

Peters Wellness Chiropractic, Inc.
Intake Form

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____ Website: _____
Social Security #: _____ Driver's License #: _____ Age: _____ Birth Date: _____
Marital Status: S M W D Sex: M F Number of children: _____
Spouse's Name: _____ Spouse's Occupation: _____
Your Occupation: _____ Your Employer: _____ Year's Employed: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Reason for today's visit: Emergency New Injury Old Injury Chronic Pain Wellness Visit
Did your injury occur during: Auto Accident, Work Related, Sports/Play, Routine/Household Activity *If your injury is work or auto related please fill out the appropriate form located on the website under optional form*

-----Do Not Write Below This Line-----

Describe your Primary Complaint: _____

Date Initial Symptoms Began: _____ and mode of initial onset: _____

Date of Recent Exacerbation: _____ and mode of recent exacerbation: _____

Rate/Circle your pain on the following scale (1 is minimal & 10 is Severe): Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Intensity: Minimal, Mild, Moderate, Severe

Characterization: Dull, Sharp, Radiating, Local, Deep, Superficial

Characterization Notes: _____

Duration / Frequency: Occasional (0-25% of day), Intermittent (26-50% of day), Frequent (51-75% of day), Constant (76-100%)

Duration Notes: _____

What Exacerbate/Worsens your condition: _____

What Ameliorates/Lessens your condition: _____

Are there any other related symptoms: _____

Describe Additional Complaint #1: _____

Date Initial Symptoms Began: _____ and mode of initial onset: _____

Date of Recent Exacerbation: _____ and mode of recent exacerbation: _____

Rate/Circle your pain on the following scale (1 is minimal & 10 is Severe): Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Intensity: Minimal, Mild, Moderate, Severe

Characterization: Dull, Sharp, Radiating, Local, Deep, Superficial

Characterization Notes: _____

Duration / Frequency: Occasional (0-25% of day), Intermittent (26-50% of day), Frequent (51-75% of day), Constant (76-100%)

Duration Notes: _____

What Exacerbate/Worsens your condition: _____

What Ameliorates/Lessens your condition: _____

Are there any other related symptoms: _____

Any Other Complaint(s) please list here: _____

Doctor Notes (please leave blank): _____

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Name: _____ Date: _____

Please provide your Primary Care Physician's information: Name: _____

Office Name: _____ Office Address: _____

Date of Last Visit: _____ Purpose of Last Visit: _____

Have you seen other doctor's for the above condition(s)? If yes please fill in information below:

Doctor 1: _____ Diagnosis: _____ X-rays: _____

Treatment: __Medication, __Physiotherapy, __Other: _____

Results: _____ Length of time under care: _____

Doctor 2: _____ Diagnosis: _____ X-rays: _____

Treatment: __Medication, __Physiotherapy, __Other: _____

Results: _____ Length of time under care: _____

Are you currently or in the past 6 months, have you had any of the following diseases, medical conditions or procedures?

- | | | | | | |
|--------------------------|------------------------------|--------------------|--------------------|------------------------|---------------------------|
| Y N Sensitivity to Light | Y N Migraines/Headaches | Y N Epilepsy | Y N Irritability | Y N Multiple Sclerosis | Y N Depression |
| Y N Ringing in Ears | Y N Dizziness/Fainting | Y N Thyroid Issues | Y N Neck Pain | Y N Arm Numbness | Y N Mood Swings |
| Y N Psychiatric Problems | Y N Sinus Problems | Y N Glaucoma | Y N Fatigue | Y N Arteriosclerosis | Y N Asthma |
| Y N Gallbladder Issues | Y N Heartburn/Gastric Reflux | Y N Pleurisy | Y N Pneumonia | Y N Rheumatic Fever | Y N Tuberculosis |
| Y N Mid-Back Pain | Y N Heart Attack/Stroke | Y N Shingles | Y N Heart Surgery | Y N Pace Maker | Y N H or L Blood Pressure |
| Y N Alcohol/Drug Use | Y N Chemo Therapy | Y N Cancer | Y N Heart Murmur | Y N Hepatitis | Y N Anemia |
| Y N Diabetes | Y N Kidney Problems | Y N Allergies | Y N Constipation | Y N Leg Numbness | Y N Hot Flashes |
| Y N Diarrhea | Y N Polio | Y N Ulcers | Y N Urinary Issues | Y N Menstrual Cramping | Y N Irregular Periods |
| Y N Venereal Disease | Y N Recurring Stomach Issues | Y N Arthritis | Y N Low Back Pain | Y N Artificial Joints | Y N Artificial Implants |

Personal History Notes: _____

List surgical operations and dates: _____

List any past serious accidents with dates: _____

Family Health History (Grand Parents/Parents/Brothers/Sisters): _____

Immediate Family Deaths: _____

Are you taking any prescription medications? __Yes, __No If yes, what: _____

Are you taking any non-prescription drugs? __Yes, __No If yes, what: _____

Do you take dietary supplements or vitamins? __Yes, __No If yes, what kind: _____

Can I have an associate call you with information regarding alternative nutritional products? __ Yes, __ No

Do you exercise? __Yes, __No If yes, # of hours per week: _____ Do you wear: __Arch Supports/Orthotics

Do you smoke? __Yes, __No If yes, how much: _____ For how long: _____

Are you dieting? __Yes, __No If so, since: _____

Are you taking birth control? __Yes, __No Are you pregnant? __Yes, __No Are you nursing? __Yes, __No

Who may we thank for referring you to us or how did you hear about us: _____

Dr Notes (please leave blank): _____

All of the above is accurate to the best of my knowledge (please sign): _____ Date: _____

I, parent/guardian, give permission for minor's care (please sign): _____ Date: _____

Peters Wellness Chiropractic, Inc.

Notice Of Privacy – HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU HAVE ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

As your health care provider, we are required, by law, to maintain the privacy and confidentiality of your protected health information and provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure Of Your Health Care Purposes

We may disclose your health care information to staff and other healthcare professionals within our practice for the purpose of consultation, treatment, payment, or healthcare operations. Additionally, we disclose your health information to your insurance provider(s), billing and insurance personnel, or medical billing clearinghouse or collection agencies for the purpose of payment for your health care services.

Workers' compensation

We may disclose your health information as necessary to comply with state Work Comp Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or on the event of an emergency.

Other

As required by law, we may disclose your health information to the following persons or entities:

-Public Health Authorities, -Law Enforcements Officials, -Medical Examiners or Coroners, -Specialized Government Agencies

Communications

We may contact you for additional communications, or other purpose, as described below:

It is our policy to call your home on the day prior to you scheduled appointment to remind you of your appointment time. A reminder message is left with a person or answering machine if you are not at home. Birthday cards and/or seasonal greeting cards may be sent to your home periodically throughout the year, which may offer you a discounted or free service, a gift, or medical reminders. If this is not desired, please tell the receptionist so alternative methods might be utilized to protect your privacy. When you are being seen in the office, other patients may hear and see the care you receive. A private area is available upon request.

Change of Ownership

In the event that this practice is sold or merged with another organization, your health record will become the property of the new owner.

Your health Information Rights

-You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

-You have the right to inspect and copy your health information.

-You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If you requested to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

-You have a right to receive an accounting of disclosures of your protected health information made by our office.

-You have a right to paper copy of this Notice of Privacy Practices at any time upon request.

Changes to This Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains.

We are required by law to maintain the privacy of your health information and provide you with notice of our legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about our privacy rights, please contact our office manager.

Complaints

Complaints about our Privacy Rights or how our office handles the use or disclosure of your health information should be directed to our office manager. If you are not satisfied with the manager in which this office handles your complaint, you may submit a formal complaint to:

DDHS, Office of Civil Rights, 200 Independence Ave., S.W., Room 509F HHH Building, Washington, DC 20201

I have read the privacy notice and understand my rights contained in the notice.

Printed Name of Patient: _____

Signature of Patient: _____

Date: ____/____/____