WEBER CHIROPRACTIC

NEW PATIENT INTAKE FORM

Personal Information

FIRST NAME:_______________________LAST NAME:________________DATE:___________

DOB (mm/dd/yyyy):__/__/____ AGE:___ SEX AT BIRTH: _____PRONOUNS:______________

HEIGHT:_____(feet)_______(inches) WEIGHT (lbs):________

MARITAL STATUS: Single / Married / Divorced / Widowed (circle)

SPOUSES NAME: ________________ NUMBER OF CHILDREN:______

EMERGENCY CONTACT:_____________RELATIONSHIP:_________PH #:(___)_________

Contact Information

ADDRESS:____

CITY:___________________________STATE:_____________________ZIP:_________

PH#: (___)______________________________________Cell / Home / Work (circle)

EMAIL ADDRESS:__________________________

APPOINTMENT REMINDERS TEXT OR EMAIL?____________________________________

Referral Information:

REFERRING PHYSICIAN:_______________REFERRED PATIENT:___________________

ADVERTISEMENT:_____________________________(Google/Yelp/Facebook/Internet/Etc.)

REFERRED DIRECTORY:____

WEBER CHIROPRACTIC LLC - DR. ANTHONY WEBER
1530 E 1st Street, Newberg Oregon 97132 - 503.538.7338

Patient Health Questionnaire

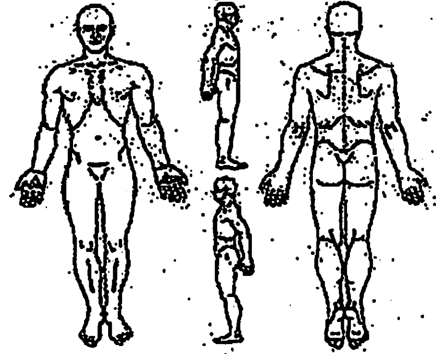
NAME____DATE___/___/____

1. Please describe your major concern:
____
____

a. Description
- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

b. Frequency
- ☐ Constant (75-100%)
- ☐ Frequently (51-75%)
- ☐ Occasional (25-50%)
- ☐ Intermittent (25% or less)

MARK ON THE PICTURE WHERE
YOU HAVE PAIN OR OTHER SYMPTOMS



c. Indicate the intensity of your pain at its lowest and highest level:

No pain 1 2 3 4 5 6 7 8 9 10 Unbearable pain

d. Your symptoms are: _____decreasing _____not changing _____increasing
e. Symptoms are worse in the: _____Morning _____Night _____Increases during the day _____Same all day

2. When did your concern begin? (Specific date if possible)____________________ Describe how your concern began:
____
____

3. Have you been treated for *this episode?* _____yes _____no
If yes, by whom? ___Chiropractor ___MD ___Osteopath ___Physical Therapist ___Occupational Therapist ___Other____________
Are you currently being seen? _____yes _____no If yes, when and what treatment?____/____/____
____
____

4. Have you been treated *in the past* for the same or a similar problem? _____yes _____no
If yes, whom did you see for that episode? ___MD ___Osteopath ___Physical Therapist ___Occupational Therapist ___Other ____________
When and what treatment did you receive?______________________________________
____

5. What makes your problem better? ___Nothing ___Lying Down ___Walking ___Standing ___Sitting ___Movement/exercise ___Inactivity

6. What makes your problem worse? ___Nothing ___Lying Down ___Walking ___Standing ___Sitting ___Movement/exercise ___Inactivity

7. How would you rate your general stress level? ___Little or No Stress ___Minimal Stress ___Moderate Stress ___Greatly Stressed

8. General Activity Level: ___No regular exercise program ___Light exercise program ___Moderate exercise ___Strenuous exercise

9. How are your complaints affecting your ability to be active?
___No effect
___Need limited assistance with common everyday tasks
___Have significant inability to function without assistance
___Some physical restrictions (able to perform light duty work and household tasks)
___Need assistance often
___Am totally impaired/disabled. Cannot care for myself.

10. Your physical activity at work is:
___Sitting more than 50% of workday ___Light manual labor ___Manual labor ___Heavy manual labor ___Repeated motion

11. Your occupation: ______________________ Has your work status changed due to this complaint? ________

12. What is your current work status?
___Full time, no restrictions
___Full time, with restrictions
___Part time, not restrictions
___Part time, with restrictions
___Off work due to restrictions
___Full time homemaker
___Unemployed
___Retired
___Full time student
___Other

Patient Signature: ______________________________________ Date___/___/_____ (Please continue on page 2.)

To assist your doctor in more thoroughly understanding your state of health, please provide information concerning past and present conditions and diseases. If you have ever had a listed condition in the past, please check the *Past* column. If a condition is troubling you presently, check it in the *Present* column.

Past	Present	
☐	☐	Neck Pain
☐	☐	Shoulder Pain
☐	☐	Pain in upper arm or elbow
☐	☐	Hand Pain
☐	☐	Wrist Pain
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip
☐	☐	Pain in Lower Leg or Knee
☐	☐	Pain in Ankle or Foot
☐	☐	Jaw Pain
☐	☐	Swelling/Stiffness of Joints
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitis (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight ☐Gain ☐Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Irregular Menstrual Flow
☐	☐	Profuse Menstrual Flow
☐	☐	Breast Soreness/Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/irregular Bowel Habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	Cancer/Tumor
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Arthritis/Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver/Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Systemic Lupus
☐	☐	Other ____________________

Please check any of the following that apply to you.

Past	Present	
☐	☐	Pregnancy
☐	☐	Birth Control Pills
☐	☐	Hormone/Estrogen replacement
☐	☐	Medications (list if not listed elsewhere) ____________________
☐	☐	Hospitalization/Surgical Procedures ____________________
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffeinated Soft Drinks: cups/cans per day:__________

Please mark if a family member has had any of these:

- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ High Blood Pressure
- ☐ Epilepsy
- ☐ Chronic Back Problems
- ☐ Chronic Headaches
- ☐ Lupus
- ☐ Other Conditions ____________________

___Yes ___No Do you have a permanent disability rating?

Location:____________________

Date rating received ___/___/_____

Rating Percentage __________%

Present: Weight ________lbs Height ____ft, ____in

Doctor's Additional Comments/General Health Concerns:

____

Patient's Signature: ______________________________ Date: ____/____/______

Notice of Privacy Practices

We want you to know how your patient health information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company provided by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance company requires for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all the precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment, and healthcare operations, the Chiropractic Physician has the right to refuse to give care.

I have read and understand how my patient health information will be used and I agree to these policies and procedures.

____

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other procedures by Weber Chiropractic LLC. The following points have been explained to me, to my satisfaction, and I have had an opportunity to discuss them with the Dr. and/or other clinic personnel.

-Chiropractic care is the science, philosophy and art of locating and correcting spinal joint dysfunction (misalignments) and as such, is oriented toward improvement of spinal function relative to range-of-motion, muscular and neurologic aspects. There has been no promise implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic.
-I understand that the chiropractor will use his/her hand or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click".
-As with the practice of medicine, the practice of chiropractic is not an exact science, but relies upon information related by the patient, information gathered during the examination, and the doctor's interpretation thereof, as well as the doctor's judgement and expertise in working with similar cases.
-It is not reasonable to expect my chiropractor to be able to anticipate, or explain all possible risks and complications of a given procedure on any particular visit. And I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he/she feels at the time to be in my best interest.
-An undesirable result, or side effect, does not necessarily indicate error in judgement or an improper treatment.
-As with any health care procedure there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to sprains/strains, dislocations, fractures, disc injuries, or cerebral-vascular accidents. These complications are extremely rare occurrences.

Clinic Account Policy
-Payment is expected at the time of service.
-As a service to you, we will bill your insurance company. We will ask you to pay the amount your insurance company will not pay at the time of each office visit. i.e.; deductible, percentage, co-pay, non-covered service.
-We make every effort to get accurate information from insurance companies. However, insurance companies make mistakes. For example, sometimes they tell us they'll cover certain charges and then not pay them when they receive the billing. For this reason, we periodically review accounts and may have to inform you of a balance due.
-Information received from the insurance company IS NOT A GUARANTEE OF BENEFITS. You are responsible for all charges incurred in this office.
-If you have a personal injury (automobile accident) account, we'll bill your insurance company. The insurance company may not cover 100% of your bill. You are responsible for the difference. We'll keep you updated on the payment activity on your account, and ask that you keep us updated on any new information you may receive regarding your account. We reserve the right to charge 18% interest per year on any outstanding claims over 30 days.
-Weber Chiropractic has a 24 hour cancellation policy, a $60 fee will be charged for missed appointments.

I have read the above consent, or had it read to me and I am comfortable with the information provided and consent to chiropractic treatment and management on that basis.

____________________	________________________________	____________
Patient's Name (printed)	Patient's Signature (Parent or Guardian)	Date

Weber Chiropractic LLC Notice of Privacy Practices

________ I have received a copy of Weber Chiropractic's Notice of Privacy Practices.
Initial