

PATIENT INTAKE

Name: _____ Age _____ Gender: M F Today's Date: _____
Home Address: _____ Home Phone: () _____
City, State, Zip: _____ Work Phone: () _____
Email Address: _____ Cell Phone: () _____
Birth Date: ____/____/____ Social Security #: _____ - _____ - _____ Marital Status: S M D W
Occupation: _____ Employer Name: _____
Spouse's Name: _____ Spouse's Birthdate: _____ Do you have any children? Yes No
How were you referred to this office? _____

I give my consent to be contacted by text and/or email regarding information including but not limited to insurance coverage, diagnostic tests (i.e. MRI), and appointment scheduling. I understand that my protected health information may not be securely protected by this office's email provider or my personal email carrier.

PURPOSE OF THIS VISIT

Reason for this visit: _____

Is this purpose related to an auto accident / work injury? Yes No If so, when: _____

Describe: _____

Please describe the pain & its location: _____

Indicate your current level of pain from 0 (No Pain) to 10 (Excruciating): 0 1 2 3 4 5 6 7 8 9 10

When did this condition begin? ____/____/____ When did you first notice it? _____

Is this condition getting worse? Yes No Is this condition: Constant Comes & goes Activity related

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

What activities aggravate your symptoms? _____

Is there anything that has relieved your symptoms? Yes No Describe: _____

Have you experienced this condition before? Yes No If so, please explain: _____

Have you had treatment anywhere else for this condition? Yes No What type of treatment? _____

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming Other: _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

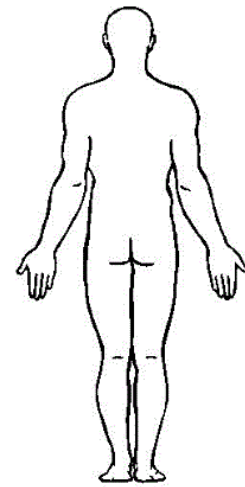
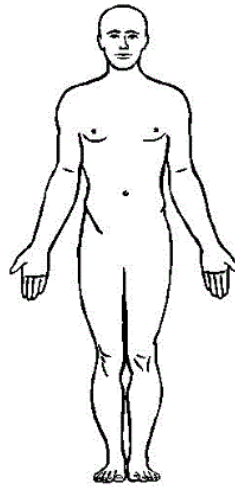
Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

Have you seen a Chiropractor before? Yes No Approximately last visit to Chiropractor? _____

How did you respond? _____

Please use the diagram to indicate where you experience pain and discomfort and the type of pain or discomfort following the key below:

- A – Dull/ache
- N – Numbness
- T – Tingling
- S – Sharp or Stabbing
- B – Burning
- St – Stiffness
- Th- Throbbing
- D – Deep
- C- Cramping



HEALTH CONDITIONS

Please indicate if you currently have or have a history of any of the following injuries or illnesses.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Allergies/Sinusitis | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Pain into shoulders/Arms | <input type="checkbox"/> Numbness/Tingling in Arms/Hands | <input type="checkbox"/> Grip Weakness |
| <input type="checkbox"/> TMJ Pain/clicking | <input type="checkbox"/> Low Energy/Fatigue | <input type="checkbox"/> Visual or Hearing Trouble | <input type="checkbox"/> Mid Back Pain |
| <input type="checkbox"/> Pain around ribs/chest | <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Nausea | <input type="checkbox"/> Asthma/Wheezing |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heart Conditions _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers/Gastritis |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Numbness/Tingling in Legs/Feet | <input type="checkbox"/> Pain into Hips/legs/feet | <input type="checkbox"/> Weakness in legs/feet |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Cramping in legs/feet | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Thyroid Conditions | <input type="checkbox"/> Dislocations/Fractures | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> “Hump” at base of neck | <input type="checkbox"/> Hives/Eczema | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Varicose Veins |

Women Only: Menstrual Irregularities Currently Pregnant? Yes No

Please list any conditions not mentioned: _____

Please list any medications / surgeries: _____

Have you ever had any injuries to your spine? Yes No

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following?

- | | | | | |
|---|---------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease/Heart Attack | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Polio | <input type="checkbox"/> Mumps | <input type="checkbox"/> Neurological Conditions | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Eczema | <input type="checkbox"/> Depression | <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dementia/Alzheimers | <input type="checkbox"/> Lung Conditions |

AUTHORIZATION OF CARE and INFORMED CONSENT

I authorize and agree to allow the doctor(s) and/or physical therapist to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I acknowledge and understand that even though negative results are rarely experienced, as with any form of treatment they are possible. Some of the potential risks may include but are not limited to: fractures, worsening of symptoms, muscle injury, joint irritation/dislocation. I recognize it is my responsibility to inform of the doctor of any and all conditions that may affect my care.

Although no significant data shows a correlation between chiropractic adjustments and the cause of stroke, I understand that there is concern in certain situations and if I have questions I agree to consult with my doctor. In the uncommon case that negative results from treatment occur at any time, I will notify the doctor immediately so that proper treatment can be administered and the result noted for future reference.

It is with full understanding and acknowledgment that I authorize and agree to the recommended course of treatment for conditions related to my spine and joints as prescribed by my doctor in this office.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or physical therapist specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I authorize the assignment of all insurance benefits be directed to the doctor and/or chiropractic office(s) for all services rendered.

Patient's Name Printed

Patient's signature

Date

Minors Name

Guardian/Spouse's Signature of Authorizing care for minor

Date

RADIOGRAPH CONSENT

I do hereby give my consent to allow this office and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

Signature of Patient/or Guardian of said Minor _____ Date _____

Females Only: I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? YES NO (please circle)

Patients Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

*I hereby authorize Dr. Kevin Morford, Dr. Brenda Hooper, Dr. April Morford and/or Dr. Ryan Hooper to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Please only fill out the following information if we have not received a copy of your insurance card

Name of Insurance Co. _____ Policy# _____

Address _____ Phone # _____

Insured's Name _____

Relationship to Insured _____ Subscriber's Birthdate ____/____/____

Employer _____

Who should receive charges on your account?

Patient Spouse Parent/Guardian Workers Comp Auto Insurance Personal Health Insurance

IN CASE OF EMERGENCY

Name _____

Relationship _____

Work Phone _____

Home Phone _____

Cell Phone _____

**The Chiropractic Offices of
Dr. Brenda Hooper, Dr. Kevin Morford, Dr. April Morford & Dr. Ryan Hooper
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(p) 405.844.4492 (f) 405.341.8291**

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have been made aware of and/or received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

Signature: _____ Date: _____

Please list anyone you give permission to view your private health records in the case of emergency or if we are unable to contact or communicate with you.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify) _____

Staff signature

Date