of the day ____ ; 50% of the day ____ ; 75% of the day ____ ; 100% of the day ____

What other treatment have you had for this complaint? _____

What makes it feel worse? _____

What makes it feel better? _____

Other Complaints: _____

Please indicate on the diagram where you have pain or other symptoms:

Numbness: = =
= =

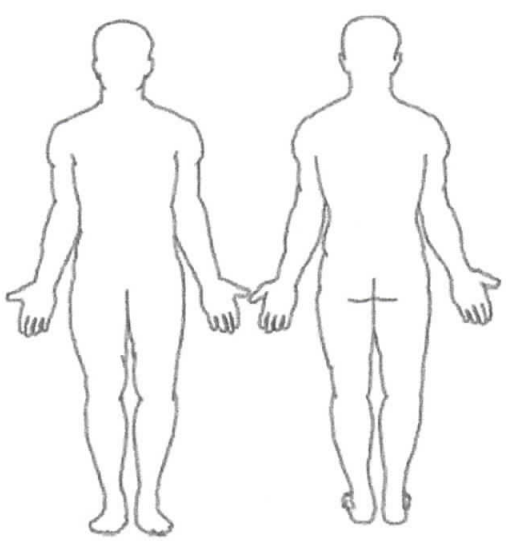
Burning: X X
X X

Pins and Needles: ○ ○
○ ○

Sore: □ □
□ □

Ache: △ △
△ △

Stabbing: / / /
/ / /



NAME LAST	FIRST	MIDDLE INIT.	DATE OF BIRTH	HEIGHT	WEIGHT	SEX	DATE

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

OCCASIONAL	FREQUENT	GENERAL
☐	☐	Alergy (list below)*
☐	☐	Convulsions
☐	☐	Dizziness or Fainting
☐	☐	Headache
☐	☐	Neuralgia
☐	☐	Numbness
		MUSCLE & JOINT
☐	☐	Arthritis
☐	☐	Bursitis
☐	☐	Foot Trouble
☐	☐	Low Back Pain
☐	☐	Neck Pain or Stiffness
☐	☐	Pain Between Shoulders
☐	☐	Sciatica
☐	☐	Swollen Joints
☐	☐	Pain, Numbness or Cramps
☐	☐	Shoulders
☐	☐	Arm Pain
☐	☐	Elbow Pain
☐	☐	Hand Pain
☐	☐	Hip Pain
☐	☐	Leg Pain
☐	☐	Knee Pain
☐	☐	Foot Pain
☐	☐	General Stiffness

OCCASIONAL	FREQUENT	GASTRO-INTESTINAL
☐	☐	Colon Trouble
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Difficult Digestion
☐	☐	Distension of Abdomen
☐	☐	Gall Bladder Trouble
☐	☐	Hemorrhoids
☐	☐	Liver Trouble
☐	☐	Pain Over Stomach
		EYES, EARS NOSE & THROAT
☐	☐	Asthma
☐	☐	Colds
☐	☐	Deafness
☐	☐	Earache
☐	☐	Ear Discharge
☐	☐	Ear Noises
☐	☐	Eye Pain
☐	☐	Nasal Obstruction
☐	☐	Nosebleeds
☐	☐	Sinus Infection
		CARDIO-VASCULAR
☐	☐	Hardening of Arteries
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Pain Over Heart
☐	☐	Poor Circulation
☐	☐	Rapid Heart Beat
☐	☐	Slow Heart Beat
☐	☐	Swelling of Ankles

OCCASIONAL	FREQUENT	RESPIRATORY
☐	☐	Chest Pain
☐	☐	Chronic Cough
☐	☐	Difficult Breathing
☐	☐	Spitting up Blood
☐	☐	Spitting up Phlegm
☐	☐	Wheezing
		SKIN
☐	☐	Bruise Easily
☐	☐	Dryness
☐	☐	Skin Eruptions (Rash)
☐	☐	Varicose Veins
		GENITO-URINARY
☐	☐	Bed-wetting
☐	☐	Blood in Urine
☐	☐	Frequent Urination
☐	☐	Inability to Control Kidneys
☐	☐	Kidney Infection or Stones
☐	☐	Painful Urination
☐	☐	Prostate Trouble
☐	☐	Pus in Urine
		FOR WOMEN ONLY
☐	☐	Congested Breasts
☐	☐	Cramps or Backache
☐	☐	Excessive Menstrual Flow
☐	☐	Hot Flashes
☐	☐	Irregular Cycle
☐	☐	Lumps in Breast
☐	☐	Menopausal Symptoms
☐	☐	Painful Menstruation
☐	☐	Vaginal Discharge

Pregnant ☐ Yes ☐ No ☐ Not Sure

Date of Last Period_____

Previous Miscarriages ☐ Yes ☐ No

DATE OF LAST: (Approx.)

_____ Physical Examination
_____ Blood Test
_____ Chest X-Ray
_____ Spine X-Ray
_____ Dental X-Ray
_____ Urine Test

HABITS:

☐ Alcohol
☐ Coffee
☐ Tobacco
☐ Drugs
☐ _____

YES	NO	**HAVE YOU EVER:**
☐	☐	Been Knocked Unconscious?
☐	☐	Used Crutches, or Other Support?
☐	☐	Been Treated For Spine Problems or ☐ Nerve Disorder?
☐	☐	Had a Fractured Bone?
☐	☐	Been Hospitalized For Other Than Surgery?
☐	☐	Had Surgery? (list below)*

*Please List any Medications Now Taken, Allergies and Past Surgeries: _____

_____

_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBER

HAVE	HAD								
☐	☐	Alcoholism	☐	☐	Diabetes	☐	☐	Gout	☐	☐	Multiple Sclerosis	☐	☐	Stroke
☐	☐	Anemia	☐	☐	Eczema	☐	☐	Heart Disease	☐	☐	Polio	☐	☐	Tuberculosis
☐	☐	Appendicitis	☐	☐	Emphysema	☐	☐	Miscarriage	☐	☐	Rheumatic Fever	☐	☐	Ulcers
☐	☐	Cancer	☐	☐	Goiter							☐	☐	Foot Problem

After reading and filling out the Health Questionnaire, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely

Sign Your Name _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

THIE PRIVACY OF YOUR HEALTH INFORAMTION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you have approved.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health Related Services: We will not use your health information for marketing communication without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

PATIENT ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES

AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, _____, acknowledge that I have either received a copy of this office's **NOTICE OF PRIVACY PRACTICES** or that this office's **NOTICE OF PRIVACY PRACTICES** was made available to me to receive.

I, _____, consent to the use and disclosure of my personal health information by your office for Treatment, Billing / Payment and Health Care Operations as outlined in the **NOTICE OF PRIVACY PRACTICES**.

X _____

Wise Cracks

Massage Therapy Informed Consent

By signig below, the patient agrees to the following:

1. Massage Therapy has been recommended to me as a part of my treatment plan and that it is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage.
2. All massage treatments, information, and records will be kept confidential and securely stored for use only by the massage therapist and the chiropractor.
3. Written consent must be given by me prior to any disclosure or sharing of my personal and clinical information with any third party.
4. Privacy will be assured as I have the right to undress only to my comfort level and according to the requirements of treatment.
5. Draping will be used by the therapist as required to expose only those parts of my body that require treatment and/or as I choose to ensure my comfort during treatment.
6. If at any time during the treatment, I feel uncomfortable with the treatment for any reason, I have the right to immediately terminate the session or request modification to the treatment, regardless of any prior consent given.
7. I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so that he/she may adjust accordingly.
8. I understand that while performing the massage, the therapist will maintain a professional distance from sensitive areas of my body. If my condition requires massage therapy in proximity to a sensitive areas, this will be discussed with me, and my permission will be obtained before working in proximity to these areas.
9. I understand that based on my personal preference, I have the right to request wither a male or female therapist. If I do not specifically request a male or female massage therapist, I may receive a massage from wither, depending on my appointment time.

I, _____ **(Print Name)** have read and understand the information above and consent to receiving massage therapy.

PATIENT SIGNATURE: _____ Date: _____

Joshua Tanner, D.C.
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Altamonte Springs, FL 32701