Chiropractic Center of Lakeland

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional):_____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature:_____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

CHIROPRACTIC CENTER OF LAKELAND

New Patient Intake

Name: _____ **Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Ph:** _____ **Wk Ph:** _____

Birthdate: _____ **SSN:** _____ **Email:** _____

Status: Single Married Divorced Widowed **Children:** Yes No **How Many:** _____

Are you considered a minor? Yes No **If Yes, who is the responsible payer?** _____

Occupation: _____ **Employer:** _____

Family Doctor: Yes No **Name of Doctor:** _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Do you have insurance we will be using? Yes No **Insurance Company:** _____

How did you hear about our office?: _____

Rate your overall internal health: Excellent Good Fair Poor **Rate your external health:** Excellent Good Fair Poor

Past Medical History

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

Condition	Past	Present
Headaches	☐	☐
Neck Pain	☐	☐
Upper Back Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Shoulder Pain	☐	☐
Elbow/Arm Pain	☐	☐
Wrist Pain	☐	☐
Hand Pain	☐	☐
Hip Pain	☐	☐
Upper Leg Pain	☐	☐
Knee Pain	☐	☐
Ankle/Foot Pain	☐	☐
Jaw Pain	☐	☐
Joint Pain/ Stiffness	☐	☐
Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Cancer	☐	☐
Tumor	☐	☐

Condition	Past	Present
Asthma	☐	☐
Sinus Problems	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Angina	☐	☐
Kidney Stones	☐	☐
Kidney Disorders	☐	☐
Bladder Infection	☐	☐
High Cholesterol	☐	☐
Loss of Bladder Ctrl	☐	☐
Prostate Problems	☐	☐
Abnormal Wt Loss/Gain	☐	☐
Loss of Appetite	☐	☐
Abdominal Pain	☐	☐
Ulcer	☐	☐
Hepatitis	☐	☐
Liver Disorder	☐	☐
Gall Bladder Disorder	☐	☐

Condition	Past	Present
General Fatigue	☐	☐
Thyroid Disorder	☐	☐
Muscular Incoordination	☐	☐
Visual Disturbances	☐	☐
Dizziness	☐	☐
Diabetes	☐	☐
Excessive Thirst	☐	☐
Frequent Urination	☐	☐
Addiction Drug/Alcohol	☐	☐
Allergies	☐	☐
Depression	☐	☐
Systemic Lupus	☐	☐
Fibromyalgia	☐	☐
Epilepsy	☐	☐
Skin Conditions	☐	☐
HIV/AIDS	☐	☐
For Women:	☐	☐
Birth Control	☐	☐
Hormone Replacement	☐	☐

List Treatments for <u>Past</u> Conditions: _____

List ALL Medications you are <u>Currently</u> Taking: _____

_____

List any Allergies: (including food) _____

List any Surgeries: _____

Family Medical History

Please indicate if you have any immediate family members with the following conditions:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus/Fibromyalgia
☐ Heart Problems ☐ Cancer ☐ Mulitple Sclerosis

Other Family Medical history: _____

Social History

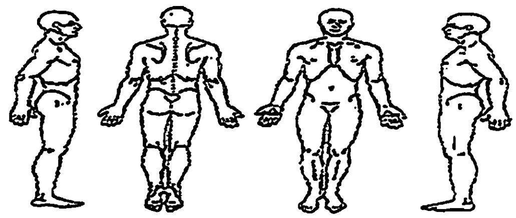
Do you smoke: Yes No **How Much:** _____ **Drink Alcohol:** Yes No **How Much:** _____

For Women Only: Pregnant? Yes No **How Long:** _____ **Nursing?:** Yes No

CHIROPRACTIC CENTER OF LAKELAND

New Patient Intake

Please indicate on the drawing below where you are experiencing your symptoms



Where does it hurt: ________________________________ **When Did It Start:** ________________________
Pain Level (0= No Pain/10=Highest Pain) 0 1 2 3 4 5 6 7 8 9 10
How often does it occur: Occasionally (0-25% of the time) Intermittently (26-50% of the time) Frequently (51-75% of the time) Constantly (76-100% of the time)
Please describe your pain: Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing
What aggravates your symptoms: ____
Doctor's Notes: ____
____
____

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Pain Level (0= No Pain/10=Highest Pain) 0 1 2 3 4 5 6 7 8 9 10
How often does it occur: Occasionally (0-25% of the time) Intermittently (26-50% of the time) Frequently (51-75% of the time) Constantly (76-100% of the time)
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Please describe your pain: Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing
What aggravates your symptoms: ____
Doctor's Notes: ____
____
____

Current Treatment of Symptoms
Have you seen anyone else for these symptoms: *Yes* *No* Who: ________________________
List any treatment given for these symptoms: ____
List any medications given for these symptoms: ____

Patient Signature: ____ **Date:** ____________________

Chiropractic Center of Lakeland

Term of Acceptance

When a patient care at the Chiropractic Center of Lakeland and we accept a patient for such care, it is essential for both to be working toward a common goal.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interferes with the expression of the body's innate wisdom. It is important all patients understand both the objective and the method used to attain our goal. The following definitions will help to educate each patient.

Health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Adjustment: A specific application of forces to facilitate the body's correction of the spinal Subluxation. Our method of correction is performed by mechanical device as well as by hand.

Spinal Subluxation: A misalignment of one or more of the 24 vertebrae in the Spinal Column which causes alteration and interference with the transmission of information from the brain to all systems of the body, thus having a positive effect on the body's organs and systems, even down to the cellular level.

We do not offer to diagnose or treat any disease or condition other than vertebral Subluxation. However if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend our patients seek care fro a health care provider who specializes in that area. Regardless of the specific condition we cannot provide care of give advice on the care provided by other practitioners.

Our Practice objective is to eliminate major interference to the expression of the body's innate wisdom.

All questions regarding the doctor's objectives pertaining to my care in this office have been fully answered.

_____

Print Name

_____ _____

Sign Name **Date**

Chiropractic Center of Lakeland

The claims for treatment for my current condition which the Doctor will diagnose with an onset date of _____, is ***not*** related to an automobile accident, workers compensation claim or any other accident involving a third party or payor.

If you have any question please ask a Chiropractic Center of Lakeland Staff member.

_____

Print Name

_____ _____

Sign Name **Date**

Chiropractic Center of Lakeland

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or canceled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your canceled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses—you, the doctor and other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or canceled appointments, please realize how important it is to keep your reserved time. However, if you are scheduled for a Massage, a $25 cancellation fee is enforced for the inconvenience of others. Thank you for your consideration of our policies and the opportunity to be your chiropractic office of choice.

_____ _____

Signature Date

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)