Intake Form

Name_____**Date**_____/_____/_____**Age**_____**Male/Female**

Address_____**City**_____**State**_____**Zip**_____

Phone: Home_____**Cell**_____

Email Address_____**Date Of Birth**_____/_____/_____

Occupation_____**Employer's Name**_____

Single / Married / Divorced / Widowed **Spouse's Name**_____

Number of Children_____ **Names, Ages & Gender** _____

_____

Who may we thank for referring you?_____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____
5._____	_____	_____	_____	_____	_____

CIRCLE ANY AND ALL OF THESE PROBLEMS YOU HAVE CURRENTLY

OR IN THE PAST:

Dizziness	Throat Issues	Kidney Problems	Liver Disease	Infertility
Headaches	Thyroid Problems	Mid Back Pain	Shoulder Pain	Epilepsy
Vertigo	Asthma	Irritable Bowel	Chronic Fatigue	Lupus
Ear Infections	Ulcers	Sciatica	Disc Problem	Other:_____
Nausea	Numbness in Arms	Numbness in Legs	Fibromyalgia	_____
TMJ	Numbness in Hands	Numbness in Feet	Chest Pain	_____
Neck Pain	Menstrual Disorder	Low Back Pain	Arm Pain	_____
Migraines	Heart Disorders	Hip Pain	ADD/ADHD	_____
Anxiety	Stomach Disorders	Leg Pains	Nervousness	_____
Chronic Sinus	Bladder Problems	Knee Pain	Gastric Reflux	_____

CIRCLE ANY CONDITION YOU HAVE CURRENTLY OR IN THE PAST:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES

SPINAL BONE FRACTURE SCOLIOSIS DIABETES

LIST ALL SURGICAL OPERATIONS AND YEARS_____

_____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_

WHEN WAS YOUR LAST AUTO ACCIDENT

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IF YOU HAVE, DR. & DATE _____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO

FRACTURED A BONE? YES / NO IF YES, PLEASE DESCRIBE_____

_____

OTHER TRAUMA:_____

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD_____

I AUTHORIZE DR. DANIEL JOHNSTON AND/OR DR. TATUM JOHNSTON AND ANY AND ALL SOUTHSIDE FAMILY CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY SOUTHSIDE FAMILY CHIROPRACTIC.

_____ _____

DATE GUARDIAN SIGNATURE

_____ _____

WITNESS SIGNATURE GUARDIAN'S RELATIONSHIP TO MINOR/CHILD

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT I HAVE CERTAIN RIGHTS OF PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILTY ACT OF 1996 (HIPAA). I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

1. CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY
2. OBTAIN PAYMENT FROM THIRD-PARTY PAYERS
3. CONDUCT NORMAL HEALTHCARE OPERATIONS, SUCH AS QUALITY ASSESSMENTS AND PHYSICIANS CERTIFICATIONS

I ACKNOWLEDGE THAT I MAY REQUEST YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I ALSO UNDERSTAND THAT I MAY REQUEST, IN WRITING, THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED TO DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATION. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU AGREE, THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

_____ _____

SIGNATURE OF PATIENT DATE

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00.
THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY. **PLEASE NOTE:** X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE ***VERTEBRAL SUBLUXATIONS.***
THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF SOUTHSIDE FAMILY CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____
PRINT YOUR NAME HERE DATE

_____ _____
SIGNATURE YOUR AGE

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT SOUTHSIDE FAMILY CHIROPRACTIC.

_____ _____
SIGNATURE DATE

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINE HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THE THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT PATIENT'S NAME HERE

_____ _____

PATIENT'S SIGNATURE DATE

IF PATIENT IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

_____

RELATIONSHIP TO MINOR/CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) DATE

Health Goals

Please circle all that apply

To reduce headaches/migraines

To reduce pain

To reduce sciatic pain

To reduce numbness in the hands/fingers

To reduce numbness in the feet/toes

To decrease _____ spasms

To increase productivity

To have more energy

To boost immunity

To defeat infertility

To be able to work out without pain

To be able to play with my kids

To sleep better

To breathe better

To manage asthma

To manage allergies

To manage ADHD/ADD

To manage carpel tunnel

To manage TMJ

To have more mobility and range of motion

To reduce seizures

To reduce medications