Patient Information

Date of Birth_________

M F Age__________

Name_________________________________ Minor/Parent_______________________

Address____________________________________ City/State__________ Zip_______

Home Phone (______)_____________________ Cell Phone (_____)______________

Social Security#__________________ Email Address_________________________

Emergency Contact______________________ Phone___________________________

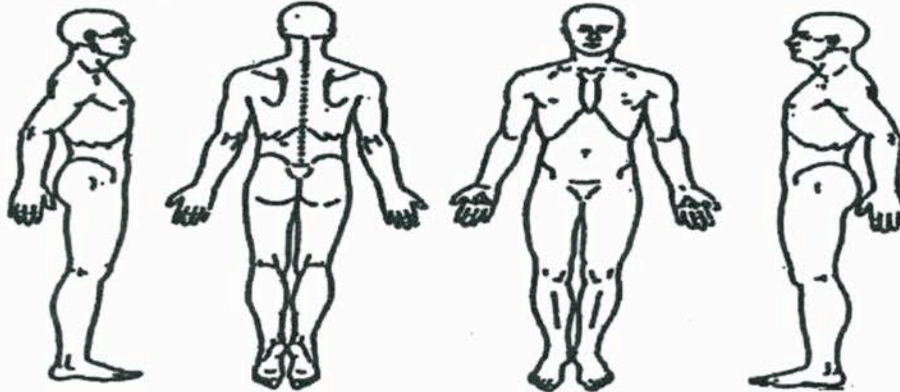
How did you hear of **Advance Back & Neck Care**______________________________

PATIENT INTAKE FORM

Patient Name: ______________________________ Date: _______________

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

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 □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ 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 □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____________
□ Massage Therapist □ Physical Therapist □ 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** ___________

Occupation ______________________________

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

17. What type of exercise do you do?
□ Stenuous □ 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	**For Females Only**	
□	□ 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, why ______________________________

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?______________________________

Patient Signature______________________ **Date:**______________

At Advanced back and Neck Care, we recognize two types of diseases, the first being infectious and contagious, and the second is functional disorder. Some examples of infectious and contagious diseases are hepatitis, influenza, and malaria. Functional disorder is our specialty. Some examples of Functional Disorders are migraine headaches, sleeplessness, poor posture, arthritic changes, fatigue, irritable bowel syndrome, dizziness, pain, etc... These are all functional disorders caused by one of the following:

1. Biochemical deficiencies - overweight, poor nutrition, processed food, etc.
2. Stress - causing hormone imbalances.
3. Neurological damage - caused by trauma, falls, car accidents, sports injuries, etc.

Our protocols for treating patients are different, and because our methods are different, we get **Results** where other healthcare providers you've seen have not.

Please fill out the information below so that we can better know your goals and expectations for your healthcare.

I would like my care to be managed in the following way:

- ☐ I would like the underlying cause of my symptoms addressed and have a treatment plan that will ultimately strengthen and balance my body to correct the functional disorders.
- ☐ I would like to be treated for my acute pain only without addressing the underlying cause and return for care when the pain returns. This will not correct the functional disorders.

I am willing to do the following to improve my health and decrease my pain and discomfort:

- ☐ Chiropractic care
- ☐ Physical therapy
- ☐ Pain management consultation with an Anesthesiologist
- ☐ Massage
- ☐ In office exercise program
- ☐ Home exercise program
- ☐ Lose weight

If the condition that I came to the office for today was gone, my life would be different in the following way:

____

____

____

To get rid of the condition that I came into the office for today, I think I will need to:

____

____

____

PATIENT FINANCIAL AGREEMENT

PLEASE READ THE FOLLOWING CAREFULLY.

I, the undersigned patient, understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that I am personally responsible for payment of treatments, and for any costs of collection, attorney's fees or court costs required to collect these payments. Some insurance companies have changed policies regarding payments, and the EOBs (Explanation of Benefits) and accompanying checks may be sent directly the patient. As a result of this, **it is mandatory that you bring the EOBs and/or insurance checks to our office ASAP.**

This agreement authorizes direct payment to said provider from any and all proceeds from any insurance policy, settlement, compromise, judgment verdict or damages to which I may be entitled and paid in connection with the settlement of claims or litigation, in such sums necessary to fully compensate the health care provider from whom I have received care. This agreement shall have priority from the time and date on which said documents are actually filed, or recorded or served on the liable parties, over any subsequent liens or assignments of my interests in claims arising from this treatment/accident.

In exchange for providing necessary medical care without requiring payment in full at the time service is received, I agree to be responsible for all charges associated with my care, regardless of the insurance companies' reimbursement, settlement or compromise. Charges for which I agree to be responsible include any administrative expenses associated with processing my claim(s). Also included are any collection charges or legal costs and fees incurred by the provider while attempting to collect the medical bills related to this claim should such activity becomes necessary. In the event that this indebtedness is referred to a collection agency for collections, I expressly agree to pay to the collection agency 25% of the principal amount assigned as a reasonable collection fee. I understand that 25% of the principal amount assigned may be more or less than the actual costs of collection and that it is extremely difficult to calculate the collection agency's actual costs.

Hour therapy appointments are subject to a **24 hour notice cancelation** policy. In the event you fail to provide at least a 24 hour notice, you may be subject to a **$15.00 fee**. Please provide this courtesy so that we may treat another patient at that time.

______________________________ ______________________________
Patient's Signature Date

______________________________ ______________________________
Guardians' Signature Date
[If patient is a minor]

1055 West Queen Creek Road, #3 Chandler, Arizona 85248
PH#(480) 814-7115 • FAX#(480) 814-7792

INFORMED CONSENT

I understand and agree the health and accident insurance policies are arrangement between an insurance carrier and my. I clearly understand and agree that all services rendered me are charges directly to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will immediately due and payable. I will be responsible for any cost of collection, attorney's fees or court required to collect my bill.

I hereby authorize physicians and staff at Advance Back and Neck Care to treat my condition as deemed appropriate. It is understood and greed the amount paid the doctor for X-ray negatives will remain the property of the office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically-diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or staff member of Advance Back and Neck Care responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risk prior to initiating care. While chiropractic treatment is remarkably safe, you need to be advised about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in the office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness- chiropractic adjustments and physical therapy procedures are sometimes accompanied by post-treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury-Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament tendon or other soft tissue.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment X-ay are taken for causes considered at risk. Treatment is preformed carefully to minimize such risk.

Physical Therapy Burns- Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but it occurs you should report to your doctor or a staff member at Advance Back and Neck Care.

Stroke-Stroke is the most serious completion of chiropractic treatment. The most recent studies (Journal of the CAA, VOL. 37, NO2, JUNE, 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Other Problems- There is occasionally other types of the side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask the doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature　　　　　　　　　　Date

Parent/Legal Guardian Signature　　　　　　　　　　Date