Unity CHIROPRACTIC & WELLNESS CENTER

New Patient Intake Form

Name:		**Date of Birth:**
Address:		
Cell Phone:		**Email address:**
Home/work phone:		**Occupation:**
Referred by:		
Marital status:	**Spouse/partner's name:**	**Phone:**
Emergency contact:	**Relationship:**	**Phone:**
Children's names:		**Ages:**

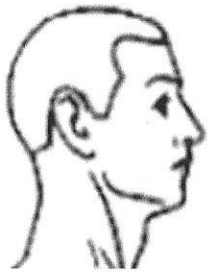
Initial: _____

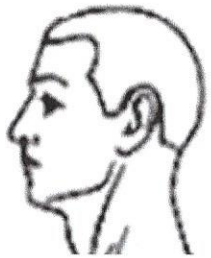
Unity CHIROPRACTIC & WELLNESS CENTER

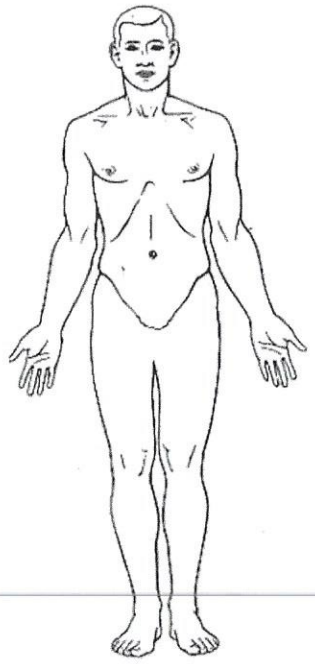
Current Complaints

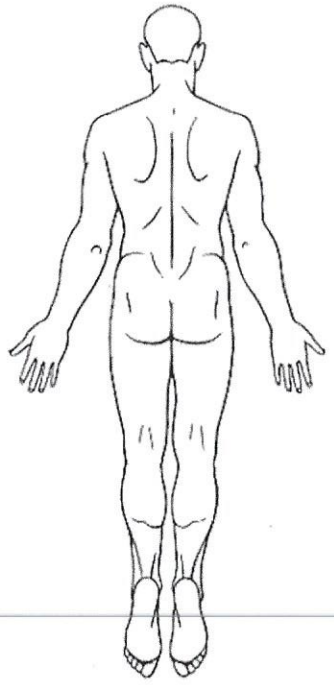
Patient Name: _____ Date: _____

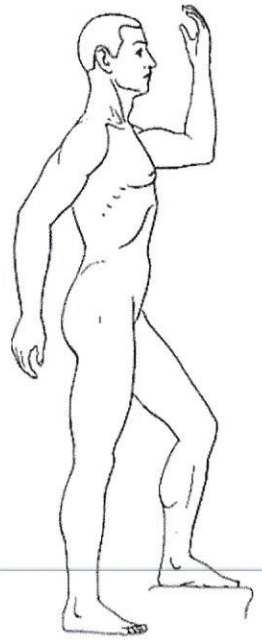
Please mark on the body where your discomfort is, using:
A = Aching
B = Burning
S = Stabbing
N = Numbness.
P = Pins and Needles

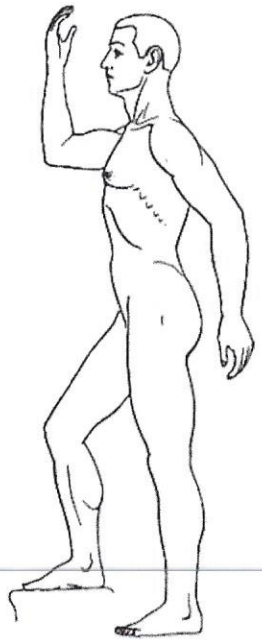












Initial: _____

Unity CHIROPRACTIC & WELLNESS CENTER

Current Complaints

Complaints:	Pain Scale: 0-10	Frequency: Occasional, Intermittent, Frequent, Constant	Type: Aching, Burning, Dull, Pulling, Sharp, Shooting, Stabbing, Stinging, Throbbing

Injury Date: _____

Prior tests and studies received for this condition:

Prior medications received for this condition:

Height:	Weight:	Blood Pressure:	Temperature:

Patient Signature: _____ **Date:** _____

I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Printed Name: _____

Parent or Guardian Signature: _____ **Date:** _____

Parent or Guardian Printed Name: _____

Initial: _____

Unity CHIROPRACTIC & WELLNESS CENTER

Medical History

Past Conditions: (Accidents, Injuries, Sprains/Strains, etc.)	Date/Year

Past Treatments: (Chiropractic, Acupuncture, Massage, etc.)	Date/Year

Surgeries:	Date/Year

Family History: (heart disease, cancer, diabetes, arthritis, etc.)

Allergies:

Medications: (Over the Counter & Prescription)	Dosage

Vitamins/Supplements:	Dosage

Habit:	Frequency: (None, Light, Moderate, Heavy)
Alcohol	
Coffee	
Tobacco	
Drugs	
Exercise	
Sleep	
Appetite	
Soda	
Water	
Salt	
Sugar/ Sweets	
Artificial Sweeteners	

Initial: _____

Review of Systems

Constitutional:
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Musculoskeletal:
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

Genitourinary:
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy/ Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

Endocrine:
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

Eyes:
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

Integumentary:
- ☐ Deny All
- ☐ Breast Lumps/Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

Neurological:
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

Hematological/ Lymphatic:
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

Cardiovascular:
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

ENMT:
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

Allergic/Immunologic:
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

  Please list:

Respiratory:
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

Gastrointestinal:
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

Psychiatric:
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

Unity CHIROPRACTIC & WELLNESS CENTER

General Care and Treatment Consent

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified conditions(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment. The consent will remain fully effective until it is revoked in writing. You have the right at any time, to discontinue services.

You have the right to discuss the treatment plan with your physician including the purpose, potential risks, and benefits of any test(s) ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request, of the practitioners here at Unity Chiropractic and Wellness Center (Doctor of Chiropractic, Massage Therapist, Acupuncturists, or Licensed Counselor), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examinations, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

By my signature below I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Signature of Patient or Legally Authorized Representative

_____ _____

Printed Name of Patient or Legally Authorized Representative **Date**

Initial: _____

Unity CHIROPRACTIC & WELLNESS CENTER

Consent to Use and Disclose Protected Health Information

Here at Unity Chiropractic and Wellness Center we take protecting your privacy very serious. While the law requires us to give you this disclosure please know that we have, and we always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for operational purposes.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

Notice of Treatment in Open or Common Areas

Private areas are available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information for reasons stated above.

_____

Signature of Patient or Legally Authorized Representative

_____ _____

Printed Name of Patient or Legally Authorized Representative **Date**

Initial: _____

Unity CHIROPRACTIC & WELLNESS CENTER

Cancellation Policy/No Show Policy for Appointments

Here at Unity Chiropractic and Wellness Center our goal is to provide quality care in a timely manner. In order to do so we have had to implement an appointment cancellation policy. The policy enables us to better utilize available appointments for our patients in need of care.

1. **Cancellation/No Show Policy for Chiropractic/Acupuncture/Massage Appointments**

- We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
- A "no show" is someone who misses an appointment without canceling it within a 24-hour working day in advance. No shows inconvenience those individuals who need access to care in a timely manner.

How to Cancel Your Appointment

- If it is necessary to cancel your scheduled appointment, we require that you call one working day in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care.
- To cancel an appointment, please call our office 8:30 am through 6 pm at 503-747-3388 to speak with the front desk or leave a voicemail during the hours we are closed.

2. **Scheduled Appointments**

- We understand that delays can happen, however, we must try to keep other patients and our staff on time. If you are running late, please notify the office.

If a patient is 10 minutes past their scheduled time, we may have to reschedule your appointment

The following are charges for services in the office:

Same Day Appointment Cancellation/No show for Chiropractic or Massage: $60
Same Day Appointment Cancellation/No Show for Acupuncture: $50

By my signature below I understand that I will be charged for appointments I cancel in less than 24 hours or do not show up for

_____

Signature of Patient or Legally Authorized Representative

_____ _____

Printed Name of Patient or Legally Authorized Representative **Date**

Initial: _____