NEW PATIENT
INTAKE • HEALTH PROFILE • HISTORY

Date ___/___/_____

PATIENT INFORMATION *(all fields required)*

Name: _____ Age: _____ Date of Birth: _____

Address: _____ SSN: _____ Sex: □ Male □ Female

City: _____ State: _____ Zip: _____ Employer/School: _____

Cell Phone: (____)_____ Occupation: _____

Home Phone: (____)_____ □ Married □ Widowed □ Single □ Minor

Email: _____ □ Separated □ Divorced □ Partnered for _____ years

IN CASE OF EMERGENCY, CONTACT: Spouse's Name: _____

Name: _____ Relationship: _____ Spouse's Employer: _____

Cell: (____)_____ Home: (____)_____ Whom may we thank for referring you? _____

MEDICATIONS/SUPPLEMENTS/ALLERGIES:

_____ _____ _____

_____ _____ _____

CONSENT TO EVALUATE AND TREAT A MINOR

I, _____ being the parent or legal guardian of _____, have read and fully understand the below terms of acceptance and hereby grant permission for my child to receive chiropractic care at Legacy Chiropractic.

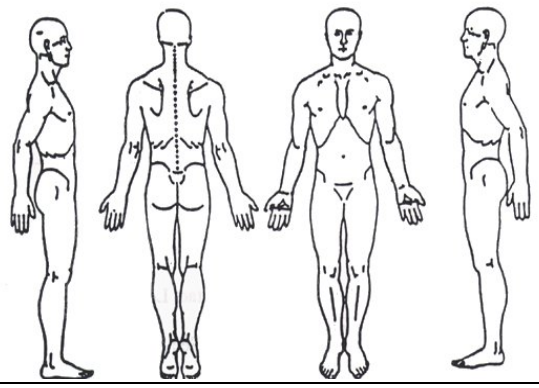
_____ _____

LEGAL GUARDIAN SIGNATURE DATE

PATIENT HEALTH CONCERNS

Health Concern: List according to severity.	Rate on Scale from: 0-10 0-None 10-Most	When did it start? Year/Month	Is it getting better or worse?	What makes it better & what makes it worse?	Sharp? Dull? Burning? Numb? Achy? Tingling? Weakness?	Intermittent (I) or Constant? (C)
1.						
2.						
3.						
4.						

Place an "X" on the diagram where you are experiencing discomfort:



Does this interfere with: □ Work □ Sleep □ Recreation □ Daily Routine

Have you sought other healthcare providers for this? Yes/No

□ Chiropractic (Dr _____ Date_____)

□ Medications (Dr _____ Date_____)

□ Surgery (Dr _____ Date_____)

□ Physical Therapy (Dr _____ Date_____)

□ Other (Dr _____ Date_____)

PATIENT HEALTH HISTORY

Family Physician: _____ May we contact this physician? Yes / No

Have you received Chiropractic care before? Y / N Name: _____ Dates: _____ to _____

Have you had SPINAL X-Rays/ MRI's/ CT's? Y / N Type/Date: _____

Check "Yes" or "No" to indicate if you have OR have ever had any of the following:

Aids/HIV	□ Yes □ No	Chicken Pox	□ Yes □ No	Liver Disease	□ Yes □ No	Rheumatoid Arth	□ Yes □ No
Alcoholism	□ Yes □ No	Diabetes	□ Yes □ No	Measles	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Allergy Shots	□ Yes □ No	Emphysema	□ Yes □ No	Migraine HA's	□ Yes □ No	Scarlet Fever	□ Yes □ No
Anemia	□ Yes □ No	Epilepsy	□ Yes □ No	Miscarriage	□ Yes □ No	Seizure	□ Yes □ No
Anorexia	□ Yes □ No	Fractures	□ Yes □ No	Mononucleosis	□ Yes □ No	Stroke	□ Yes □ No
Appendicitis	□ Yes □ No	Glaucoma	□ Yes □ No	Multiple Sclerosis	□ Yes □ No	Suicide Attempt	□ Yes □ No
Arthritis	□ Yes □ No	Goiter	□ Yes □ No	Mumps	□ Yes □ No	Thyroid Problems	□ Yes □ No
Asthma	□ Yes □ No	Gonorrhea	□ Yes □ No	Osteoporosis	□ Yes □ No	Tonsillitis	□ Yes □ No
Bleeding Dys	□ Yes □ No	Gout	□ Yes □ No	Pacemaker	□ Yes □ No	Tuberculosis	□ Yes □ No
Breast Lump	□ Yes □ No	Heart Disease	□ Yes □ No	Parkinson's Dz	□ Yes □ No	Tumors, Growths	□ Yes □ No
Bronchitis	□ Yes □ No	Hepatitis	□ Yes □ No	Pinched Nerve	□ Yes □ No	Typhoid Fever	□ Yes □ No
Bulimia	□ Yes □ No	Hernia	□ Yes □ No	Pneumonia	□ Yes □ No	Ulcers	□ Yes □ No
Cancer	□ Yes □ No	Herniated Disk	□ Yes □ No	Polio	□ Yes □ No	Vaginal Infections	□ Yes □ No
Cataracts	□ Yes □ No	Herpes	□ Yes □ No	Prostate Problem	□ Yes □ No	Venereal Dz	□ Yes □ No
Chemical		High Cholesterol	□ Yes □ No	Prosthesis	□ Yes □ No	Whooping Cough	□ Yes □ No
Dependency	□ Yes □ No	Kidney Disease	□ Yes □ No	Psychiatric Care	□ Yes □ No	Other _____	

EXERCISE

□ None
□ Moderate
□ Daily
□ Heavy

WORK ACTIVITY

□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

HABITS

□ Smoking/Previous Packs/Day _____ Date Quit _____
□ Alcohol Drinks/Week _____
□ Coffee/Caffeine Cups/Day _____
□ High Stress Reason _____

ILLNESS-WELLNESS CONTINUUM (Circle the number that best represents your overall health today.)

Pre-Mature Death ← **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** → **High-Level Wellness**

PREGNANCY

Are you currently pregnant? □ No □ Yes, I am due: _____

Number of past pregnancies: _____

Children's ages: Child #1 _____ Child #2 _____ Child #3 _____ Child #4 _____

INJURIES/SURGERIES/ACCIDENTS you have had:	**Description**	**Date(s)**
Accidents:	_____	_____
Falls:	_____	_____
Surgeries:	_____	_____
Head Injuries:	_____	_____
Broken Bones:	_____	_____
Dislocations:	_____	_____

FAMILY HEALTH HISTORY

SOME HEALTH PROBLEMS COMMONLY OCCUR IN MULTIPLE MEMBERS OF THE SAME FAMILY. THIS FORM IS TO ASSIST THE DOCTOR BY PROVIDING A COMPREHENSIVE REVIEW OF YOUR FAMILY'S CURRENT AND PAST HEALTH HISTORY. (PLACE CHECKMARKS FOR MULTIPLE CHILDREN.)

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
THYROID PROBLEMS					
TMJ					
*NOT ABOVE (LIST BELOW)					

_____ _____

PRINT PATIENT NAME DATE

INSURANCE INFORMATION

Insurance Co: _____ Insurance Phone #: _____

ID #: _____ Name of Policy Holder: _____

Group #: _____ SSN: _____ Policy Holder DOB: _____

Secondary Insurance Co: _____ Secondary Insurance Phone #: _____

ID #: _____ Employer: _____

Group #: _____ Relationship to Patient (if not self): _____

MEDICARE BENEFICIARY NOTICE

All Medicare patients are responsible for their $155 yearly deductible for chiropractic care. Medicare does not cover exams, but requires them before any adjustments of the spine can be performed. Medicare does not cover x-rays, but they may be necessary for treatment to occur. Medicare provides coverage for chiropractic adjustments when Medicare rules are met. **The patient is responsible for any services that are not covered by Medicare or supplemental insurance.**

INSURANCE POLICIES AND FEE SCHEDULE

CONSULTATION: Includes patient member history. This service is complimentary.
ASSESSMENT/EVALUATION/EXAMINATION (new or established patient): Includes one or more of the following: thermography, range of motion, heart rate variability, surface electromyography, postural and gait assessment, motion and/or static palpation, and leg check. Complimentary-$80.
CHIROPRACTIC ADJUSTMENT: The actual re-alignment of the vertebra done by hand or instrument. $20-45.
X-RAYS: Specific x-ray views will be taken if necessary to evaluate the current state of your spine. These can also be used to indicate progress after a period of care. $40-80 per series.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Dr. Mark Crowell all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. Please refer to our Notices of Privacy Practices for more information.
I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

PRINT PATIENT NAME DATE

_____ _____

PATIENT or LEGAL GUARDIAN SIGNATURE RELATIONSHIP to PATIENT

PROTECTING YOUR HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I received or have been given the opportunity to receive a copy of your Notice of Privacy Practices, the policy in effect that makes every attempt to maintain the confidentiality of all patients' information. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements.

DISCLOSURE OF MEDICAL INFORMATION

By signing, I authorize ***Legacy Chiropractic*** to use and/or disclose certain protected health information (PHI) about me for treatment, payment or healthcare operations (TPO) as listed in our extended Notice of Privacy Practices. In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to workers' compensation, auto accidents, personal injury or other similar issues.
If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

YOUR RIGHTS

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

OPEN ADJUSTING CONCEPT

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient. Sign-in sheets are part of necessary procedures here in this office. Your name will be visible on these sheets, although we will not publish this information anywhere, or discuss it outside the clinic.

NOTIFICATION BY MAIL OR PHONE

Patients may be contacted by mail, email or phone unless written notification is requested that contact be only in person.

COMPLAINTS

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

_____ _____

PRINT PATIENT NAME DATE

_____ _____

PATIENT or LEGAL GUARDIAN SIGNATURE RELATIONSHIP to PATIENT

TERMS OF ACCEPTANCE & CONSENT TO CARE

As a Chiropractic facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. **Chiropractic** is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correcting subluxations is by specific adjustments of the spine and is done by hand or instrument in this office. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal.

As with any healthcare procedure, there are certain complications that may arise during chiropractic manipulation and therapy. Possible complications include but are not limited to the following: muscle strain, dizziness, nausea, flushing, fractures, disc injuries, dislocations, cervical myelopathy, burns, costovertebral strains and separations. It is not uncommon for patients to experience temporary soreness after the first few treatments. In rare cases, manipulation of the neck has been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke.

Fractures are rare occurrences and generally result from underlying weakness of the bone for which the Doctor of Chiropractic checks during the taking of the patient's history, and during examination and X-ray. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options may include the following:
•Self-administered, over-the-counter analgesics and rest •Medical care and prescription drugs •Surgery

There are risks and benefits associated with all the above treatment options, which the patient may wish to discuss with his/her medical doctor. Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Failure to seek care could result in serious medical conditions going unrecognized.

WOMEN ONLY:

To the best of my knowledge I **am/am NOT** pregnant and **give permission/do NOT give permission** to x-ray me for diagnostic interpretations.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE LEGACY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____	_____
PRINT PATIENT NAME	DATE
_____	_____
PATIENT or LEGAL GUARDIAN SIGNATURE	RELATIONSHIP to PATIENT

MISCELLANEOUS/NOTES/FURTHER EXPLANATION