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SPINE AND WELLNESS

Patient Intake Form (PIF)

Date: _____ /_____ /_____

PATIENT INFORMATION

Name: _____
(First Name Middle Initial Last Name)

Address:_____

City:_____ St:____ Zip:_____

Sex □ Male □Female

Date of Birth:_____/_____/_____ Age: _____

If minor, Parent's Name:_____

Marital Status:

□ Married □ Single □ Widowed
□ Separated □ Divorced □ Minor

Number of children:_____

PHONE NUMBERS/EMAIL

Home: (_____) _____-_____
Work: (_____) _____-_____
Mobile: (_____) _____-_____
Email Address:_____
Contact Preference(s):
□ Mobile □ Home □ Work □ Email □ Any

Employment Information:

Occupation:_____
Employer:_____

Military Status: □ Active □ Retired □ None

HOW DID YOU HEAR ABOUT US?

Please circle one of the following:

1. Referred by a patient
2. Google Search
3. Social Media
4. Health Fair / Local Event

If Patient,

Whom may we thank for referring you to us?

_____

IN CASE OF EMERGENCY, PLEASE CONTACT

Name: _____ Relationship:_____
Home Phone: (_____) _____-_____
Mobile Phone: (_____) _____-_____

INSURANCE INFORMATION

Policy Holder's Name:_____
Relationship to Patient: _____
Insurance Company:_____
Person responsible for account, if other than self?
Name: _____
Phone: (_____) _____-_____

CHIEF COMPLAINT(S)

Main reason that brought you in to the office:

_____

Symptoms are worse in the:
□Morning □ Afternoon □ Evening □ Night

When did the pain start? _____ /_____ /_____
How did it happen? _____

Were symptoms a result of a (an):

□ Job-related injury □ Auto Accident
□ Gradual onset □ Illness
□ Other accident □ Unknown cause

□ Date of occurrence: _____ /_____ /_____

How would you rate your current pain Level:
Lowest 1 2 3 4 5 6 7 8 9 10 Highest

Treatments that you have received for this condition:

_____
_____
_____
_____

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What activities **aggravate** your condition:

_____

_____

What activities **relieve** your condition:

_____

_____

Have you seen a Chiropractor before? □Yes □No

If yes, who?_____

Have you experienced a similar pain before? **Y / N**

If yes, when? _____

GOALS FROM TREATMENT

Describe your goals from receiving treatment

□ I want to correct the problem.

□ I just want temporary relief from the pain/symptoms.

Are there any other symptoms or health problems that you are being treated for:

- _____
- _____
- _____

Are you currently taking any supplements?

□ Yes □ No

What kind:_____

(If more space is needed please use additional page)

Are you pregnant or trying to get pregnant?

□ Yes □ No

Describe your tobacco use?

□ Never □ Previously □ Occasionally □ Daily

Describe your alcohol consumption.

□ Never □ Previously □ Occasionally □ Daily

BioMetrics:

Height: ____'_____" Weight: _____lbs

Weight Goals: □ Lose | □ Gain | □ Maintain

MEDICAL HISTORY

Have you been treated by a physician for any health conditions in the last year? □ Yes □ No

Describe condition:

_____

_____

Primary Medical Doctor's Name:

_____

Phone: (_____) _____-_____

MEDICATIONS

Are you currently taking any medications? □ Yes □No

MEDICATION NAME	DOSE & FREQUENCY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any medication allergies? □ Yes □ No

MEDICATION NAME	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any FOOD allergies? □ Yes □ No

FOOD NAME	REACTION
_____	_____
_____	_____
_____	_____

Are you Gluten Intolerant? □ Yes □ No □ ?

SURGICAL HISTORY

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

4:_____Date:_____

PLEASE INDICATE WHERE YOU ARE EXPERIENCING YOUR SYMPTOMS

Please place the following indicators where you are experiencing the below symptom:

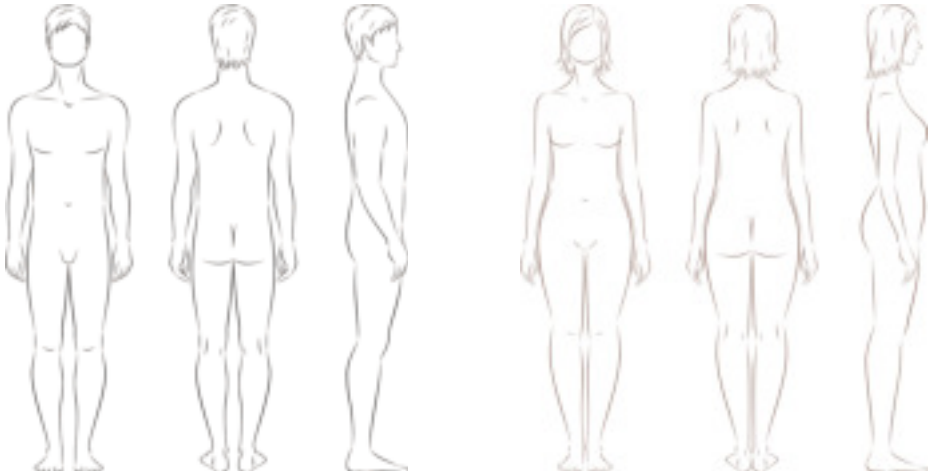
X = Pain

N = Numbness

T = Tingling

B = Burning

S = Shooting pain
(Please draw a line to indicate the direction that the pain travels.)



MEDICAL HISTORY

At Restoration Spine and Wellness we focus on the integrity of your nervous system, which controls and regulates your entire body. To help our doctors gain a comprehensive understanding to what you are experiencing please darken the boxes beside any condition that you've experienced **within the last year.**

a. Musculoskeletal
□ Neck Pain □ Back problems □ Osteoporosis □ Arthritis □ Scoliosis □ Hip disorders □ Knee injuries
□ Foot/ankle pain □ Shoulder problems □ Elbow/wrist pain □ TMJ issues □ Poor posture □ None

b. Neurological
□ Migraines □ Anxiety □ Depressions □ Dizziness □ Pins and needles □ Numbness □ None

c. Digestive
□ Bloating □ Indigestion □ Heartburn □ Constipation □ Diarrhea □ Muscle Cramps □ Anorexia/bulimia
□ Muscle Cramps □ Ulcer □ Food sensitivities □ None

d. Respiratory
□ Asthma □ Apnea □ Emphysema □ Shortness of breath □ Pneumonia □ None

e. Cardiovascular
□ High blood pressure □ Low blood pressure □ High cholesterol □ Poor circulation □ Angina □ Bruising □ None

f. Sensory
□ Blurred vision □ Ringing in ears □ Hearing loss □ Chronic ear infection □ Loss of smell □ Loss of taste □ None

g. Skin
□ Skin cancer □ Psoriasis □ Eczema □ Acne □ Hair loss □ Rash □ None

h. Endocrine
□ Thyroid issues □ Eye sensitive to light □ Trouble FALLING asleep □ Trouble STAYING asleep
□ Night Sweats □ AutoImmune disorders □ Hypoglycemia □ Low energy □ None

i. Genitourinary
□ Kidney stones □ Infertility □ Bedwetting □ Prostate issues □ Erectile dysfunction □ PMS symptoms □ None

j. Constitutional
□ Headaches □ Low libido □ Poor appetite □ Fatigue □ Sudden weight loss □ Sudden Weight Gain □ Fainting
□ Overal weakness □ None

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ACTIVITIES OF DAILY LIVING

Rate your current <u>difficulties</u> of performing daily living activities by placing the appropriate number in the box.

NOTE: If an activity does not cause your pain or if pain does not affect an activity, leave the box blank.

[1] This activity cause some pain, but it is only a minor annoyance.
[2] This activity causes a significant amount of pain, but I can do it.
[3] I cannot perform this activity due to pain and disability.

<u>Physical Activities</u>

[ ] standing	[ ] walking	[ ] reaching	[ ] bending right	[ ] twisting right
[ ] sitting	[ ] squatting	[ ] bending forward	[ ] bending left	[ ] twisting left
[ ] reclining	[ ] kneeling	[ ] bending back	[ ] looking left	[ ] looking right

<u>Functional Activities</u>

[ ] carrying small objects	[ ] lifting object off floor	[ ] pushing/pulling while seated	
[ ] carrying large objects	[ ] lifting weights off table	[ ] pushing/pulling while standing	
[ ] carrying briefcase/purse	[ ] climbing stairs/incline	[ ] exercising upper body	[ ] exercising lower body

<u>Difficulties With Traveling</u>

[ ] driving a car [ ] riding as passenger [ ] Sitting in a car for long periods of time

<u>Please place a CHECK MARK next to any of the following social/recreational activities that you participate in.</u>

[ ] walking [ ] running/jogging [ ] weight Lifting [ ] swimming [ ] biking [ ] yoga
[ ] golfing [ ] horseback riding [ ] gardening [ ] pilates [ ] playing a musical instrument
[ ] competitive sports: _____ [ ] other:_____
[ ] other:_____ [ ] other:_____

<u>List any activities that the pain/symptoms are preventing you from participating in that you would like to enjoy again.</u>

_____ _____ _____
_____ _____ _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- **Restoration Spine & Wellness** reserves the right to change the privacy policy as allowed by law.
- **Restoration Spine & Wellness** has the right to restrict the use of the information but **Restoration Spine & Wellness** does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

- May we leave a message on your answering machine at home or on your cell phone? **YES | NO**
- May we discuss your medical condition with any member of your family? **YES | NO**
  If YES, please name the members allowed on the lines provided below:

_____ _____ _____

_____ _____ _____

Name: _____
(PRINT NAME PLEASE)

Signature:_____ Date: ____ /____ /____
Patient's Signature: (parent, if minor)