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.

Name: _____ Date: _____

Insurance: _____

Date of Birth _____ Gender: ☐ Male ☐ Female

Cell Phone #: _____ Alternate #_____

Address: _____ City _____ State_____ Zip_____

Email Address:_____

Occupation:_____ Employer:_____

Primary Reasons For Seeking Chiropractic Care:
1._____

2._____

Other Contributing Factors: _____

Chief Complaint:_____

Location of Complaint:_____

When and How did the Complaint Begin?_____

Please check the Quality of the complaint/pain:
☐ Dull ☐ Aching ☐ Sharp ☐ Shooting ☐ Burning ☐ Throbbing ☐ Deep ☐ Nagging
☐ Other:_____

Does your complaint/pain radiate or travel (shoot) to any other areas of your body? ☐ Yes ☐ No

If so, where?: _____

Are you experiencing and numbness or tingling in your body? ☐ Yes ☐ No

If so, where? _____

Please rate the Intensity/Severity of the Complaint/Pain:

No Pain Possible 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

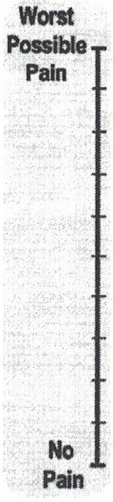
How frequent is complaint occurring/How long does it last? _____

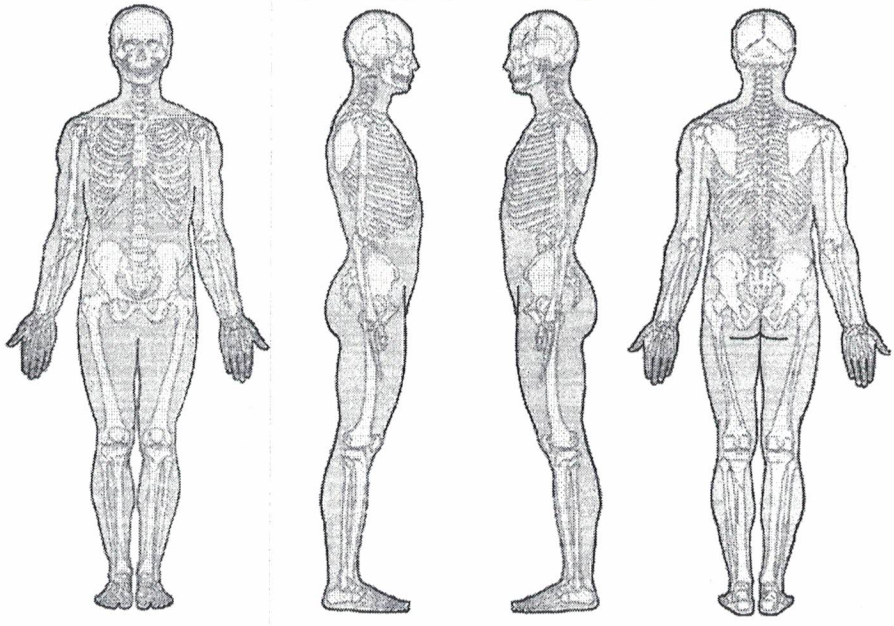
What makes the complaint better? _____

What makes the complaint worse?_____

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

Please place a mark at the level of your pain on the scale below:





Does this condition effect your ability to: ☐ Work ☐ Sleep ☐ Other:_____

Have you previously sought any other treatments, interventions, medications, surgery or care for this complaint? ☐ Yes ☐ No If yes, please describe:_____

Do you have any allergies? ☐ Yes ☐ No If yes, please list: _____

Are you currently taking any medications? ☐ Yes ☐ No

Type of Medication:	Reason for Taking

Have you had any previous surgeries/procedures? ☐ Yes ☐ No

Type of Surgery/Procedure:	Reason For Surgery/Procedure:	Outcome:

Females/Pregnancy: Have you ever been pregnant? ☐ Yes ☐ No

Date of Delivery	Outcome:

What was the date of your last menstrual period?_____

Check ☑ and indicated the age when you had any of the following:

General:
☐ Allergies
☐ Depression
☐ Dizziness
☐ Fatigue
☐ Fever
☐ Headaches
☐ Loss of Sleep
☐ Mental Illness
☐ Nervousness
☐ Tremors
☐ Weight Loss/Pain

Muscle/Joint:
☐ Arthritis
☐ Rheumatism
☐ Bursitis
☐ Foot Trouble
☐ Muscle Weakness
☐ Low Back Pain
☐ Neck Pain
☐ Mid Back Pain
☐ Joint Pain

Skin:
☐ Boils
☐ Bruise Easily
☐ Dryness
☐ Hives or Allergies
☐ Itching
☐ Rash
☐ Varicose Veins

Eye, Ears, Nose and Throat:
☐ Colds
☐ Deafness
☐ Ear Ache
☐ Eye Pain
☐ Gum Trouble
☐ Hoarseness
☐ Nasal Obstruction
☐ Nose Bleeds
☐ Ringing of the Ears
☐ Sinus Infection
☐ Sore Throat
☐ Tonsillitis
☐ Vision Problems

Genitourinary:
☐ Bed-wetting
☐ Bladder Infection
☐ Blood in Urine
☐ Excessive Urge to Urinate
☐ Frequent Urination
☐ Kidney Infection
☐ Kidney Stones
☐ Prostate Trouble
☐ Stress Incontinence
☐ Painful Urination

Cardiovascular:
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Hardening of the Arteries
☐ Irregular Pulse
☐ Pain Over Heart
☐ Palpitation
☐ Poor Circulation
☐ Rapid Heart Beat
☐ Slow Heart Beat
☐ Swelling of Ankles

Respiratory:
☐ Asthma
☐ Chest Pain
☐ Chronic Cough
☐ Difficulty Breathing
☐ Hay Fever
☐ Shortness of Breath
☐ Spitting up Phlegm/Blood
☐ Wheezing

Gastrointestinal:
☐ Abdominal Pain
☐ Bloating
☐ Blood or Tarry Stool
☐ Colitis/Crohn's
☐ Constipation
☐ Diarrhea
☐ Diverticulitis
☐ Gallbladder Trouble
☐ Hernia
☐ Hemorrhoids
☐ Jaundice
☐ Liver Trouble
☐ Nausea
☐ Painful Defecation
☐ Stomach Pain
☐ Poor Appetite
☐ Vomiting
☐ Vomiting Blood

Women Only:
☐ Congested Breasts
☐ Hysterectomy
☐ Hot Flashes
☐ Lumps in Breasts
☐ Menopause
☐ Vaginal Discharge
☐ Menstrual Flow
☐ Reg. ☐ Irreg. ☐ Pain/Cramps
Days of flow:_____
1st day of last period:_____
Are you pregnant? ☐ Yes ☐ No
If yes, how many months?_____
How many children do you have?_____

Check if you have or have ever had:

☐ Alcoholism ☐ Anemia ☐ Appendicitis ☐ Arteriosclerosis ☐ Asthma ☐ Bronchitis ☐ Cancer ☐ Chicken Pox ☐ Cold Sores ☐ Diabetes ☐ Eczema ☐ Edema ☐ Emphysema ☐ Epilepsy ☐ Goiter
☐ Gout ☐ Heart Burn ☐ Heart Disease ☐ Hepatitis ☐ Herpes ☐ High Cholesterol ☐ HIV/AIDS
☐ Influenza ☐ Malaria ☐ Measles ☐ Miscarriage ☐ Multiple Sclerosis ☐ Mumps ☐ Numbness/Tingling ☐ Pace Maker ☐ Osteoporosis ☐ Pneumonia ☐ Polio ☐ Rheumatic Fever ☐ Stroke ☐ Thyroid Disease ☐ Tuberculosis ☐ Ulcers

Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	☐	☐	
... had any mental disorders?	☐	☐	
... had any broken bones?	☐	☐	
... had any strains or sprains?	☐	☐	
... ever used orthotics?	☐	☐	
Do you take minerals, herbs or vitamins?	☐	☐	

How is most of your day spent? ☐ standing, ☐ sitting, ☐ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐

Family history ***If any blood relative has had any of the following conditions, please check and indicate which relative(s)***

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

Name of Primary Care Physician_____

Phone #:_____ Permission to contact for labs etc. ☐ Yes ☐ No

How did you hear about this clinic: ☐ Walk-By ☐ Website ☐ Flyer

☐ Referral: _____ ☐ Other:_____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statues.

Signature: _____ Date:_____

Doctors Signature _____ Date:_____

HIPAA & Your Privacy Rights

We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records. As a result, we have made some changes in our office management procedures to make sure we follow the Health Information Portability and Accountability Act (HIPAA). Passed into law in 1996, HIPPA sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies and anyone they do business with. HIPPA gives you additional rights regarding control and use of your health information, meaning **you have more access and control than ever.** Please take a few minutes to review these new rights. We're happy to answer any questions you may have.

Control Over Your Health Information

All healthcare providers (and health plans) are now required to give you a written explanation of how they use and disclose your personal health information before they can treat you. This way, you can decide if a provider is doing everything they should to protect your privacy before you choose them as your caregiver.

We must, by law, post a Notice of Privacy Practices, which outlines how we secure the privacy of patient information, in a place where you can easily see it. We must get your signature for non-routine uses and disclosures of your information. A non-routine use is any situation not directly related to treatment, payment or operations. For example, if your child is going to summer camp and the camp needs a medical history, you will be asked to authorize us to release it before we can send the information. You have the right to say no, and you don't have to tell anyone why. Authorizations of non-routine information are one-time-only, case by case, for the use defined by you.

Access To Your Health Information

You can get copies of your medical records simply by asking for them. Healthcare providers are required to get you a copy of your records within 60 days of your request. There may be a cost of this service. Providers also must give you a history of non-routine disclosures if you ask for it. All you need to do is ask for the record and it is provided to you – no justification is needed. You can also amend your medical records. You can not change the existing record, but you can add notes or comment on any procedures, treatments, payments or operations. The provider then has the right to respond to your amendment. This way, you can be sure your records reflect your side of the story about treatment and payment issues.

Patient Recourse If Privacy Protections Are Violated

Every healthcare provider must also inform you of grievance procedures. If your privacy is violated, **report the incident to your Privacy Officer Immediately.** You also have the right to report any violation of the Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201.

If you decide to file a grievance either with us or with the Department of Health and Human Services, we are not allowed to discriminate or retaliate against you in any way. Aside from these new rights to access and control of your medical information under HIPPA, there are also clear limits on all healthcare providers regarding how they disclose medical information. Here are some of the key aspects of these boundaries.

Providers must ensure that health information is not used for non-health purposes. Health information (covered by the privacy rules) generally many not be used for purposes not related to health care – such as disclosures to employers to make personal decisions, or to financial institutions – without your explicit authorization.

There are clear, strong, protections against using health information for marketing. The privacy rules set new definitions, restrictions and limits on the use of patient information for certain marketing purposes. Providers must get your specific authorization before sending you any materials other than those related to treatment.

Use only the minimum amount of information necessary. In general, uses or disclosures of information will be limited to the minimum necessary. This does not apply to disclosure of records for treatment purposes, because physicians, specialists and other providers may need access to the full record to provide quality care.

Exceptions:

There are situations where healthcare providers may not have to follow these privacy rules. They include: emergency circumstances; identification of a body or the cause of death; public health needs; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. We understand your right to have your medical information kept confidential. Our compliance with the Health Information Portability and Accountability Act is one example of our advocacy and leadership on the issues of patient's rights and privacy information. We encourage you to ask questions and look forward to working together to improve the quality of your healthcare experience.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS DOCUMENT. I HAVE A RIGHT TO A COPY OF THIS DOCUMENT IF I SHOULD REQUEST ONE:

SIGNED:_____ **PRINT NAME**_____ **DATE:**_____

INFORMED CONSENT

Patient Name:_____

Clinic Name: Dr. Matt's Wellness Center_____

Doctor's Name: Dr. Matt Kulafoski DC Dr. Jacqueline Romanies DC

Add_____

Phone:_____ Fax: _____

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as a part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethertic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke, or even death. The most common complication or complaint following spinal manipulation is an ache or stiffness at the sight of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These predicitions include but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

Date:_____ _____

Printed Name

_____

Signature

AUTHORIZATION TO TREAT A MINOR CHILD

I hereby authorize this clinic to administer care as deemed necessary to my child:

_____

Printed Name

_____

Signature of Parent of Guardian

_____

Witness

Dr. Matt's Wellness Center

4031 W. Plano Pkwy Suite 201
Plano TX 75093
972-867-9900

Authorization for X-ray/Assignment of Benefits

I, _____, do hereby give my consent to this clinic to perform radiographic evaluation as deemed appropriate. I hereby declare that to my knowledge I am not pregnant.

In consideration for deferment of the time of visit financial responsibility of the balance for services rendered, I hereby authorize payment and endorsement of any insurance reimbursement directly to Dr. Matt's Wellness Center and/or Dr. Kulafofski, D.C. and/or Dr. Romanies D.C. for the intent of payment toward the balance of services rendered. Dr. Matt's Wellness Center and/or Dr. Kulafofski, D.C. and/or Dr. Romanies D.C. agrees to render mutual acceptance of this consideration, offer, intent and assignment.

_____
Patient Signature

_____
Signature of Parent or Guardian (if a minor)

Dr. Matt's Wellness Center

4031 W. Plano Pkwy Suite 201
Plano TX 75093
972-867-9900

Consent to Email and/or Text Message for Appointment Reminders:

We now have the ability to email and/or text you, reminding you of your appointments. If you would like to use this feature, please read the consent below and sign:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment.

I consent to receiving appointment reminders and other healthcare communications/information at that email and/or text from Dr. Matt's Wellness Center.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is
(_____)_____-_____Carrier:_____

_____ (Patient initials) I consent to emails, to receive communications as stated above.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information
is_____.

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Patients Signature:
_____Date:_____