# The Pain & Brain Healing Center

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## Chiropractic/Orthopedic Patient Intake Form

**Dear Patient,**
This form is to be filled out by those individuals seeking care **for basic chiropractic/orthopedic disorders**. For those individuals with a more complex chronic disorder (e.g. wide spread pain syndrome, fibromyalgia, depression, digestive disorders, metabolic syndrome) please fill out our comprehensive biomedical care questionnaire. If you have any questions please ask our staff or call us. The first four pages are your health history questionnaire, the two pages to follow are our office policies and procedures please read carefully. **If you are on Medicare** you must read and sign our Medicare Coverage form.

Name ________________________________________________ Date ____________

Address ________________________________________ City/State/Zip ___________________________

SSN# ____________________________ Home phone______________ Work phone ________________

Cell Phone __________ Age______ Birth Date_________ Marital: M S W D How many children?______

Occupation ______________________________ Employer ____________________________

Name of Spouse ___________________________ Spouse's Birth Date ___________________________

Who referred you to us? _________________________________________________________________

Is the condition due to injury or sickness arising out of employment? ____________________________________

Is the condition due to injury or sickness arising out of an auto or other type of accident? ______________________

Number of days lost from work ____________ Date symptoms appeared or accident happened ______________

Briefly describe the reason for your visit here: ____________________________________________________

______________________________________________________________________________

In the past have you ever had the same or a similar condition? ___yes ___no If yes, please describe: ______________

______________________________________________________________________________

Please list all doctors you have seen related to you current concern, also please include any chiropractors or family medical doctors. If possible list the approximate date of the last visit and their city and telephone number.
1. ____________________________________________________________________________
2. ____________________________________________________________________________
3. ____________________________________________________________________________
4. ____________________________________________________________________________

Please describe any previous tests (X-ray, MRI, EKG, blood work, etc.) to investigate your current concern.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

## OTC & Prescription MEDICATIONS What are you taking **NOW**?

| DRUG NAME | DOSAGE and # per day | Good Response | No Response | Bad Response | Bad then Good |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

# PAST MEDICAL HISTORY

Include any chronic/recurring disorder or previous problems/diseases which no longer affect you

| CONDITION | PAST TREATMENTS | CURRENT TREATMENTS | APPROXIMATE DATE (S) of TREATMENT |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

# DIETARY HISTORY

Check the most appropriate description below of my diet:
_______________ Mostly carbohydrates (bread, pasta, etc.)
_______________ Mostly dairy (milk, cheese, etc.)
_______________ Mostly meat
_______________ Mostly vegetarian (vegetables, fruits, grains, etc.)
Other. Describe: ____________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

# DIGESTIVE HEALTH

Do you have periodic loose stools/diarrhea___ Yes ___ No Offensive Gas ___Yes ___No
Undigested Food in Stools ___Yes ___No Offensive Breath ___Yes ___ No
Do you suffer with acid reflux/heartburn ___Yes ___No
Are you currently taking an acid-blocking medication such as Tagamet, Pepcid, etc. ___Yes ___ No
Do your digestive problems occur more with stress ___Yes ___No ___ Unsure
Do you produce well formed stools ___Yes ___ No
Have you ever produced formed stools ___Yes ___ No

# ANTIBIOTIC HISTORY

How many courses of antibiotics have you received in lifetime (approx): ___ 0 ___ 1-5 ___5-10
___10-15 ___15-20 ___20+
Main reason for antibiotic use: ___Ear Infections ___Bronchitis ___Pneumonia ___Sinus Infection
___Intestinal Infection ___Other (please explain)_______________________________________________
Have you ever been treated for a yeast infection following antibiotic use _____________________________

# PLEASE DESCRIBE YOUR HEALTH CONCERNS

1. What are the major problems you are experiencing? ______________________________________________

______________________________________________________________________________

2. If this is a reoccurrence, when did you originally notice the problem? ____________________ What initially caused it? ______________________________________________________________

3. Has it changed recently? ___Better ___Worse ___Same What types of treatment have you tried? __________

______________________________________________________________________________

What makes it better? _________________________________ Worse? __________________________

4. How frequent is the condition? ___________________________ How long does it last? ________________

5. Is this affecting your sleep? ___Yes ___No If yes, please describe: ________________________________

______________________________________________________________________________

6. Is this affecting your ability to perform your job or daily activities? ___Yes ___ No If yes, please describe: _______

______________________________________________________________________________

______________________________________________________________________________

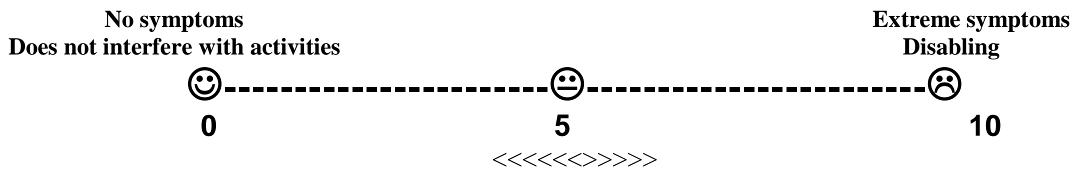
7. Are there any other symptoms that may be related to these concerns, which you have not listed? ___Yes ___No
If yes, please describe:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Please mark an "X" on the line to indicate the severity of your condition:**

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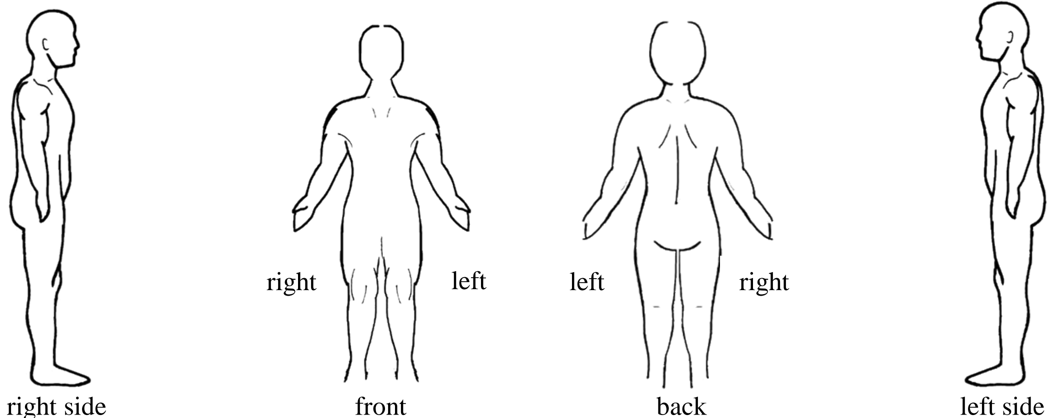
Please mark any areas of concern on the diagrams below. N – numbness P- pins & needles B- burning A- aching S-stabbing. Indicate any other problems as best you can.



# Survey of Your Health History

**Please circle all that apply. Indicate whether this is a current or old concern by providing an approximate date.**

**1. General**
Fever
Night sweats
Nervous ness
Bleeding
Diabetes
Thyroid
Headache
Fainting
Depression
Memory loss
Chills
Fatigue
Weight loss/gain
Anemia
Cancer
Substance abuse
Dizziness
Seizures
Phobias
Waking in night
Problems falling asleep
Explain any surgeries or hospitalizations: _______________
______________________________
______________________________
Any broken bones, car accidents or other injuries? _________________
______________________________

**2. Gastrointestinal**
belching/gas
vomiting
bloody stools
hernia
constipation
diarrhea
abdominal pain
nausea
liver problems
other__________________________

**3. Respiratory**
breathing problems
spitting phlegm/blood
allergies
asthma
shortness of breath
chronic cough
pneumonia
other ________________________

**4. Cardiovascular**
irregular heartbeat
racing heart
chest pain
high blood pressure
swelling
prior heart problem
pacemaker
stroke
other ________________________

**5. Musculoskeletal**
stiffness
pain
swelling
spinal curve
arthritis
weakness
twitching
tremors
numbness
other ________________________

**6. Skin**
rashes
mole changes
itching
nail changes
redness
other ________________________

**7. EENT**
blurry vision
double vision
eye pain
jaw pain
hearing loss
ringing in ears
ear infection
sinus problems
nosebleeds
throat problems
speech problems
Glasses or contacts? ______

**8. Genitourinary**
frequent/painful urination
incontinence
blood in urine or stool
urinary infection
venereal infection
other ________________________

**9. Women Only**
difficult periods
hot flashes
irregular cycles
breast pain
lump in breast
difficulty becoming pregnant
complications of pregnancy
other ________________________
Date last period ended _________
Date last gynecologic exam _____

**10. Men Only**
testicular pain
prostate problems
difficult erection
low sperm count

**11. Exercise**
none
1-2 per week
3-4 per week
5-7 per week
What type? ___________________

**12. Habits**
Smoke(___packs/day, years?____)
Alcohol (_______ drinks per wk)
Caffeine (_______ cups per day)
Recreational drug use __________

**13. Family**
Are your parents living? _______
If so do you consider them to be in good health? _________________
Ages: Mother _____ Father _____

**Circle any below that apply to your parents, siblings or children:**
Diabetes
Stroke
Hypertension
Cancer
Seizures
Tremors
Brain disorder
Heart disease
Lung disease
Arthritis
Scoliosis

I, the undersigned, understand that I am financially responsible for all charges. I consent to proceed with the interview and examination. I understand that any treatment will be explained to me and my verbal consent will be requested before any care is rendered.

Signature_____________________________________________________ Date ______________________________

# Office Policies and Procedures

### Hours: (By appointment ONLY)

☐Monday: 10AM–7PM
☐Wednesday: 10AM–7PM
☐Friday: 10AM–7PM

### Consultation, Exam Fees, Laboratory Testing, and In-Office Therapies:

We offer a cash discount to patients paying in full. We accept Cash, Check, MasterCard, and Visa. For patients needing a payment plan we accept CareCredit (see below).

### CareCredit:

CareCredit (www.carecredit.com) is a medical financing service available through our office that you can put towards office consultations, laboratory testing, and in-office therapies.

### Appointments:

☐Payment is due at the time of your consultations, exams and treatments. Methods of payment are: Cash, Visa, MasterCard, Discover, CareCredit, and check.
☐First appointment: All initial paperwork must be completed, signed, and received by our office prior to your scheduled appointment.
☐First appointment: If paying by check for a phone consultation, include the check with your mailed paperwork.
☐Follow-up consults and treatments may be scheduled in 15, 30, 45, or 60-minute blocks of time.
☐Patients who forget their appointment or don't cancel with appropriate notice will be required to pay for the missed visit. See the cancellation policy below. Please understand that a missed appointment could have gone to a patient on the waiting list.
☐Consultations with other healthcare providers and/or any research requested by the patient are billable services and will be charged at the hourly rate.
☐Scheduled consultations that include review of lab tests require that laboratory test results be received at least 24 hours prior to appointment.

### Medical Letters, Narrative Reports, Chart Note Copying, etc.

Medical letters to schools, insurance companies, disability, as well as narrative reports and chart note copying for insurance purposes, etc. are a billable service. If your insurance company requires additional information we will attempt to bill them prior to sending the requested information. Unfortunately, some insurance companies feel that paying for this service is not an allowable. If this occurs than any fees will be your responsibility

### Office Consultation and Treatment:

☐Please check in 5 minutes before your scheduled appointment.
☐Patients who are late may lose part of their time, and may be billed at the rate of the scheduled appointment, no-shows will be billed for the missed appointment.
☐Please do not wear any scented products, as many of our patients are chemically sensitive. These include lotions, cologne, perfume, hair spray, etc.

### Questions and Follow-up:

☐**Please Note:** **<u>We try to accommodate questions regarding treatment clarification at no charge.</u>** Simply put, if you have a quick question about a supplement or diagnostic test we recommended or a therapy reaction you may be experiencing, **then by all means you must contact us**. However, if the response to a question you submit requires doctor research and/or review, you may be billed for the time involved at the doctor's hourly rate.
☐Please direct e-mails, faxes or letters regarding your care to the Center's administrative assistants (info@painandbrainhealingcenter.com). Questions must be brief and concise. The office staff and/or clinic physicians will determine if a phone or office consult is needed to answer your question(s). Otherwise, a member of our office staff will respond to your inquiry. When leaving a voicemail message, please be brief and concise and always include your name and phone number, including the area code.

### Follow-Up Consultations and Treatment Visits:

☐The actual number of follow-up consultation and/or treatment visits will be based on the results of your history, test results and examination findings.

### Payment:

☐Payment is due at the time of your consultations, exams and treatments. Methods of payment are: Cash, check, Visa, MasterCard, Discover and CareCredit.

☐If paying by check for a phone consultation, include the check with your mailed paperwork.

☐If you are unable to pay by credit card, a check must be provided prior to your appointment in the amount due for the scheduled time.

### Insurance:

☐A "Superbill" receipt (form detailing diagnostic codes and fees) can be provided to you. This receipt can be submitted to your insurance carrier for reimbursement. Some services may not be covered by certain health insurance plans. It is your responsibility to know what your insurance plan covers. We are not responsible for unpaid claims by your insurance company for services we provide. **Pain & Brain Healing Center** does not accept insurance liens, assignments, or any reimbursement from your insurance carrier.

☐**Pain & Brain Healing Center** is non-participating with Medicare (See Medicare Policy at the end of this document), Champus, and Tri-Care providers.

I have read and understood the above that it is my responsibility to find out the details of my insurance coverage and I will see that my charges will be taken care of. I understand also that I have the right to refuse to sign. I also understand that by refusing to sign, Pain & Brain Healing Center may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

### Acceptance of Policies and Procedures

By completing the following you agree to the policies and procedures detailed above.

Patient (please print):______________________________________ Date: __________________

Signature (patient or responsible party): _______________________________________________________

If signed by party other than patient, print name: _______________________________________________