DOYLE CHIROPRACTIC & Family Wellness

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Email Address: _____

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

CLINICAL SUMMARIES: *(These summaries are often blank as a result of the nature & frequency of chiropractic care.)*

□ I choose to decline receipt of my clinical summary after every visit at this time.

□ I choose to receive my clinic summaries EMAILED / PRINTED (circle one) after every visit.

Patient Signature: _____ Date: _____

For office use only:

Height: _____ Weight:_____ Blood Pressure:_____ /_____

DOYLE CHIROPRACTIC & Family Wellness

PATIENT INFORMATION:

Name: _____ Date: _____

Address: _____City:_____ State: _____ Zip: _____

E-mail: _____ Home Phone: _____ Cell: _____

Birth Date: _____ Social Security # _____ Marital Status: M S W D

Job Title: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Job Title: _____ Employer: _____

Emergency Contact: _____ Phone: _____

How were you referred to our office? _____

Primary Medical Doctor: _____ Phone: _____

Date of Last Physical Exam: _____ Women Only, Are You Pregnant? ____Yes ____ No

May we have your permission to update your medical doctor regarding your care at this office? ____Yes ____No

INSURANCE INFORMATION:

Please check any and all insurance coverage that may be applicable in this case**:**

___ Major Medical ___ Worker's Comp ___ Medicare ___ FSA/HSA/HRA ___ Auto Accident ___Cash/Other

Primary Insurance: _____ Subscriber: _____ D.O.B. _____

Secondary Insurance: _____ Subscriber: _____ D.O.B. _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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.

The following person(s) have my permission to receive my personal health information:

_____ _____

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

PATIENT NAME _____ DATE _____

HISTORY OF PAST AND PRESENT ILLNESS:

Primary complaint for this appointment: _____

Is this due to: Auto Accident____ Work Accident____ Other _____

Date symptoms appeared or accident happened: _____

Have you ever had the same or a similar condition? ___ Yes ___ No

If yes, when and describe: _____

Days lost from work: _____ Date of last physical examination: _____

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ___ Yes ___ No

If yes, describe: _____

Do you have any allergies of any kind? ___Yes ___ No

If yes, describe: _____

Do you have any congenital conditions? ___Yes ___ No

If yes, describe: _____

SOCIAL HISTORY

Have you had, or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now**, or **P** if you have had these conditions **previously**.

	N = Now	**P = Previously**	
Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Disorders	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Cold Feet	_____
Tension	_____	Cold Hands	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression/Anxiety	_____
Sensitivity to Lights	_____	Loss of Memory	_____
Ringing in Ears	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____

PATIENT NAME _____ DATE _____

Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alcoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Excessive Bruising	_____
Stomach Ulcers	_____	Eczema	_____

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Sedentary Activity

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine Consumption

_____ E-Cigarette Use

_____ High Stress Activity

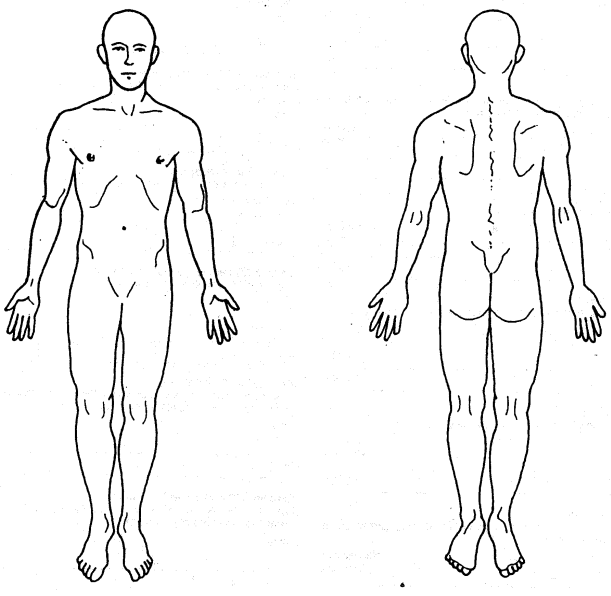
_____ Other (Please Specify)

TELL US WHERE YOU HURT

Please mark areas of pain on the figures below. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels.

Please Rate Your Pain: None 1 2 3 4 5 6 7 8 9 10 Severe

Aching ____ Numbness ____ Tingling ____ Burning ____ Stabbing ____ Throbbing ____



Patient Health Information Consent Form

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 will 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 (or companies) provided to us 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 companies require 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 the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect 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 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 formal 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 health care 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.

Patient's Signature Date