Adult Patient Intake

1. First Name: Last Name: DOB:

2. MRN #:

PATIENT INTAKE

Welcome to our online intake form. The information you fill in will be sent directly to our office, speeding up your office visit and allowing us to better serve your healthcare needs.

ABOUT YOU

3. Home Address

Address 1 Address 2

City State Zip Code

4. Contact Information

Mobile Phone Home Phone

Primary Email Address Social Security Number

5. Demographic Information

Sex:
- Male - Female
- Choose not to answer

Marital Status:
- Single - Married - Divorced - Widowed - Other

6. Spouse's Name:

7. Number of Children:

8. Personal Information

Height - Feet: Height - Inches:

Weight (in pounds):

9. Do you have Blue Cross Blue Shield?

- Yes - No

10. Insurance Policy Information (BCBS only):

Insurance Plan Name
- BCBS

ID/Policy Number: Group Number:

Relationship to Patient:
○ Self ○ Spouse ○ Parent ○ Employer ○ Caregiver ○ Other

Insured's First & Last Name: Insured's Date of Birth:

11. Insurance Card Upload

12. Emergency Contact Information Please List 2 Emergency Contacts

Emergency Contact Name: Contact Phone Number: Relationship to Patient:

13. Employer Information

Employment Status:
○ Employed ○ Student ○ Not Employed ○ Retired ○ Unknown

Employer Name: Occupation:

Physical Work Duties:

14. Referral Information

Referring Physician: Referring Patient:

How did you hear about us?
○ Word of mouth ○ Advertisement ○ Social media ○ Direct mail or email campaign ○ Event ○ Internet

Other:

VISIT PURPOSE

Readiness Assessment & Health Goals

15. What health goals do you want to achieve by working with us?

16. When was the last time you felt well?

17. Did something trigger your change in health?

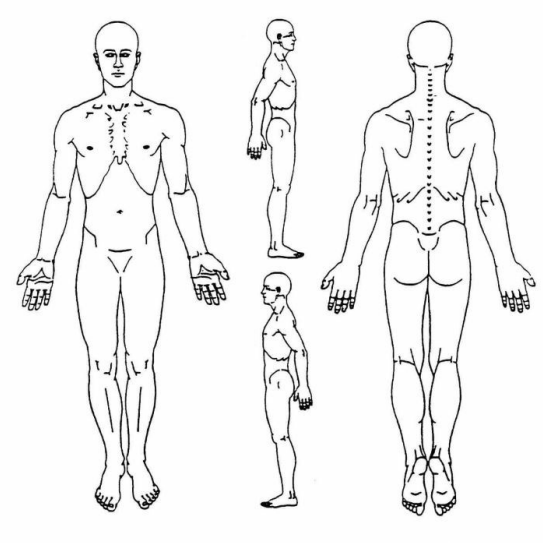
18. What makes you feel better?

19. What activities of daily living that are the most important to you are affected by your condition?

20. What do you feel needs to happen for you to get better?

AREAS OF CONCERN

21. Please circle areas of concern.



22. Approximate date this condition began (exact date not required)

What caused this condition?

23. What term(s) describes your discomfort? Choose all that apply.

	Yes	No
Aching		
Burning		
Deep		
Dull		
Intolerable		
Sharp		
Shooting		
Stabbing/Throbbing		
Stiffness		
Tightness		
Tingling		
Other		

If other, specify:

24. Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

How often do you feel this discomfort?

How has this complaint changed since onset?

25. What aggravates this condition? Choose all that apply.

	Yes	No
Almost any movement		
Athletic activity and/or exercise		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Daily child or pet care		
Getting out of bed, chair or car		
Household chores (cleaning, cooking, etc.)		
Looking over shoulder		
Lying down, getting and staying asleep		
Pulling, pushing or reaching		
Raising arm(s) above shoulder(s)		
Self care (dressing, bathing, etc.)		
Sitting in car or chair		
Squatting or bending		
Standing		
Stress		
Walking or running		
Working at a desk/computer		
Yardwork		
Unknown		
Other		

If other,specify:

26. What improves this condition or gives you relief? Choose all that apply.

	Yes	No
Nothing		
Chiropractic adjustment		
Prescription medications		
Cold packs		
Redirecting attention		
Exercise		
Rest		
Heat packs		
Stretching		
Massage		
Work		
Over-the-counter medications		
Physical therapy		
Other		

If other, specify:

_____

27. Have other health care provider(s) performed tests related to this condition?

○ Yes ○ No

If Yes, specify:

_____

28. What treatment, if any, have you received since the injury? Choose all that apply.

	Yes	No
Chiropractic care		
Massage		
Medical injection treatment		
Surgical treatment		
Over-the-counter medications		
Prescribed medications		
Natural or holistic treatment		
Acupuncture		
Physical therapy		
None		
Other		

If other, specify:

_____

29. Have you ever had any previous episodes of this condition?

○ Yes ○ No

If Yes, specify:

CURRENT HEALTH

30. Are you currently taking any medications?

○ Yes ○ No

31. Please list regularly used prescription and over-the-counter medications taken, as well as the Dosage and Frequency for each medication (e.g. 5 mg once daily)

	Medication Name	Dosage/Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

32. Medication Allergies

	Medication Name	Reaction	Onset Date	Additional Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				

33. Have you taken any of these regularly or for a long period of time?

	Yes	No
Tylenol (Acetaminophen)		
NSAIDs (Advil, Aleve, Ibuprofen, etc.) Motrin, Aspirin		
Acid Blocking Drugs (Zantac, Prilosec, Nexium, etc.)		

34. How many times have you taken antibiotics?

	<5	>5
Childhood		
Teen		
Adult		

35. Have you ever taken long term antibiotics?

○ Yes ○ No

If yes, please explain:

_____

36. How often have you taken oral steroids (Cortisone, Prednisone, etc.)

	<5	>5
Childhood		
Teen		
Adult		

Supplements

37. Please list regularly used supplements as well as dosage and frequency for each

	Supplement	Dosage / Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Patients Birth/Childhood History

38. You were born:

○ Term ○ Premature ○ Unsure

39. Were there any pregnancy or birth complications?

○ Yes ○ No

If yes, explain:

_____

40. You were:

	Yes
Breastfed	
Formula	
Unsure	

How long?

_____

41. As a child, were there any foods that were avoided be because they gave you symptoms?

○ Yes ○ No

42. If yes, what foods and what symptoms? (Ex: Milk- gas and diarrhea)

_____

43. Did you eat a lot of sugar or candy as a child?

○ Yes ○ No

44.

	Yes	No
Have you had any surgical procedures?		
Are there any past illnesses or conditions we should be aware of?		
Do you have a past history of accidents or trauma?		

If yes, please explain:

_____

Dental History

45. Check if you have any of the following; provide number if applicable:

☐ Silver Mercury Fillings _____
☐ Gold Fillings _____
☐ Root Canals _____
☐ Implants _____
☐ Caps/Crowns _____
☐ Tooth Pain _____
☐ Bleeding gums _____
☐ Gingivitis _____
☐ Problem Chewing _____
☐ Other _____

46. Have you had any mercury fillings removed?

○ Yes ○ No

If yes, when?

_____

47. Do you brush regularly?

○ Yes ○ No

Environmental / Detoxification History

48. Do any of these significantly affect you?

☐ Cigarette Smoke ☐ Perfume / Cologne ☐ Auto Exhaust Fumes
☐ Other

49. In your work or home environment are you regularly exposed to: (Check all that apply)

☐ Mold ☐ Water leaks ☐ Renovations
☐ Chemicals ☐ Electromagnetic Radiation ☐ Damp Environments
☐ Carpets or Rugs ☐ Old Paint ☐ Stagnant / Stuffy Air
☐ Smokers ☐ Pesticides ☐ Herbicides
☐ Airplane Travel ☐ Cleaning Chemicals ☐ Harsh Chemicals
☐ Heavy Metals ☐ Other

50. Have you had a significant exposure to any harmful chemicals?

○ Yes ○ No

If yes, list chemical name, length of exposure, and date:

_____

51. Do you have any pets or farm animals?

☐ Yes ☐ No

52. If yes, do they live:

	Answer
Inside	
Outside	
Both Inside & Outside?	

Women's History (Skip if Male)

Obstetric History (check and provide a number to all that apply)

53.☐ Pregnancies ☐ Vaginal Deliveries ☐ Miscarriages

_____ _____ _____

☐ Cesarean ☐ Abortions ☐ Term Births

_____ _____ _____

☐ Living Children ☐ Premature Birth

_____ _____

54. Did you develop any problems in or after pregnancy? (Toxemia, Diabetes, Postpartum Depression, Breast-feeding Issues)

○ Yes ○ No

If yes, please explain:

_____

Menstrual History (Skip if Male)

55. ☐ Age of First Cycle ☐ Date of Last Cycle ☐ Length of Cycle

_____ _____ _____

☐ Time Between Cycles

_____

56. Other problems with your cycle?

○ Yes ○ No

If yes, describe:

_____

57. Use of hormonal birth control?

○ Birth Control Pills ○ Birth Control Patch ○ Nuva Ring
○ Other

58. Other forms of contraception?

○ Yes ○ No

59. ○ Condoms ○ Diaphrahm ○ IUD
○ Partner Vasectomy

60. Are you in menopause?

○ Yes ○ No

61. Do you currently have symptomatic problems with menopause? (Check all that apply)

☐ Hot Flashes ☐ Mood Swings ☐ Headaches
☐ Joint Pain ☐ Concentration / Memory Loss ☐ Vaginal Dryness
☐ Weight Gain ☐ Decreased Libido ☐ Urine Control Loss
☐ Palpitations

62. Are you on hormone therapy?

○ Yes ○ No

If yes, for how long & for what reason?

_____

Other Gynecological Symptoms (Check all that apply)

63. ☐ Endometriosis ☐ Infertility ☐ Fibrocystic Breasts
☐ Pelvic Inflammatory Disease ☐ Ovarian Cysts ☐ Fibroids
☐ Reproductive Cancer ☐ Sexually Transmitted Diseases ☐ Other

STD (describe):

Men's History (Skip if Female)

64. Check if Applicatable

☐ Testicular Mass ☐ Testicular Pain ☐ Prostate Infection
☐ Change in Libido ☐ Impotence ☐ Premature Ejactulation
☐ Difficulty Obtaining Erection ☐ Loss of Urine Control ☐ Urinary Stream Issues
☐ Vasectomy ☐ Prostate Enlargement ☐ Difficulty Maintaining Erection
☐ Nocturia (unrination at night) ☐ Sexually Transmitted Disease (describe): ☐ Other

STD describe:

Lifestyle Review

65. How many hours of sleep do you get on average?

66.

	Yes	No
Problems falling asleep?		
Problems with insomnia?		
Staying asleep?		
Do you snore?		
Do you feel rested upon awakening?		
Do you use sleeping aids?		

If yes, please explain:

67. Personal Social Habits

	Yes	No
Smoke or use tobacco products		
Drink alcohol		
Drink caffeine		
Use recreational drugs		
Other, to be discussed with doctor		

68. Present Exercise Habits

	Yes	No
No current exercise		
Exercise daily		
Exercise 3+ times per week		
Cannot return to exercise due to current condition		

69. Do you have any intolerances to the following?

- ☐ Gluten (Wheat)
- ☐ All Dairy Products
- ☐ Lactose
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast

70. Any known food allergies or sensitivities?

_____

71. Are there any foods that you crave or binge on?

- ☐ Yes
- ☐ No

If yes, please explain?

_____

72. Do you adversely react to: (Check all that apply)

- ☐ Monosodium glutamate (MSG
- ☐ Chocolate
- ☐ Artificial sweeteners
- ☐ Garlic/onion
- ☐ Cheese
- ☐ Citrus foods
- ☐ Preservatives
- ☐ Food colorings
- ☐ Other

73. Do you drink caffeinated beverages?

- ○ Yes
- ○ No

74. Coffee (cups per day)

- ○ 1
- ○ 2-4
- ○ >4
- ○ None

75. Tea (cups per day)

- ○ 1
- ○ 2-4
- ○ >4
- ○ None

76. Caffeinated sodas - diet or regular (cans per day)

- ○ 1
- ○ 2-4
- ○ >4
- ○ None

77. Do you have adverse reactions to caffeine?

- ☐ Yes
- ☐ No

If yes, please explain:

_____

Smoking

78. Do you smoke currently?

○ Yes ○ No

If yes, packs per day and number of years?

79. Have you attempted to quit?

○ Yes ○ No

If yes, what methods?

80. Are you regularly exposed to second hand smoke?

○ Yes ○ No

Alcohol

81. How many alcoholic beverages do you drink a week? (1 drink = 5oz wine, 12oz beer, 1.5oz spirits)

○ 1-3 ○ 4-6 ○ 7-10

○ >10 ○ None

82. Have you had an alcohol problem?

○ Yes ○ No

If yes, when?

Other Substances

83. Do you currently use recreational drugs?

○ Yes ○ No

If yes, what type?

Stress

84. Do you feel like you have an excessive amount of stress in your life?

○ Yes ○ No

85. Do you feel you can easily handle the stress in your life?

○ Yes ○ No

86. How much stress do each of the following cause on a daily basis? (rate on a scale 1-10, 10 being highest)

Work

Family

Social

Finance

Health

Other

87. Do you use relaxation techniques?

- ○ Yes
- ○ No

88. If yes, which techniques?

- ☐ Meditation
- ☐ Breathing
- ☐ Tai Chai
- ☐ Yoga
- ☐ Prayer
- ☐ Other
- ☐ None

If other:

89. Have you ever sought counseling?

- ○ Yes
- ○ No

90. Are you currently in therapy?

- ○ Yes
- ○ No

91. Have you ever been abused, a victim of crime, or experienced a significant trauma?

- ○ Yes
- ○ No

92. What are your hobbies or leisure activities?

Family History

93. Is there anyone in your immediate family who has experienced the following? If yes, please select and indicate who.

	Mother	Father	Brother(s)	Sister(s)	Child 1	Child 2	Child 3	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother	Other
Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Autoimmune Disease												
Arthritis												
Kidney Disease												
Thyroid Problems												
Seizures/Epilepsy												
Psychiatric Disorders												
Anxiety												
Depression												
Asthma												
Allergies												
Eczema												
ADHD												
Autism												
Irritable Bowel Syndrome												
Dementia												
Substance Abuse												
Genetic Disorders												
Other												

Health History

Personal Medical History (Check if you have had any of the following:)

94. Gastrointestinal

- ☐ Irritable Bowel Syndrome
- ☐ GERD (reflux)
- ☐ Crohn's Disease/Ulcerative Colitis
- ☐ Peptic Ulcer Disease
- ☐ Celiac Disease
- ☐ Gallstones
- ☐ SIBO
- ☐ Other
- ☐ None

If other, please explain or specify:

95. Respiratory

- ☐ Bronchitits
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sinusitis
- ☐ Sleep Apnea
- ☐ Other
- ☐ None

If other, please specify:

_____

96. Urinary / Genital

- ☐ Kidney Stones
- ☐ Gout
- ☐ Interstitial Cystitis
- ☐ Frequent Yeast Infections
- ☐ Urinary Tract Infections
- ☐ Sexual Disfunction
- ☐ Sexually Transmitted Diseases
- ☐ Other
- ☐ None

If other, please specify:

_____

97. Musculoskeletal

- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Chronic Pain
- ☐ Other
- ☐ None

If other, please specify:

_____

98. Skin

- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Skin Cancer
- ☐ Other
- ☐ None

If other, please specify:

_____

99. Cardiovascular

- ☐ Angina
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Hypertension (High Blood Pressure)
- ☐ Stroke
- ☐ High Blood Fats (Cholesterol, Triglycerides)
- ☐ Rheumatic Fever
- ☐ Arrythmia (Irregular Heart Rate)
- ☐ Murmur
- ☐ Mitral Valve Prolapse
- ☐ Other
- ☐ None

If other, please specify:

_____

100. Endocrine / Metabolic

- ☐ Diabetes
- ☐ Hypothyroidism (Low Thyroid)
- ☐ Hyperthyroidism (Overactive Thyroid)
- ☐ Polycystic Ovarian Syndome
- ☐ Infertility
- ☐ Metabolic Syndrome / Insulin Resistance
- ☐ Eating Disorder
- ☐ Hypoglycemia
- ☐ Other
- ☐ None

If other, please specify:

_____

101. Inflammatory / Immune

- ☐ Rheumatoid Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Multiple Chemical Senitivities
- ☐ Autoimmune Disease
- ☐ Immune Deficiency
- ☐ Mononucleosis
- ☐ Hepatitis
- ☐ Other
- ☐ None

If other, please specify:

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102. Neurological / Emotional

- ☐ Epilepsy / Seizures
- ☐ ADD / ADHD
- ☐ Headaches
- ☐ Migraines
- ☐ Depression
- ☐ Anxiety
- ☐ Autism
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Dementia
- ☐ Other
- ☐ None

If other, please specify:

---

103. Cancer

- ☐ Lung
- ☐ Breast
- ☐ Colon
- ☐ Ovarian
- ☐ Skin
- ☐ Other
- ☐ None

If other, please specify:

---

104. Injuries

	Date	Additional Information
Concussion / Head Injury		
Other		

If other, please specify:

---

105. Surgeries

Surgeries	Date	Additional Information
Surgery		
Surgery		
Surgery		

106. Hospitalizations

	Date	Additional Information
Hospitalizations		
Hospitalizations		
Hospitalizations		

Symptom Review

107. General

- ☐ Cold Hands and Feet
- ☐ Cold Intolerance
- ☐ Day Time Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Nightmares
- ☐ Can't Remember Dreams
- ☐ Low Body Temperature
- ☐ None

108. Head, Eyes, And Ears

- ☐ Conjunctivitis
- ☐ Distorted Sense of Smelll
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Ringing / Buzzing
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Eyelid Margin Redness
- ☐ Headache
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Migraines
- ☐ Loud Noise Sensitivity
- ☐ Vision Problems
- ☐ None

109. Musculoskeletal

- ☐ Back Muscle Spasms
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Twitches (around eyes)
- ☐ Muscle Twitches (arms or legs)
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasms
- ☐ Tendinitis
- ☐ Tension Headache
- ☐ TMJ Problems
- ☐ None

110. Mood / Nerves

- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Blackouts
- ☐ Depression
- ☐ Difficulty Concentration
- ☐ Difficulty With Balance
- ☐ Difficulty With Thinking
- ☐ Difficulty With Judgement
- ☐ Difficulty With Speech
- ☐ Difficulty with Memory
- ☐ Dizziness
- ☐ Fainting
- ☐ Fearfulness
- ☐ Lightheadedness
- ☐ Irritability
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor / Trembling
- ☐ Visual Hallucinations
- ☐ None

111. Cardivascular

- ☐ Angina / Chest Pain _____
- ☐ Breathlessness _____
- ☐ Heart Attack _____
- ☐ Heart Murmur _____
- ☐ High Blood Pressure _____
- ☐ Irregular Pulse _____
- ☐ Mitral Valve Prolapse _____
- ☐ Palpitations _____
- ☐ Phlebitis _____
- ☐ Swollen Ankles / Feet _____
- ☐ Varicose Veins _____
- ☐ None _____

112. Urinary

- ☐ Bed Wetting
- ☐ Hesitancy
- ☐ Infection
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leaking / Incontinence
- ☐ Pain / Burning
- ☐ Urgency
- ☐ None

113. Digestion

- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Bloating
- ☐ Blood in Stool
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Consipation
- ☐ Cracking at Corner of Lips
- ☐ Poor Chewing with Dentrues
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Flatuence
- ☐ Fissures
- ☐ Reflux
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Liver Disease / Jaundice
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stool
- ☐ Nausea
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Oder
- ☐ Undigested Food in Stool
- ☐ Upper Abdominal Pain
- ☐ Vomiting
- ☐ None

114. Eating

- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Carbohydrate Craving
- ☐ Carbohydrate Intolerance
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Frequent Dieting
- ☐ Sweet Cravings
- ☐ Caffeine Dependency
- ☐ None

115. Respiratory

- ☐ Bad Breath
- ☐ Bad Odor In Nose
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Sore Throat
- ☐ Wheezing
- ☐ Winter Stuffiness
- ☐ None

116. Nails

- ☐ Biten
- ☐ Briddle
- ☐ Curve Up
- ☐ Frayed
- ☐ Finger Fungus
- ☐ Toe Fungus
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft
- ☐ Thickening of Finger Nails
- ☐ Thickening of Toe Nails
- ☐ White Spots / Lines
- ☐ None

117. Lymph Nodes

- ☐ Enlarged
- ☐ Tender
- ☐ None

118. Skin Problems

- ☐ Acne
- ☐ Athletes Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Easy Bruising
- ☐ Eczema
- ☐ Herpes / Genital
- ☐ Hives
- ☐ Jockitch
- ☐ Lackluster Skin
- ☐ Moles with Color / Size Change
- ☐ Oily Skin
- ☐ Psoriasis
- ☐ Rash
- ☐ Red Face
- ☐ Sensitive to Bites
- ☐ Sensitive to Poison Ivy
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Strong Body Odor
- ☐ Vitiligo
- ☐ None

119. Male Reproductive (Skip if Female)

- ☐ Discharge from Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Infection
- ☐ Lumps in Testicles
- ☐ Poor Libido (Low sex drive)
- ☐ None

120. Female Reproductive (Skip if Male)

- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Low sex drive)
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Infertility
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain
- ☐ None

121. Premenstrual: (Skip if Male)

- ☐ Bloating
- ☐ Breast Tenderness
- ☐ Carbohydrate Craving
- ☐ Chocolate Craving
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability
- ☐ None

Readiness Assessment and Health Goals

122. Rate on a scale 1 (not willing) to 5 (very willing): In order to improve your health, how willing are you to:

	1	2	3	4	5
Significantly Modify your Diet					
Take Several Nutritional Supplements Each Day					
Modify your Lifestyle (e.g., Work demands, sleep habits)					
Practice a Relaxation Technique					
Engage in Regular Exercise					

123. Rate on a scale 1 (very unsupportive) to 5 (very supportive):

	1	2	3	4	5
At the present time, how supportive do you think the people in your household will be to your implementing the above changes?					

_____
Signature

124. Primary Insurance

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

New Member Intake and Financial Policies – Consents

Contact

I authorize Smiley Family Chiropractic & Wellness Center to contact me via phone, text, or email. Contact purposes are typically, but not limited to being informative in nature – appointment reminders and/or info about closings and important dates. On occasion I may send notifications about current research or goings on in the field of chiropractic, Functional Medicine, Functional Neurology, Functional Endocrinology, or health in general. Dr. Jessica Smiley and/or Dr. Brittany Steward will also use these contacts to follow up when that is necessary. Your contact info will never be sold or solicited. I authorize Smiley Family Chiropractic & Wellness Center to utilize smileyfamilychiropractic@msn.com and/or drsmiley_sfcwc@hotmail.com, or (423)442-2100 and/or (423)295-4406 to contact me when needed.

- I agree

Insurance and Billing

I understand that Smiley Family Chiropractic & Wellness Center, will not in any way bill my insurance, nor will they give billing codes for reimbursement from insurance for any services outside of Chiropractic. I understand that I am responsible for full payment for any service at the time of service, unless otherwise agreed upon. I agree that if an invoice is emailed or mailed after the service that I will submit payment within 7 days of receiving the invoice, unless otherwise agreed upon. If payment is not received within 7 days Smiley Family Chiropractic & Wellness Center may begin collection procedures if deemed necessary and/or begin to add 5% interest to the uncollected balance per month from the date of service.

- I agree

Cancellation Policy

I fully acknowledge that Smiley Family Chiropractic & Wellness Center will enforce a cancellation policy if I fail to cancel my appointment more than 24 hours in advance for Functional Neurology or Functional Medicine appointments and more than 7 days for Intensive Functional Neurology appointments. The policy is as detailed below:

- If a Functional Neurology or Functional Medicine appointment is not cancelled within 24 hours a 50% cancellation fee will be charged.
- If an Intensive Functional Neurology appointment is cancelled between 8-14 days before the appointment, 50% cancellation fee may be collected. If an appointment is cancelled within 0- 7 days a 100% cancellation fee will be collected.

If you do not show up to your scheduled appointment, your card will be charged for 100% of the scheduled appointment fee.

- I am aware of the cancellation policy, and I agree

Credit Card

Based on the details noted above I authorize Smiley Family Chiropractic & Wellness Center to charge the credit card given in the amount dictated per guidelines for the cancellation policy above

- I agree

HIPPA

I have read or been given the chance to read over the HIPPA guidelines (posted on the website/from)

- I agree

Medical Information

I agree to allow Smiley Family Chiropractic & Wellness Center to obtain and/or send medical information as deemed medically necessary for my care. I also agree to allow Smiley Family Chiropractic & Wellness Center to consult with providers that I am seeing or have seen as needed for my care.

- I agree

Media Release

I authorize Smiley Family Chiropractic & Wellness Center to use various photos and videos as deemed necessary for educational and academic purposes. Mediums that these photos and videos may be used for includes but is not limited to; lectures and social media (Smiley Family Chiropractic & Wellness Center's Facebook Page and Instagram). Due to the nature of what we do in the office it is important that people see and understand this new form of healthcare. Our goal with any information shared is to further the understanding of functional neurology, laser therapy, chiropractic, and other modalities or methods utilized. All photos and videos will be tactful.

- o I agree
- o I disagree

Non-Refundable Deposit

I understand that for intensive appointments that have more than 3 hours booked in one week, the office will request a nonrefundable deposit of $1,000 to hold the appointments. I understand that the deposit amount will go toward the full cost of the intensive and is non-refundable and non- transferable.

- o I agree

Acknowledgement

By signing below, you acknowledge that you have fully read or have had the chance to read all information contained within this document and have had an opportunity to ask any questions or concerns and are in agreement with these terms and information.

- o I agree

_____ Date____/_____/_____

Signature

_____ Date____/_____/_____

Parent or legal guardian (if under the age of 18)

Smiley Family Chiropractic & Wellness Center
NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW THIS NOTICE CAREFULLY. *This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated.*

NO CONSENT REQUIRED - The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment – In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

(b) Payment – In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

The Practice may also use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information – Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate – To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations –
   (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
   (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers – If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence – To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities – Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(p) Disclosure of immunizations to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER - The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice: a postcard mailed to you at the address provided by you; and telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

DIRECTORY/SIGN-IN LOG - The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS - The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:
(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure. (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

PRACTICE'S REQUIREMENTS - The Practice:

- is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- is required to abide by the terms of this Privacy Notice.
- reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- will distribute any revised Privacy Notice to you prior to implementation.
- will not retaliate against you for filing a complaint.

YOUR RIGHTS - You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and obtain a copy of your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

(e) Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy).

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Receive notice of any breach of confidentiality of your PHI by the Practice.

(i) Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

(j) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(k) Request copies of your PHI in electronic format.

To obtain more information on or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Dr. Jessica Smiley-Hedrick, at **423-442-2100** or via email at **drsmiley@sfcwc@hotmail.com**.

QUESTIONS AND COMPLAINTS - You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below that is the Privacy Officer and Contact person appointed for this practice. The Privacy Officer Dr Jessica.

You may file a complaint with the Privacy Officer if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Privacy Officer. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE - This Notice is in effect as of 6/29/2022

_____ (Patient) _____ (Date)

Smiley Family
Chiropractic & Wellness Center

Financial Policy

1. It is the policy of this office that all services rendered be ultimately the responsibility of the patient, including those that are not reimbursed by third party payers.

2. All payments/co-payments/deductibles are payable when services are rendered or at the beginning of each week or month as credit to your account with no exceptions, unless prior arrangements have been made. If you choose to pay in advance you will be saving time at the front desk. If you are prepaid and pre-scheduled no wait is necessary, you can return your chart to the front desk counter and leave.

3. This office does not promise that an insurance company will reimburse for the usual and customary charges submitted by this office. We will honor what they communicate to us at the time of benefit verification, but as they do not guarantee benefits until claim is processed and released, neither can we.

4. This office will accept payment from secondary insurance but will not file with a secondary insurance and cannot guarantee charges will be reimbursed. Unpaid balances older than **60 days** will become patient's responsibility automatically.

5. Since we do not own your policy and occasionally we experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying a situation on any of your bills older than **30 days**. 30 days after your acknowledgment we send you a bill.

6. SFCWC will NOT enter into a dispute with an insurance company over the amount of reimbursement.

7. It is the patient's responsibility to communicate to this office any changes in status of his/her insurance company policy, or new information on auto accident and worker's compensation. Failure to do so will result in patient being responsible for bills up to the date of our acknowledgment.

8. Returned checks will be subject to an additional $35.00 collection fee. All balances over 30 days will be subject to a late fee of **10% of total owed every 30 days or a past due fee of $10, whichever one is greater**.

9. All accounts not paid within **90 days** will automatically be turned over to SFCWC's Attorney. If SFCWC must file a lawsuit for unpaid balances, Patient agrees to cover all Attorney fees and Court costs.

10. All patients whose visitation schedule is once per month (or longer) will not be eligible for insurance assignment; since that frequency constitutes a well visit, insurances will not cover maintenance care.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions in regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for a mutual benefit.

I HAVE READ, UNDERSTOOD, AND AGREED WITH THE ABOVE **FINANCIAL AGREEMENT.**

Patient Signature: _____ Date: ____/____/_____

I HAVE READ, UNDERSTOOD, AND AGREED WITH THE **OFFICE AND APPOINTMENT POLICIES** explained to me of which I hold the original copy.

Patient Initials: _____

New Member Intake and Financial Policies

This document serves to inform you about potential risks that can be associated with care in our office. Please read and ask questions as needed. Dr. Jessica Smiley and Dr. Danielle Barron are licensed Chiropractors in the state of Tennessee. Dr. Smiley and Dr. Barron have pursued post graduate courses in Neuroscience. Dr. Smiley and Dr. Barron are currently working towards their fellowship as board eligible Functional Neurologists with a focus in Developmental Functional Neurology. Both doctors have also received extensive post graduate training in Functional Medicine. Dr. Smiley and Dr. Barron are board certified by the American Veterinary Chiropractic Association in animal chiropractic. Dr. Smiley also holds a license in Pastoral Medicine. With that being said, please read each statement accordingly:

Smiley Family Chiropractic and Wellness Center will not claim to treat or cure any medical conditions, but rather will attempt to restore balance and function to your health and wellness. This process may include examinations, chiropractic adjustments, functional neurology assessments and therapies, music / acoustic therapy, color / light therapy, vestibular rehab, physical therapy exercises, muscle work (muscle stripping, massage, stretching, rehab), supplemental recommendations, diet alteration, blood chemistries, stool samples, saliva samples, various intake forms, and other methods and modalities may be used as well.

If any dietary or supplemental recommendations are made Smiley Family Chiropractic and Wellness Center, we do recommend that you bring these recommendations to your medical providers before beginning. Any recommendations made are not intended to diagnose, treat, cure, or manage any medical condition.

Chiropractic, Functional Medicine, and Functional Neurology comprise various methods of establishing balance within one's body. The methods that Smiley Family Chiropractic and Wellness Center utilizes should not replace that of traditional medical approaches, and it is always advised that anyone under our care should follow up with their medical providers to discuss any care recommendations. At times, an adjustment/manipulation/fast stretch may be performed to help improve your function and eliminate the effects of vertebral subluxation. As with all types of health care interventions, there are some risks to care, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains and sprains. There are very rare occurrences when stroke has been linked to an adjustment - many studies have been performed on this topic, some try to demonstrate a very weak association, but most studies show that chiropractic manipulations are not directly linked to this type of injury. The methods that Dr. Jessica Smiley and Dr. Danielle Barron utilizes minimize all the above-mentioned risks. Historically, Chiropractic is a very safe and effective means to achieve a more optimal state of health and wellness. In this practice Dr. Jesscia Smiley and Dr. Danielle Barron will need to perform an exam prior to commenting on the state of your health and prior to making any recommendations.

Smiley Family Chiropractic and Wellness Center may use various types of photos biomodulation during your appointments. This will involve the use of a laser / light. Laser therapy has been heavily researched and proven safe and effective for many different conditions over the past several decades. We do not claim to treat, cure, manage, or diagnose any medical condition with photobiomodulation. We are

simply improving the overall function of your body via the various proven effects of the laser / light therapy.

Smiley Family Chiropractic and Wellness Center acknowledges the scope of Chiropractic in the state of Tennessee is very limited and we will stay within this scope of practice. All therapies and procedures performed will be geared toward the following goals: to reduce the effects of the vertebral subluxation complex via various reflexogenic systems, to establish balance within your body, and to improve your overall health and wellness.

If you have any concerns or reservations prior to care with Smiley Family Chiropractic and Wellness Center, please do not hesitate to ask. If you ever experience something that causes any concern, please discuss the matter with us immediately.

By signing below, you acknowledge that you have fully read or have had the chance to read all information contained within this document and have had an opportunity to ask any about any questions or concerns and agree with these terms and information.

Pertinent to Intensive Functional Neurology Patients Only

I fully acknowledge that Smiley Family Chiropractic and Wellness Center will enforce a cancellation policy if I fail to cancel my appointment more than 14 days in advance. The policy is as detailed below: • If appointment is canceled between days 8-14 days before the appointment a 50% cancellation fee may be collected. • If appointment is canceled between days 0-7 days before the appointment a 100% cancellation fee may be collected. • If you do not show up at your scheduled appointment, your card will be charged for 100% of the scheduled appointment fee.

- ○ I agree

Pertinent to Functional Neurology and Functional Medicine Patients

I fully acknowledge that Smiley Family Chiropractic and Wellness Center will enforce a cancellation policy if I fail to cancel my appointment less than 24 hours in advance. If a Functional Neurology or Functional Medicine appointment is not cancelled within 24 hours a 50% cancellation fee of services rendered will be collected.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message or a text message.

- ○ I agree