New Patient Intake Form

GERLACH CHIROPRACTIC

Patient Information

Full Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Female: _____ Male: _____

Social Security Number: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I prefer to receive calls at (circle) Home/Work/Cell I am (circle) Under Age18/Single/Married/Divorced/Widowed/Separated

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

How did you hear about us: _____

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Major Complaint: _____ Have you seen any other doctor for this condition? _____

If yes, Name of Doctor:_____ Date seen by Doctor: _____ Phone Number of Doctor: _____

Type of Treatment: _____ Results: _____

Are your symptoms: Improving ☐ Getting Worse ☐ Staying the Same ☐ Intermittent (Come and Go) ☐

Has this condition occurred before? Yes/ No If yes, when did your symptoms begin? _____

Is this condition job related? Yes/ No Auto Accident? Yes/ No

If yes, date of accident? _____ Reported to Employer? Yes/ No

Do you suffer from any condition other than that which you are now consulting us? Yes/ No If yes, explain_____

Consent for Treatment

Assignment & Release *- By signing below, I authorize Gerlach Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Gerlach Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____

NAME LAST	FIRST	MIDDLE INIT.	DATE OF BIRTH	HEIGHT	WEIGHT	SEX	DATE

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

OCCASIONAL FREQUENT

GENERAL

- ☐ ☐ Alergy (list below)*
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or Fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE & JOINT

- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot Trouble
- ☐ ☐ Low Back Pain
- ☐ ☐ Neck Pain or Stiffness
- ☐ ☐ Pain Between Shoulders
- ☐ ☐ Sciatica
- ☐ ☐ Swollen Joints
- ☐ ☐ Pain, Numbness or Cramps
- ☐ ☐ Shoulders
- ☐ ☐ Arm Pain
- ☐ ☐ Elbow Pain
- ☐ ☐ Hand Pain
- ☐ ☐ Hip Pain
- ☐ ☐ Leg Pain
- ☐ ☐ Knee Pain
- ☐ ☐ Foot Pain
- ☐ ☐ General Stiffness

OCCASIONAL FREQUENT

GASTRO-INTESTINAL

- ☐ ☐ Colon Trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult Digestion
- ☐ ☐ Distension of Abdomen
- ☐ ☐ Gall Bladder Trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver Trouble
- ☐ ☐ Pain Over Stomach

EYES, EARS NOSE & THROAT

- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear Discharge
- ☐ ☐ Ear Noises
- ☐ ☐ Eye Pain
- ☐ ☐ Nasal Obstruction
- ☐ ☐ Nosebleeds
- ☐ ☐ Sinus Infection

CARDIO-VASCULAR

- ☐ ☐ Hardening of Arteries
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Pain Over Heart
- ☐ ☐ Poor Circulation
- ☐ ☐ Rapid Heart Beat
- ☐ ☐ Slow Heart Beat
- ☐ ☐ Swelling of Ankles

OCCASIONAL FREQUENT

RESPIRATORY

- ☐ ☐ Chest Pain
- ☐ ☐ Chronic Cough
- ☐ ☐ Difficult Breathing
- ☐ ☐ Spitting up Blood
- ☐ ☐ Spitting up Phlegm
- ☐ ☐ Wheezing

SKIN

- ☐ ☐ Bruise Easily
- ☐ ☐ Dryness
- ☐ ☐ Skin Eruptions (Rash)
- ☐ ☐ Varicose Veins

GENITO-URINARY

- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in Urine
- ☐ ☐ Frequent Urination
- ☐ ☐ Inability to Control Kidneys
- ☐ ☐ Kidney Infection or Stones
- ☐ ☐ Painful Urination
- ☐ ☐ Prostate Trouble
- ☐ ☐ Pus in Urine

FOR WOMEN ONLY

- ☐ ☐ Congested Breasts
- ☐ ☐ Cramps or Backache
- ☐ ☐ Excessive Menstrual Flow
- ☐ ☐ Hot Flashes
- ☐ ☐ Irregular Cycle
- ☐ ☐ Lumps in Breast
- ☐ ☐ Menopausal Symptoms
- ☐ ☐ Painful Menstruation
- ☐ ☐ Vaginal Discharge

Pregnant ☐ Yes ☐ No ☐ Not Sure

Date of Last Period_____

Previous Miscarriages ☐ Yes ☐ No

DATE OF LAST: (Approx.)

_____ Physical Examination
_____ Blood Test
_____ Chest X-Ray
_____ Spine X-Ray
_____ Dental X-Ray
_____ Urine Test

HABITS:

- ☐ Alcohol
- ☐ Coffee
- ☐ Tobacco
- ☐ Drugs
- ☐ _____

YES NO **HAVE YOU EVER:**

- ☐ ☐ Been Knocked Unconscious?
- ☐ ☐ Used Crutches, or Other Support?
- ☐ ☐ Been Treated For Spine Problems or ☐ Nerve Disorder?
- ☐ ☐ Had a Fractured Bone?
- ☐ ☐ Been Hospitalized For Other Than Surgery?
- ☐ ☐ Had Surgery? (list below)*

*Please List any Medications Now Taken, Allergies and Past Surgeries: _____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBER

HAVE HAD

- ☐ ☐ Alcoholism
- ☐ ☐ Anemia
- ☐ ☐ Appendicitis
- ☐ ☐ Cancer
- ☐ ☐ Diabetes
- ☐ ☐ Eczema
- ☐ ☐ Emphysema
- ☐ ☐ Goiter
- ☐ ☐ Gout
- ☐ ☐ Heart Disease
- ☐ ☐ Miscarriage
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ Polio
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Stroke
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcers
- ☐ ☐ Foot Problem

After reading and filling out the Health Questionnaire, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely

Sign Your Name _____ Date _____

GERLACH CHIROPRACTIC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

GERLACH CHIROPRACTIC

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____

Print Patient's Name Date

I,_____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,_____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

GERLACH CHIROPRACTIC

CONFIDENTIAL PATIENT HISTORY
PAIN DIAGRAM

The following information is necessary for our files. Please answer all questions completely

Print name: _____

Signature: _____

Date: _____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbols. Include all affected areas. Just to complete the pictures, please draw in your face.

Numbness: = =
= =

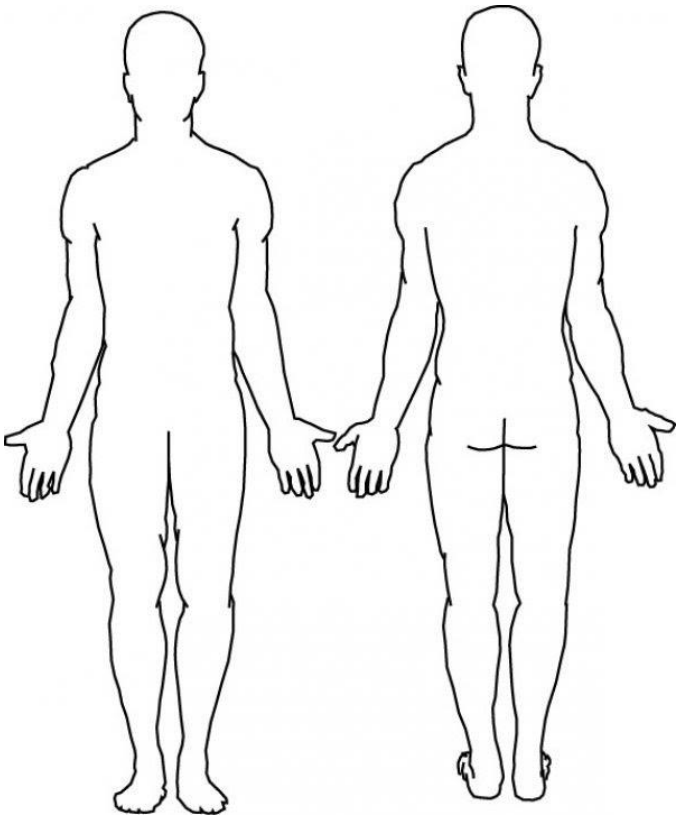
Burning: X X
X X

Pins and Needles: ○ ○
○ ○

Sore: □ □
□ □

Ache: △ △
△ △

Stabbing: / / /
/ / /



GERLACH CHIROPRACTIC

VISUAL ANALOG SCALE

FOR LOW BACK PAIN

The line below represents the intensity of low back pain. Please mark an "X" at the position on the scale which indicates how much pain you feel in your low back at this time.

_____

No Pain — Worst Pain Imaginable

FOR PAIN OTHER THAN LOW BACK PAIN

This line below represents the intensity of your pain. Please mark an "X" at the position on the scale which indicates how much pain you feel at this time.

_____

No Pain — Worst Pain Imaginable

Name: _____ Date: _____

GERLACH CHIROPRACTIC

215 Spencerport Road, Rochester NY 14606
585-429-5680

2507 Browncroft Blvd, Suite 105, Penfield NY 14625
585-662-5259

Acknowledgement and Financial Responsibility Statement

This form was developed to ensure that Health Insurance members understand when a service is not covered by their Health Insurance Plan.
When a service is not covered **and** the member is put on notice that the service is not covered, the member will be financially responsible for the full cost of the service.
This form must be completed it its entirety **before** the non-covered service is provided.

I have been advised that the following recommended services may not be covered benefits under my health insurance plan.

Procedure Code	Description of Service	Charges
99203	Exam, Initial Exam, Re-Exam *New exam charge will be applied to patients who have not been seen in 3+ years, to re-evaluate previous care and new symptoms.	$50.00
98941	Spinal Manipulation	$50.00
97014	Electric Stimulation	$20.45
97035	Ultrasound Therapy	$18.53
N/A	K-Laser Therapy	$30.00
N/A	SpineMed Traction	$70.00

-I acknowledge that my Health Insurance Plan may not pay for these services.
-I further acknowledge that I am financially responsible for the cost of the services and for any services that are denied due to limitations.
-All questions regarding limitations or non-covered charges should be directed to your insurance carrier representative, per your policy guidelines.

Office Name	Gerlach Chiropractic PLLC
Patient Name (please print)	
Insurance Plan / Company	
Patient Signature	
Date of Acknowledgement and Signed	

A copy has been provided to the patient for their record.