INTAKE FORM

Date: _____

PATIENT INFORMATION

Name _____ Date of Birth _____/_____/_____
(Last) (First) (MI)

Address _____

City _____State _____ Zip _____

Primary Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Email _____ May we leave a message on phone/email? Yes No

Preferred Method of Contact? (circle one or more) Email Phone Work Phone

Emergency Contact _____

Relationship _____ Phone (_____) _____ - _____

How did you hear about us? (circle one) Referral from _____

Online Search Mailer Newspaper Other _____

We are in network with Blue Cross Blue Shield of Michigan, Medicare, Cofinity, HAP, and Aetna. All other insurances will be processed as "out of network" and payment is expected at the time services are rendered.

If using insurance, please give information to front desk.

STATEMENT OF FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO TREAT:

I understand that I am financially responsible for all services rendered to me or my dependent at Proactive Chiropractic. I hereby authorize Proactive Chiropractic or its successors to submit claims & necessary notes/documentation regarding my care to my insurance company or other third party on my behalf. If my insurance company denies payment on my behalf I understand that I am financially responsible for any remaining balance which is due within 30 days of receipt of bill from Proactive Chiropractic. I understand that co-pays, co-insurances , and deductibles are due at the time services are rendered. I understand that Proactive Chiropractic is not responsible for misquotes from my insurance company regarding my coverage, as my insurance is a contract between my insurance company and me.

I further authorize my insurance company to direct payment to Proactive Chiropractic on my behalf.

I authorize the physician to diagnose and treat me or my dependent/minor child and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan.

Signature _____ **Date** _____ / _____/ _____

I HAVE RECEIVED A COPY OF THE PRIVACY PRACTICES POLICY. _____ Initial, please.

COMPREHENSIVE MEDICAL HISTORY

Name of Primary Care Physician?

_____

Date of last physical exam? _____

*Please mark the letter **C** if you are currently experiencing, the letter **P** if you have previously experienced, or leave blank if not applicable.*

CONSTITUTIONAL

1. _____ Cancer
2. _____ Allergies
3. _____ Fever or chills
4. _____ Weight loss or gain
5. _____ Night sweats
6. _____ Fatigue
7. _____ Insomnia or sleep changes
8. _____ Other

_____

ENDOCRINE

9. _____ Diabetes
10. _____ Thyroid disease
11. _____ Other

_____

EYE, EAR, NOSE, THROAT

12. _____ Pain in the eye
13. _____ Deafness/difficulty hearing
14. _____ Hoarseness
15. _____ Other

_____

PULMONARY

16. _____ Asthma
17. _____Tuberculosis
18. _____ Difficulty breathing
19. _____ Chronic cough or phlegm
20. _____ Coughed up blood
21. _____ Other

_____

GASTROINTESTINAL

22. _____ Appendicitis
23. _____ Jaundice or hepatitis
24. _____ Colon polyps
25. _____ Abdominal pain
26. _____ Frequent heartburn
27. _____ Other

_____

CARDIOVASCULAR

28. _____ Heart disease
29. _____ High cholesterol
30. _____ High blood pressure
31. _____ Stroke
32. _____ Chest pain
33. _____ Irregular/rapid heartbeat
34. _____ Fainting/lightheadedness
35. _____ Other

_____

BLOOD

36. _____ Anemia
37. _____ Bleeding disorder
38. _____ Other

_____

SKIN

39. _____ Change in mole
40. _____ Itching or rash
41. _____ Other

_____

GENITOURINARY

42. _____ Kidney disease or stones
43. _____ Bloody or discolored urine
44. _____ Other

_____

MALE SPECIFIC

45. _____ Prostate disease
46. _____ Difficulty urinating
47. _____ Other

_____

FEMALE SPECIFIC

48. _____ Live births
49. _____ Breast lump or pain
50. _____ Hot flashes
51. _____ Other

Are currently pregnant? Y N

Due Date: _____

_____

COMPREHENSIVE MEDICAL HISTORY
(cont.)

NEUROLOGIC/PSYCH

52. _____ Headache
53. _____ Psychiatric disorder
54. _____ Weakness
55. _____ Numbnes/tingling
56. _____ Dizziness
57. _____ Tremor or twitching
58. _____ Arm/leg pain
59. _____ Other

_____

MUSCULOSKELETAL

60. _____ Fracture or dislocation
61. _____ Arthritis
62. _____ Scoliosis/spinal curvature
63. _____ Neck/upper back pain
64. _____ Mid back pain
65. _____ Lower back pain
66. _____ Swollen/painful joints
67. _____ Other

_____

TRAUMA

68. _____ Motor vehicle accident
69. _____ Other

_____

HOSPITALIZATIONS/SURGERIES

70. _____
71. _____

_____

FAMILY HISTORY

73. _____ Kidney disease
74. _____ Heart disease or stroke
75. _____ High blood pressure
76. _____ Cancer
77. _____ Thyroid disease
78. _____ Diabetes
79. _____ Neurological disease
80. _____ Musculoskeletal disease
81. _____ Psychiatric disease
82. _____ Other

_____

SOCIAL HISTORY

83. _____ Smoke/chew tobacco
84. _____ Alcohol use
85. _____ Recreational drug use
86. Are you married/partnered? Y N
87. Occupation? _____

ALLERGIES

(medicine, dust, ragweed, certain foods, etc):

_____
_____
_____
_____
_____
_____

MEDICATIONS

(name of medication, dosage, and reason):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SUPPLEMENTS/HOMEOPATHICS

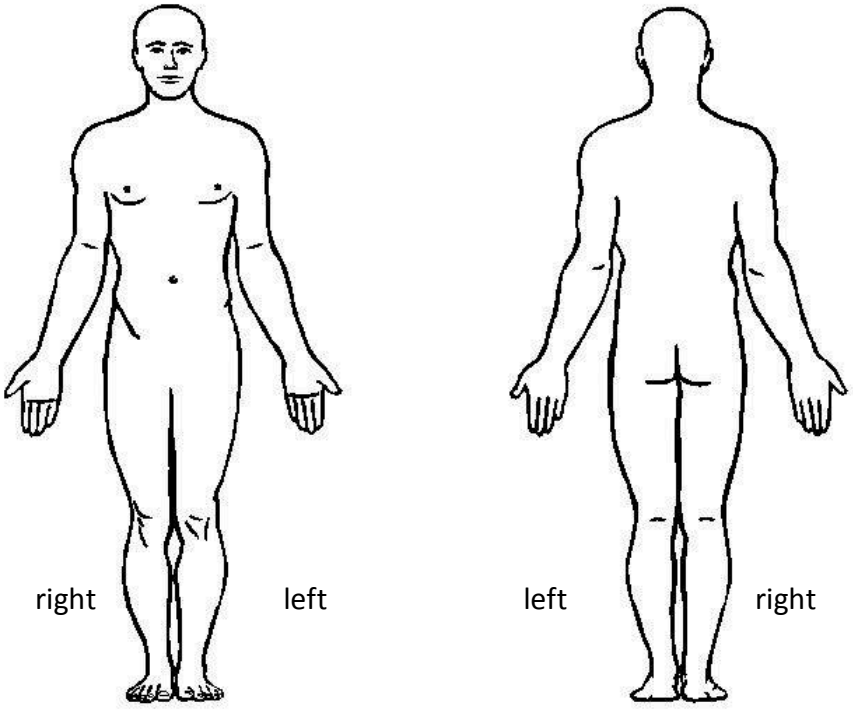
(name of supplement, dosage, and reason):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PAIN CHART

Please show area(s) of pain or unusual feelings on the diagrams below. Mark the areas using the indicated symbols.

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
----------	OOOOO	XXXXX	•••••••	///////



VISUAL PAIN SCALE

Please indicate the area of the body you are referring to, and then place an "X" at the position on the line that indicates how much discomfort you feel in that area.

AREA #1 (ex: neck pain): _____

no discomfort worst pain imaginable

AREA #2 (ex: low back pain): _____

no discomfort worst pain imaginable

PRIMARY COMPLAINT FORM

Brief description of primary complaint:

_____

_____

_____

_____

Date of injury/condition onset: _____

Was this an accident/injury due to: auto work other _____

Other doctor consulted for condition:

Name _____ Date consulted _____

Diagnosis _____ Treatment _____

Imaging taken? X-ray MRI CT Date taken _____

Medications tried? _____

Brief description of secondary complaint:

_____

_____

_____

_____

Habits

Sleep ____ hrs per night **Exercise** ____ x/week **Type? _____**

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures

Here are some examples of how we are allowed to disclose your private health care information for treatment, payment or clinic operations.

1. Your health care provider or a staff member may disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.
2. Our insurance and billing staff may disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3. Your health care provider and members of the practice staff may use your health information, examination and treatment records, and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your health care provider and member of the practice staff may use your name, address, telephone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not available to receive an appointment reminder, a message will be left for you.

The HIPAA privacy rule permits us to communicate with you regarding your health care. We will notify you by phone (or email if you so choose) if we have to change, alter or cancel your scheduled appointment. Authorization or permission to call is not required. HIPAA allows a message to be left on an answering machine, voice mail or with a third party. Information will be limited to no more than necessary.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Permitted Uses and Disclosures Without Your Consent or Authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

1. We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
2. We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
3. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
4. We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain consent after attempting to do so.
5. We are permitted to use or disclose your health information if there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care to you.

Other than the circumstances described in the preceding five examples, and in the section Uses and Disclosures of this document, any other use or disclosure of your health information will only be made with your written authorization.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to our office. There are two circumstances under which we will not be able to honor your revocation request:

1. If we already released your health information before we received your request to revoke your authorization.
2. If you were required by law to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

If you wish to revoke your authorization, please write to us at:

Proactive Chiropractic
350 N. Main St. Ste. 250
Chelsea, MI 48118

Your Right to Inspect and Copy Your Health Information

You have the right to inspect and/or copy your health care information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

Your Right to Amend Your Health Information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.
We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms, the change will apply for all of your health information in our files.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside organizations.

Signing here indicates that you have read and understand the Notice of Privacy Practices for Protected Health Information:

_____ _____

Patient Signature **Date**

Informed Consent to Chiropractic Care

Proactive Chiropractic
350 N. Main St. Suite 250
Chelsea, MI 48118
Ph: (734) 636-0111

I hereby request and consent to the performance of chiropractic manipulation or adjustments by the Doctor of Chiropractic at Proactive Chiropractic and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back up for the Doctors of Chiropractic at Proactive Chiropractic.

Other procedures, including various modes of physical medicine on me (or on the patient names below for whom I am legally responsible) may be performed by either the Doctor of Chiropractic or office personnel trained in those areas.

I have been given opportunity to discuss with one or more Doctors of Chiropractic at Proactive Chiropractic and/or with office or clinical personnel the nature and purpose of chiropractic manipulation or adjustment and other chiropractic procedures, including various modes of physical medicine. I understand that results are not guaranteed.

I understand, and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the Doctor of Chiropractic to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known; is in my best interest.

I have read, or have had read to me the above consent. I also had an opportunity to ask questions about its content, and by signing below I agree to the above names procedures. I intend this consent form to cover my entire course of treatment for my present condition and for any further treatment I present myself for at Proactive Chiropractic.

Patient Signature: _____ Date: _____

To be completed by the patient's representative, if necessary, e.g., if patient is a minor or physically or otherwise legally incapacitated.

Signature or Patient's Representative: _____ Date: _____

No Call No Show Policy

We understand that unforeseen circumstances occur and because of this, every patient will be allowed one no call/no show without penalty. *On any subsequent no call/no shows a $40 fee will be charged to the patient's card on file (or billed to the patient) for time reserved.*

If you need to cancel or reschedule, please call by 10 am the day of your appointment.

We greatly appreciate everyone's understanding of the policy and thank you for your cooperation.

I have read and understand Proactive Chiropractic's no call/no show policy.

_____ _____

Signature **date**