Initial Intake Questionnaire

*Instructions: Please take time to provide full and complete responses to the questions below. If you need additional room to respond to a question, please use the backside of this questionnaire.

PATIENT INFORMATION

Title: ○ Mr. ○ Mrs. ○ Ms. ○ Miss (Check one)

First Name: _____ Middle Initial:_____ Last Name: _____

Address:_____

City:_____ State:_____ Zip:_____

Mobile #: (_____) _____-_____ Sex: ○ Male ○ Female ○ Other

Email: _____Marital Status: ○ Single ○ Married ○ Other

Date of Birth: ____/_____/_____ Social Security #:_____

Employer Data:

Employment Status: ○ Employed ○ FT Student ○ PT Student ○ Other

Employer Name: _____ Telephone #: (____) _____-_____

Emergency Contact:

Name: _____ Telephone #: (____) _____-_____

Policy Holder on Insurance:

○ Patient/Listed above ○ Other: _____ (Relation to Policy Holder) Ex: Spouse, Child

If you selected other, please put the name and address below.

First Name: _____ Last Name: _____ DOB: _____

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

To whom do we send bills to? ○ Patient/Address listed above ○ Other:

If you selected other, please put the name and address below.

First Name: _____ Last Name: _____

Address:_____

City:_____ State:_____ Zip:_____

How did you hear about our clinic?

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O Family Member	O Yellow Pages	O Physician	O Brochure
O Friend	O Internet	O Health Class	O Existing Patient
O Employer	O Building Sign	O Website	O Other

Who can we thank for your referral?/If you selected “other” please describe

_____

Medical Conditions
O Arthritis
O Heart Disease
O Stroke
O Skin Disorder
O Hypertension
O Psychiatric Illness
O Cancer
O Diabetes
O Other:_____

Surgeries:
O Appendectomy
O Hysterectomy
O Cardiovascular
O Radical prostatectomy
O Joint Replacement
O Laminectomies
O Cervical Disk
O Transurethral prostate
O Other:_____

Allergies:
O Eggs
O Fish & Shellfish
O Milk or Lactose
O Peanut
O Soy
O Sulfites
O Wheat/ Gluten
O Other:_____

Social History:

Caffeine Use:	O Occasionally	O Often	Tobacco Use:	O Occasionally	O Often
Alcohol Use:	O Occasionally	O Often	Exercise:	O Occasionally	O Often
Stress:	O Occasionally	O Often	Smoke:	O Never	O <1 Pack O >1 Pack
Wear seat belt:	O Always	O Never O Usually			

Family History: (P) = Parent (S) = Sibling

O Arthritis (P)	O Arthritis (S)	O Cancer (P)	O Cancer (S)
O Cholesterol (P)	O Cholesterol (S)	O Diabetes (P)	O Diabetes (S)
O Heart (P)	O Heart (S)	O Thyroid (P)	O Thyroid (S)
O Psychiatric (P)	O Psychiatric (S)	O Stoke (P)	O Stroke (S)
O H. Blood Pressure (P)	O H. Blood Pressure (S)		

Occupational Activities:

O Administration	O Business Owner	O Clerical/Secretarial	O Computer User
O Construction	O Daycare/childcare	O Executive/legal	O Food Service
O Health care	O Heavy Eqpt. Operator	O Heavy Labor	O Home services
O Household	O Light Labor	O Manufacturing	O Medium Labor

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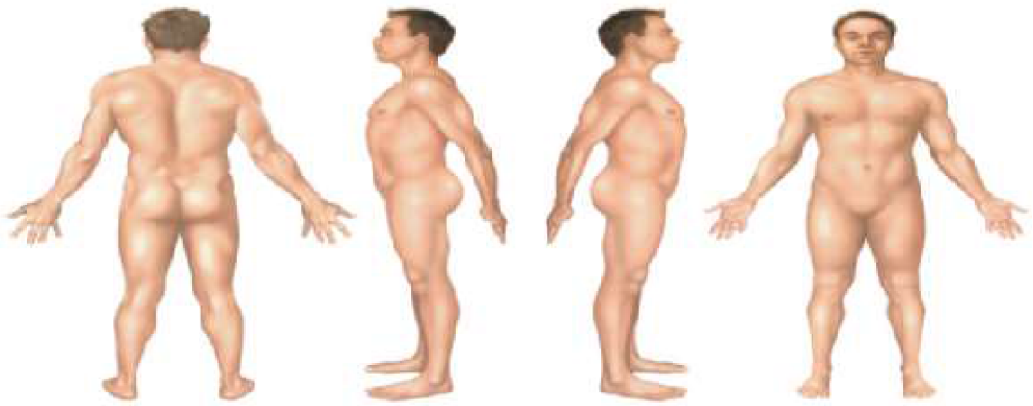
By using the key below, indicate on the body diagram where you are experiencing the following symptoms:
 # = Numbness X= Burning / = Stabbing 0 = Pins & Needles + Dull Ache



Describe your symptoms:

_____

_____

When did your symptoms start? Month_____ Day_____ Year_____

How did your symptoms begin?

_____

_____

How often do you experience your symptoms?

O Constantly (76-100% of the day) O Frequently (51-75% of the day) O Occasionally (26-50% of the day) O Intermittently (0- 25% of the day)

What describes the nature of your symptoms?

O Sharp O Dull Ache O Numb O Shooting O Burning O Tingling O Stabbing

How are your symptoms changing?

O Getting better O Not changing O Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms:
(0=none to 10= Unbearable)

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10
None Unbearable

During the past 4 weeks, how much pain has interfered with your normal work (including both work outside the home and housework):

O Not at all O A little bit O Moderately O Quite a bit O Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

O All of the time O Most of the time O Some of the time O A little of the time O None of the time

In general, would you say your overall health right now is…?

O Excellent O Very good O Good O Fair O Poor

Who have you seen for your symptoms?

O No One O Other Chiro. O Medical Doctor O Physical Therapist O Other

When did you receive this treatment?

O In the last month O 2-3 months ago O 3-6 months ago O 6-12 months ago
O 1-2 years ago O 2-5 years ago O 5-10 years ago

What tests have you had for your symptoms

O X-Rays O MRI O CT Scan O Other

When were these tests done?

O In the last month O 2-3 months ago O 3-6 months ago O 6-12 months ago
O 1-2 years ago O 2-5 years ago O 5-10 years ago

Have you had similar symptoms in the past?

O Yes O No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

O This office O Other Chiro. O Medical Doctor O Physical Therapist O Other

What is your occupation?

O Professional/Executive O FT Student O Tradesperson O Laborer
O White Collar/ Secretarial O Homemaker O Retired O Other

If you are not retired, a homemaker, or a student, what is your work status?

O Full- Time O Part-Time O Self-Employed O Unemployed O Other

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Review of Systems:

Have you had trouble with any of the following?

Cardiovascular: No_____

	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heart Beat			
Swelling of the Legs			

Hematologic/ lymphatic: No_____

	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/ Chills/ Sweats			

Neurologic: No_____

	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinches Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/ Balance			

Constitutional: No_____

	Present	Past	No
Weight loss/ gain			
Energy Level Problem			
Difficulty Sleeping			

Respiratory: No_____

	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat: No_____

	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Eyes: No_____

	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary: No_____

	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Psychiatric: No_____

	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Allergic/Immunologic: No_____

	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Alergy Shorts			
Cortisone Use			

Gastrointestinal: No_____

	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/ Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal: No_____

	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joint Replaced			

Endocrine: No_____

	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

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FINANCIAL AND OFFICE POLICIES

INSURANCE

- Patient is responsible for understanding their insurance benefits.
- Zen Spine & Sport will submit all claims to Primary and Secondary Carriers (if applicable).
- Patient authorizes Zen Spine & Sport to submit insurance claims on their behalf, and to accept payment of medical benefits for services rendered.
- Patient authorizes Zen Spine & Sport to initiate a complaint to their insurance company, and/or Insurance Commissioner on their behalf.
- Patient authorizes the release of medical information to their Insurance Company, Adjuster, or Attorney involved in the processing of their claims.

PLEASE BE AWARE THAT IN MOST CASES, INSURANCE WILL ONLY COVER A PORTION OF THE FEE FOR YOUR TREATMENT. PATIENT IS FINANCIALLY RESPONSIBLE FOR ANY AMOUNTS NOT COVERED.

PATIENT BALANCES

- Patient is ultimately responsible for their account balance regardless of insurance coverage.
- Zen Spine & Sport will send monthly statements to Patients with current balances

OFFICE POLICY

- Patient will provide new contact and insurance information to Zen Spine & Sport front desk whenever the information changes.
- There will be a $35 services charge for returned or bounced checks.
- If your account is turned over to an outside collection agency, your balance will be increased by 33% to cover the cost of the collection agency's fee.

MISSED APPOINTMENT POLICY

- Missed appointments result in lost time which could be used for another patient waiting to receive treatment. If you are more than 5 minutes late for an appointment, we may ask for you to reschedule in order to get the full attention from our treatment staff.
- Depending on the nature of the cancellation, any combination of failing to give adequate cancellation notice or not showing up for an appointment may result in a $65 fee. This fee is not covered by insurance and is due before your next visit.
- If you fail to show for 2 scheduled appointments, all future appointments you may have scheduled will be cancelled. If you wish to continue treatment in our office, you must call to schedule a new appointment.

Print Patient Name: _____ Print Guardian Name: _____

Signature of Patient/Guardian: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE, PURPOSES OF TREATMENT, PAYMENT, & HEALTHCARE OPTIONS

In this document, “I” and “my” refer to the patient and “Chiropractor” refers to Zen Spine & Sport.

I hereby request and consent to the performance of chiropractic adjustments, physical examinations, and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible).

I understand and am informed that, as in the practical medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest.

I consent to the use of disclosure of my protected health information by chiropractor for the purposes of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand the analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

My “protected health information” means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is posted in the waiting room at 5705 NW 100th St, Suite 200, Johnston, IA 50131. I may obtain a revised Notice of Privacy Practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

Print Patient Name: _____ Print Guardian Name: _____

Signature of Patient/Guardian: _____ Date: _____

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INFORMED CONSENT FOR TEXT MESSAGES AND EMAILS

Note: In order for us to correspond via text or email, it is necessary to sign the Consent Form

A. Risk of using text messages. Zen Spine & Sport occasionally offer clients the opportunity to communicate via text messages. Transmitting client information by text messaging has a number of risks to be considered before making a final decision regarding its use. These include but are not limited to:
   - Text messages can be circulated, forwarded or stored in electronic files
   - Text messages can be immediately broadcast worldwide and received by many intended and unintended recipients.
   - Senders can easily misaddress a text message.
   - Text messaging is easier to falsify than handwritten or signed documents.
   - Backup copies may exist even after sender and/or recipient has deleted their copies
   - Text messages can be intercepted, altered, forwarded or used without detection or authorization
   - Text messages can be lost in transmission
- Conditions for the use of text messaging. We will use reasonable means to protect the security and confidentiality of text messaging information sent and received; however, because of the risks outlined above, we cannot guarantee the security and confidentiality of text messaging communication and will not be liable for improper disclosure that is not caused by our intentional misconduct. Therefore, clients will need to specifically grant permission for the use of text messaging. Withdrawal of text message consent must be informed via written communication.

Patient acknowledgement and agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks as outlined above and consent to the conditions outlined above. In addition

O I would like to receive Text Messages and Emails

Email Address: _____

Phone Number: _____

O Please exclude me from text message appt. reminders and email information regarding my appt.

Print Patient Name: _____ Print Guardian Name: _____

Signature of Patient/Guardian: _____ Date: _____

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HIPAA RELEASE AND CONSENT FORM

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or appointment status without my specific written permission. Zen Spine & Sport will not speak with anyone without my written consent in accordance with this document.

O **I DO NOT** grant any access of my medical information, records, or appointment information.

O **I WISH TO** grant access of my healthcare providers and/or medical information to the following.

_____/_____ (Print Name; indicate his/her relationship to you)

_____/_____ (Print Name; indicate his/her relationship to you)

I give the above-named individual(s) permission to contact and speak with any physician or member of the staff regarding my care. I understand that I can withdraw consent at any time by providing Zen Spine & Sport a written notice indicating the change.

Print Patient Name: _____ Print Guardian Name: _____

Signature of Patient/Guardian: _____ Date: _____