WELCOME

MANHATTAN HOUSE CHIROPRACTIC, PC

PATIENT INFORMATION

Date: _____

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Phone #:

(H) _____ (M) _____ (W) _____

Can we call you at work? □ Yes □ No

Date of Birth: _____ (mm/dd/yyyy)

Sex: □ Male □ Female

Marital Status:

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

Occupation: _____ Employer: _____

Person to be notified in the case of an emergency:

Name: _____ Relation: _____ Phone #: _____

How did you hear about our practice? _____

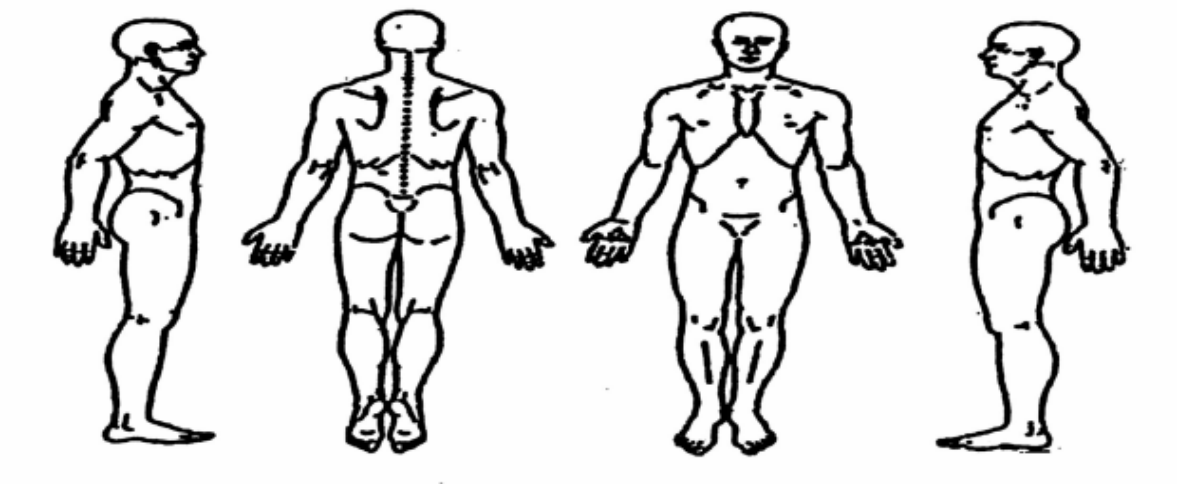
PATIENT INTAKE FORM

1. **What is your chief complaint?**

   _____

2. **Is today's problem caused by:** □ Auto Accident □ Injury at work □ Other

3. **Indicate on the drawings below where you have pain/symptoms**



4. **How often do you experience your symptoms?**
   - □ Intermittently (1-25% of the time)
   - □ Occasionally (26-50% of the time)
   - □ Frequently (51-75% of the time)
   - □ Constantly (76-100% of the time)

5. **How would you describe the type of pain?**
   - □ Sharp
   - □ Dull
   - □ Diffuse
   - □ Achy
   - □ Burning
   - □ Shooting
   - □ Stiff
   - □ Numb
   - □ Tingly
   - □ Sharp with motion
   - □ Shooting with motion
   - □ Other: _____

6. **How are your symptoms changing with time?**
   □ Getting Worse □ Staying the Same □ Getting Better

7. **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*)

8. **How much has the problem interfered with your work?**
   □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. **How much has the problem interfered with your social activities?**
   □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

10. **Who else have you seen for your problem?**
    - □ Chiropractor
    - □ ER physician
    - □ Massage Therapist
    - □ Neurologist
    - □ Orthopedist
    - □ Physical Therapist
    - □ Primary Care Physician
    - □ No one
    - □ Other:_____

11. **How long have you had this problem?**

    __ Day(s) __ Week(s) __ Month(s) __ Year(s)

12. How do you think your problem began?

_____

13. Which side is the pain worse on?

□ Left □ Right

14. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

15. What makes your problem better?

_____

16. What makes your problem worse?

_____

17. What is your:

Height_____ (ft/inch) **Weight** _____ (lbs) **Age** _____

18. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

19. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

20. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Other
□ Heart Problems □ Cancer

21. 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	□	□ Chronic Sinusitis	□	□ Dizziness
□	□ 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 Dependence
□	□ 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	□	□ High Blood Pressure
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Diabetes
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Asthma
□	□ Arthritis	□	□ Hepatitis		
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	**For Females Only**	
□	□ Cancer	□	□ General Fatigue	□	□ Birth Control Pills
□	□ Tumor	□	□ Muscular Incoordination	□	□ Hormonal Replacement
□	□ Visual Disturbances	□	□ Other: _____	□	□ Pregnancy

22. What is your daily intake of the following?

□ Caffeine ___ cups/day □ Alcohol ___ drinks/wk □ Cigarettes ____ packs/day

23. List all prescription medications you are currently taking:

_____
_____
_____

24. List any medications you are allergic to:

_____

25. List all of the over-the-counter medications you are currently taking:

_____

26. List all surgical procedures you have had:

_____

27. 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
□ **Other:** _____	□ Most of the day	□ Half of the day	□ A little of the day

28. What activities do you do outside of work?

_____

29. Have you ever been hospitalized? □ No □ Yes
If yes, why
_____

30. Have you had significant past trauma? □ No □ Yes
If yes, please explain
_____

31. What concerns you the most about your problem; what does it prevent you from doing?

□ It could be serious
□ It isn't going away
□ It is affecting leisure activities
□ It is affecting work
□ It is getting worse
□ It is affecting golf
□ It is affecting sleep
□ It is affecting mental outlook
□ It is affecting relationships
□ Other: _____

32. Anything else pertinent to your visit today? _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient Signature _____ **Date:** _____

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office.

NEUROLOGICAL/VASCULAR QUESTIONNAIRE

1. Do you suffer from neck pain with pain in your shoulders, arms or hands? □ NO □ YES
   Comment: _____
2. Do you have weakness, numbness, tingling or burning in your shoulders, arms or hands? □ NO □ YES
   Comment: _____
3. Do your arms or hands fall asleep regularly? □ NO □ YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your arms or hands? □ NO □ YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? □ NO □ YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? □ NO □ YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? □ NO □ YES
   Comment: _____
8. Do you your legs or feet fall asleep regularly? □ NO □ YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs or feet? □ NO □ YES
   Comment: _____
10. Do you suffer from cold hands or feet? □ NO □ YES
    Comment: _____
11. Have you tried any medications such as anti-inflammatory? □ NO □ YES
    If yes, what kind of medication? _____
12. Have you tried any Physical Therapy before? □ NO □ YES
    If yes, when? For how long? What kind? _____
13. Have you tried any Chiropractic treatments before? □ NO □ YES
    If yes, when? For how long? What kind? _____
14. Have you had an MRI? □ NO □ YES
    If yes, when? Who ordered it? What was it ordered for? _____
15. Have you had X-rays? □ NO □ YES
    If yes, when? Who ordered it? What was it ordered for? _____
16. Have you used any splint or braces or other prescribed treatments by an M.D.? □ NO □ YES
    If yes, when? What kind? Who ordered it? _____
17. Do you have a history of varicose veins or spider veins? □ NO □ YES
    Comment: _____
18. Do you have a history of ankle or calf skin discoloration (such as purple or brown pigmentation)? □ NO □ YES
    Comment: _____
19. Do you have a history of ankle or calf ulcers or open wounds which have taken a long time to heal? □ NO □ YES
    Comment: _____
20. Do you have calf or ankle swelling or edema? □ NO □ YES
    Comment: _____
21. Do you have aching leg pain, especially at the end of the day? □ NO □ YES
    Comment: _____
22. Do you have leg tiredness or fatigue, especially with prolonged standing? □ NO □ YES
    Comment:_____
23. Do you have itching or burning in your legs? □ NO □ YES
    Comment: _____
24. Do you suffer from leg cramps? □ NO □ YES
    Comment: _____
25. Do you have throbbing in your legs? □ NO □ YES
    Comment: _____
26. Do you have restless legs? □ NO □ YES
    Comment: _____

Insurance/Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone #: _____

Credit/Debit Card Information: (print legibly)

Name of card holder: _____

Credit Card #: _____ Card Type: _____

Expiration Date: _____ CVV Code (3 or 4 digit #):_____

Do you have health insurance? □No □Yes

Name of Carrier: _____

Name of Policy Holder: _____ Date of Birth of policy holder:_____

Do you have a Secondary Insurance? □No □Yes

Name of Carrier: _____

Name of Policy Holder: _____ Date of Birth of policy holder:_____

If your spouse carries the health insurance, what is their social security #? _____

It is the sole responsibility of the patient to inform us of any and all insurance plans and/or changes; insurance policies are an arrangement between the insurance carrier and the patient. Failure to do so will result in the patient being billed for any outstanding claims. It is the patient's responsibility to make sure that their insurance policy is effective & inform us of which is primary and which is secondary!

Are you enrolled in a section 125? □No □Yes

□(HSA) Health Savings Account

□(FSA) Flex Spending Account

□(HRA) Health Reimbursement Account

Please provide this office with a copy of your insurance card (s) and driver license/photo id.

Assignment and Release (insured patients)

I, certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICAL/MEDICAL PRACTICE INSURANCE BENEFITS OTHERWISE PAYBALE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary, including diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient Policies:

Setting the groundwork for positive Doctor-Patient relations:
The purpose of these agreements is to allow us to completely serve you and to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreements get the best results.

Sign-In Policy

When you arrive, please sign in; you will be called in the order in which you have signed in.

Office Hours Policy

Your doctor has specific office hours; the receptionist will schedule your appointment accordingly. Our general office hours are:

Monday	10:00am-7:00pm
Tuesday	10:00am-7:00pm
Wednesday	10:00am-7:00pm
Thursday	10:00am-7:00pm
Friday	10:00am-7:00pm
Saturday	10:00am-2:00pm

Upsets:

We are here to serve you; please speak with your doctor about any upsetting matter. We see your comments as helping us to help you.

Financial Office Policies

- **Any checks sent to you by the insurance company should be brought to our office within 7 days even if they are payable under your name or your spouse's name (in this case, please sign the check). Also, bring the attached insurance payment stub or explanation of charges to record which services were paid.**

- **Do not cash any checks from the insurance company for services rendered here. If you cash any insurance checks your account will be referred to the collection department. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees and or collection costs incurred in collecting the account balance.**

- Your insurance will be verified promptly and will be reviewed with you if applicable; all patients are on a cash basis until our staff can verify all insurance coverage(s). After the verification of your coverage and deductibles, this office may accept assignment on most policies provided the insured/patient signs and appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
- Any medical or other records or information necessary to process any claims will be released from our office.
- This office accepts Master Card, Visa, American Express, Discover Card, personal checks and cash for payment.
- If you have any questions concerning this or any other matter, please speak with the new patient coordinator or our financial department prior to seeing the doctor.

Missing or Changing Appointments Policies:

It is our wish that each and every one of our patients receive the very best care and service possible. Your treatment program consists of a specific series of treatment given over a pre-planned time span. If you don't follow the plan, then you will not receive the desired results. If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

- Meet all your appointments. Arrange the activities in your life so that this can occur.
- If you are unable to make your appointment due to an emergency, please call us and let us know so we can reschedule your appointment. If you need to change the time of your appointment, plan to come another time on the same day. If the same day is not possible, be sure to make up the missed appointment within one week.
- With the exception of an unexpected emergency, we require that you notify us 6 hours in advance as to any appointment changes to avoid being charged.
- For no call/no show appointments or cancellations less than 24 hours in advance, there is a **non-refundable $40.00 service charge** that will be billed to you or your credit card/debit card on file.

By signing below you affirm that you have read, understand and agree to follow the above policies.

Patient Signature: _____ Date: _____

Consent to Care

A patient coming to the doctor gives his/her permission and authority to care for them in accordance with the appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through healthcare procedures from whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the physician. I affirm that I am not an agent or representative of any insurance company or any other business trying to collect information. All injuries/problems mentioned are true and I am here solely for the treatment of the said problem.

I have read and understand the consent to care.

Signature: _____ Date: _____

X-Ray Questionnaire: For Women Only

Our consultation & examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name:_____

- ☐ There is a possibility that I may be pregnant at this time
- ☐ Yes, I am definitely pregnant
- ☐ No, I am definitely not pregnant at this time
- ☐ I request that x-ray films not be taken at this time because_____

Date of last menstrual period:_____

Signature:_____ Date:_____