Back to Wellness Chiropractic

11216 Manchester Road
(314)394-2093

Patient Intake Form

WELCOME

Patient Information

Date: ______________________
Last Name: ______________________
First Name: ______________________
Middle Initial: ______________________
Address: ______________________
City: ______________________
State: ______________________
Zip: ______________________
E-mail: ______________________
Sex □M □F Age: ________
Birthdate: ______________________
□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered for _____ years
Occupation: ______________________
Employer/School: ______________________
Employer/School Address: ______________________
____
Employer/School Phone: (____) ______________________
Spouse's Name: ______________________
Birthdate: ______________________
Spouse's Employer: ______________________

Whom may we thank for referring you?
____

Phone Numbers

Home Phone (_____) ______________________
Cell Phone (_____) ______________________
Cell Carrier: ______________________

IN CASE OF EMERGENCY, CONTACT:
Name: ______________________
Relationship: ______________________
Home phone: (_____) ______________________
Work phone: (_____) ______________________

Appointment Cancellation/ No Show Policy

There will be a $25 cancellation fee for appointments that are not cancelled with a 24 hour notice and for any no show appointments

This will not be covered by your insurance.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel your appointment or show up 15 or more minutes late, you may be preventing another patient from getting much needed treatment on top of delaying your own. We are here to help you get the results you need and want by helping you stay on the recommended care plan. We will do our best to schedule appointments that fit your schedule. The front desk will pre-schedule your appointments to ensure this. If you are unable to pre-schedule your appointments each week, the front desk will call until you are scheduled so you do not fall behind in your treatment plan.

Please be courteous to the office and other patients by cancelling 24 hours in advance. You may contact the office at 314-394-2093.

Sign: ______________________
Date: ______________________

Accident Information

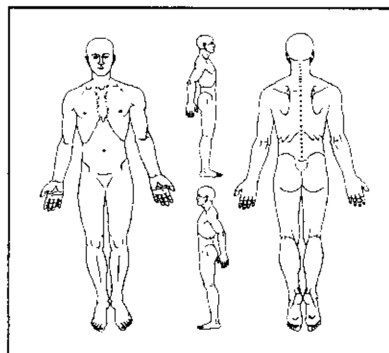
Is condition due to an accident? □ Yes □ No Date: __________

Type of accident: □ Auto □ Work □ Home □ Other ________
To Whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Worker Comp. □ Other____
Attorney Name (if applicable)
____

Patient Complaints

Please List all of the complaints/problems you would like the doctor to look at today. Mark an X on the picture for each problem. Please prioritize them from most important to least important. You will be given complaint forms for each problem listed to more thoroughly describe each problem.

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

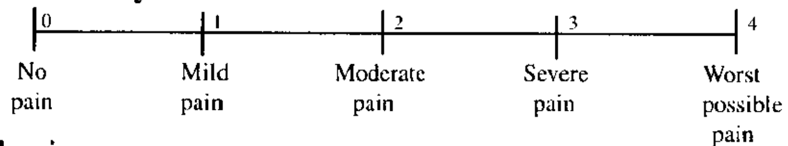


Functional Rating Index

For use with **Neck and/or Back Problems** only.

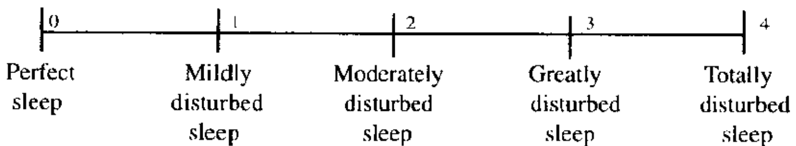
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



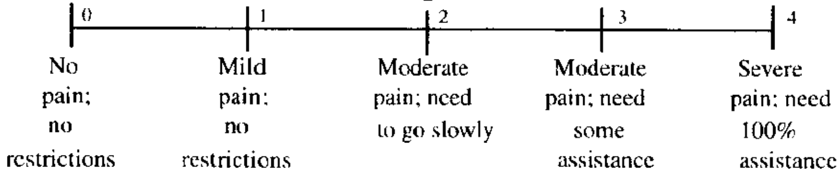
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



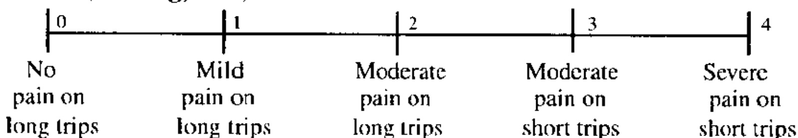
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



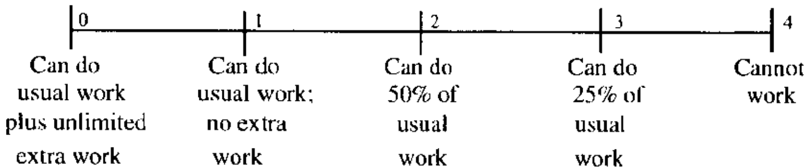
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



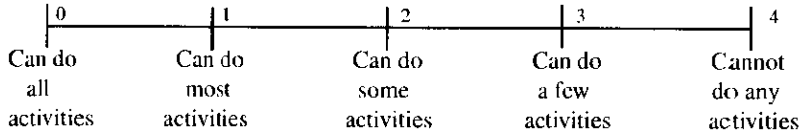
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



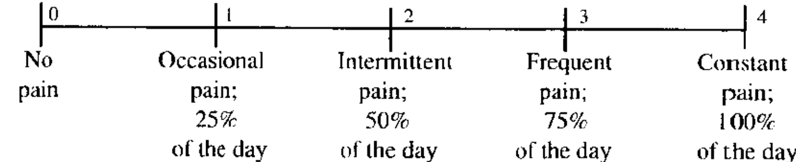
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



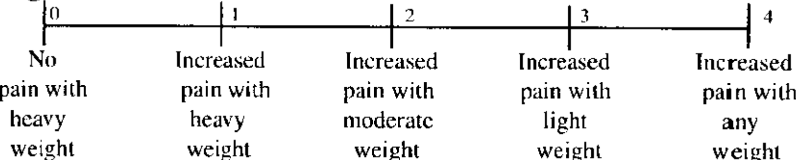
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



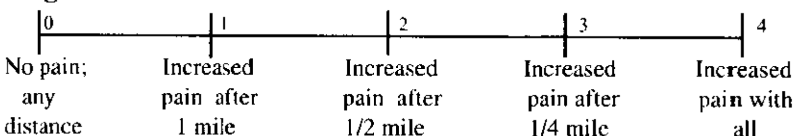
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



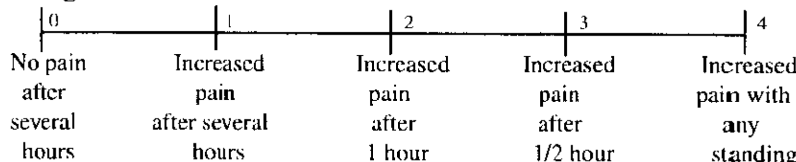
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name ______________________________

PRINTED

____

Signature

____

Date

Total Score __________

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Patient Advisory and Acknowledgement
Receiving Medical Treatment During the Covid-19 Pandemic

Dear Patient:

You have presented to our office today for chiropractic care that is not of the urgent nature. Please be advised of the following. In order to reduce the risk of spreading the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which is known to cause the coronavirus disease 2019 (Covid-19), our office follows established infection control guidelines. We cannot, however, make any guarantee as to whether or not you will be exposed to or contract Covid-19 here. Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading Covid-19, we have asked you a number of screening questions below. For the safety of our staff, other patients, and yourself, we require that you confirm the following, to the best of your knowledge. If you cannot positively affirm to all of these statements, you will be asked to postpone or reschedule your visit to a late date.

Patient affirmation: I do not currently, nor have I had in the last 14 days, a fever, shortness of breath, cough, runny nose, sore throat, loss of smell or taste, chills, fatigue, or any other common cold or flu-like symptoms. I have not, within the last 14 days, had any contact with any person who has or had suspected, presumed positive, or diagnosed Covid-19 or is under orders to quarantine for Covid-19. Within the last 14 days, no one in my household has suspected, presumed positive, or diagnosed Covid-19 or is under orders to quarantine for Covid-19

Within the last 14 days, neither I nor a member of my household has traveled outside of the country. Members of my household, including me, have stayed "home as much as possible" and any travel outside of my local area has been essential travel consistent with CDC guidelines on Coronavirus and travel in the United States, posted here: https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-in-theus.html.

By signing this form below, I agree that I will not hold Back to Wellness Chiropractic or the doctor or any of its staff personally responsible should I, or someone I come in contact with, become positively or presumptively positive diagnosed with Covid-19. There are certain inherent risks associated with medical visits, including chiropractic care, during a pandemic, and I assume full responsibility for a personal illness that may result and further release and discharge Back to Wellness Chiropractic, the doctor, and staff for injury loss or damage arising out of my visit. I understand that Covid-19 infection can lead to illness, disability, or even death and I knowingly take the risk of exposure.

Patient signature:____________________ Date:____________________

Print legal name:____________________ Date of birth:____________________

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. 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, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was *1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.*

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ______________________ Signature: ____________________ Date:

Parent or Guardian: ____________________ Signature: ____________________ Date:

Witness Name: ______________________ Signature: ____________________ Date:

Patient Insurance Coverage

Insurance Coverage

Your insurance policy is an agreement between you and your insurer, not between your insurer and this office. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the insured to pay co-insurance, co-payment and / or deductible.

We will call your insurer to verify your benefits; however we are not responsible for your insurer's final payment and benefit determinations.

Payment

In order to help determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

___*Private Pay*: As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services as they are rendered or unless other arrangements have been made.

___*Health Insurance*: I would like this office to bill my insurance. I understand I am responsible for the costs of treatment that my insurance does not cover, including insurance plan co-payments, or deductibles.

___*Personal Injury (Car Accident)*: I agree to provide all necessary information in regards to my case, and in the event I receive a direct payment from the insurance company, I agree to remit payment to Back to Wellness Chiropractic in 30 calendar days of the check date.

Balances are due within thirty (30) days of the billing statement date. Any balance unpaid after (90) days will be turned over to a collection agency.

We will work hard to accommodate appointments that fit your schedule and medical needs. We ask that you let us know about cancellations or changes twenty-four hours in advance. There will be a $25 fee for failure to give the required 24 hours notice to cancel the appointment. Habitual missed appointment are grounds for dismissal from the practice.

I agree with the above written statements.

______________________	______________________	__________
Name (please print)	*Signature*	*Date*

Back to Wellness Chiropractic

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operation. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- The Protected health information may be disclosed or used for treatment, payment, or health care operations
- The practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice
- The practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

This consent was signed by:

____

Printed Name – Patient or Representative **Date**

____

Signature – Patient or Representative **Date**

I agree to have my health information disclosed to the following person(s):

____

Name – Relationship to Patient

____

Name – Relationship to Patient

Witnessed by:_____ Date:_______