MURPHY CHIROPRACTIC

PATIENT INTAKE FORM

Patient Name: ______________________________ **Date:** _______________

Address:____

____

Home #:_____________________ **Cell #:** _________________________

Work #:____________________ **Email:**______________________________________

Social Security # (last 4):____________________ **DOB:**_____/______/_______

Age: ____________ **Status: Single Married Widowed Divorced Separated**

Emergency Contact Person:______________________________________

Relationship to you:_________________ **Contact #:**___________________________

Employer:____

Your Occupation:____

EmployerAddress:____

Primary Care Physician:_________________________ **Telephone:**_______________

How did you hear about our office?____

Insurance Company Name:____

Policy #:_____________________________ **Group #:**_____________________________

Do you have chiropractic benefits? ____

Name of insured:____________________________ **Insured's DOB:**_______________

Relationship to insured:_________________

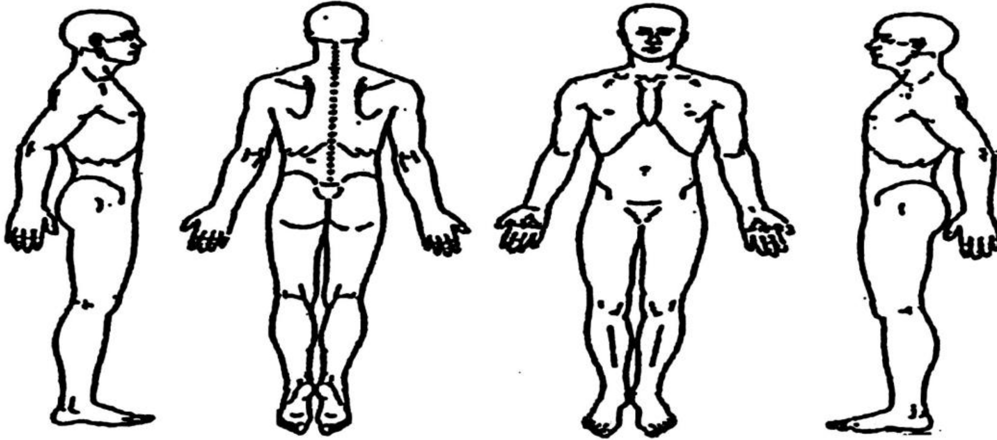
I authorize Murphy Chiropractic to process all insurance forms on my behalf as well as to release all necessary information for said processing to my insurance company. I also authorize that my insurance company pay all medical benefits directly to Murphy Chiropractic .

Patient/Guardian Signature:____

MURPHY CHIROPRACTIC

1. Is today's problem caused by: □ **Auto Accident** □ **Workman's Compensation** □ **Other** _________

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ **Constantly (76-100% of the time)**
□ **Occasionally (26-50% of the time)**
□ **Frequently (51-75% of the time)**
□ **Intermittently (1-25% of the time)**

4. How would you describe the type of pain?

□ **Sharp**
□ **Dull**
□ **Diffuse**
□ **Achy**
□ **Burning**
□ **Shooting**
□ **Stiff**
□ **Numb**
□ **Tingly**
□ **Sharp with motion**
□ **Shooting with motion**
□ **Stabbing with motion**
□ **Electric like with motion**
□ **Other:**___________________

5. How are your symptoms changing with time?

□ **Getting Worse** □ **Staying the Same** □ **Getting Better**

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

□ **Not at all** □ **A little bit** □ **Moderately** □ **Quite a bit** □ **Extremely**

8. How much has the problem interfered with your social activities?

□ **Not at all** □ **A little bit** □ **Moderately** **Quite a bit** □ **Extremely**

9. Who else have you seen for your problem?

□ **Chiropractor**
□ **ER physician**
□ **Massage Therapist**
□ **Neurologist**
□ **Orthopedist**
□ **Physical Therapist**
□ **Primary Care Physician**
□ **Other:**_____________
□ **No one**

10. How long have you had this problem? _______________________________

11. How do you think your problem began?

____

12. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

13. What aggravates your problem?
____

14. What concerns you the most about your problem; what does it prevent you from doing?
____

15. What is your: Height___________ Weight _____________ Date of Birth ___________

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		<u>For Females Only</u>
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:___________________________				

20. List all prescription medications you are currently taking:

____

21. List all of the over-the-counter medications you are currently taking:

____

22. List all surgical procedures you have had:

____

23. What activities do you do at work?

□ Sit:	**□ Most of the day**	**□ Half the day**	**□ A little of the day**
□ Stand:	**□ Most of the day**	**□ Half the day**	**□ A little of the day**
□ Computer work:	**□ Most of the day**	**□ Half the day**	**□ A little of the day**
□ On the phone:	**□ Most of the day**	**□ Half of the day**	**□ A little of the day**

24. What activities do you do outside of work?

____

25. Have you ever been hospitalized? □ No □ Yes
If yes, when? And why?

____

26. Have you had significant past trauma? □ No □ Yes
If yes, please explain:

____

____

____

27. Have you had any previous motor vehicle accidents? □ No □ Yes
If yes, please explain:

____

____

____

28. Anything else pertinent to your visit today?

____

____

____

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

____

Patient's Signature **Date**

CONSENT TO TREATMENT OF MINOR

I/We, the undersigned, parent(s)/ person having legal custody/ legal guardianship of ________________________________, a minor, do hereby authorize Murphy Chiropractic as agent(s) for the undersigned to consent to any examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of a licensed chiropractor.

It is understood that this authorization is given of any specific diagnosis or treatment being required but is given to provided authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the interest of his/her best judgment, deem advisable.

This authorization will remain effective until revoked in writing delivered to the agent(s) noted above.

I have read and understand the foregoing.

Date:___________________________

____

Signature

MURPHY CHIROPRACTIC

Financial Policy

To avoid any misunderstanding, we are providing you with this copy of our office's financial policy. Please be advised that your payment is expected at the time services are rendered unless PRIOR arrangements have been made. For your convenience, you may pay by check, or we accept, VISA, MasterCard, and Discover cards. If you have health insurance with a plan that we participate in you will be responsible for paying your co-payment at the time of service. If your plan requires a referral, it is your responsibility to obtain one from your primary care physician. We encourage you to contact your insurance company to verify your chiropractic benefits.

Please note that our office participates with most insurance companies. If you are insured by an insurance company that we do not participate with, you will be responsible to pay for services on an out-of-network basis, providing that your plan allows for such benefits. This means that you will have to satisfy your annual deductible. Once your deductible has been met, you will then be responsible to pay the applicable co-insurance according to your plan's benefits.

In addition, you will be held financially responsible for all care/services not covered or paid by your insurance company. If you have specific questions concerning your insurance coverage, please contact your insurance company. As always, we strive to ensure that you are kept informed of any/all out of pocket expenses prior to the service being rendered, however, there may be instances when coverage is denied. For example, if care is pre-certified and you utilize more than the number of visits authorized, you will be personally billed for the non-covered services at our usual and customary fee. Presently, our fee for a spinal manipulation is $50.00. Missed appointments or those which are not cancelled within 24-hours will be subject to a $40.00 missed appointment fee.

Our fee for a returned check is $15.00.

Thank you for your co-operation and promptness concerning this matter.

By signing this form, I certify that I have read, understand and agree to this policy.

____ Date:__________________
Patient/Guardian Signature

MURPHY CHIROPRACTIC

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees this chiropractic office to submit requested (PHI) to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all (PHI) to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their (PHI). Our office is not obligated to agree to these restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.
8. The patient may be sent birthday cards, newsletters, and other mailings pertaining to our office.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

____ ____________________

Patient Signature **Date**

____

Print Name