Patient Name: _____ DOB:_____ Date: _____

New Practice Member Intake Form

First Name: _____
Last Name: _____
Nickname: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Age: _____ Date of Birth: _____
Sex: ☐ Male ☐ Female
☐ Sing. ☐ M. ☐ Div. ☐ Sep. ☐ Wid.
Social Security #: _____- _____- _____
☐ Other: _____

Type of work: _____
Insurance: ☐ Work Comp ☐ Auto ☐ MA
☐ Medicare ☐ Private: _____
Whom may we thank for referring you to our office? _____
How were you referred to our office?
_____
In case of an emergency, please contact:
Name: _____
Phone: _____
Relationship: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____

Your Health Profile

Please rate your overall health status: Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What other wellness professionals are currently parts of your health care team?

☐ Massage Therapist ☐ Acupuncturist ☐ Naturopath ☐ Homeopath ☐ Other: _____

How many Medical Doctor's office visits did you have last year? ☐ None ☐ < 5 ☐ > 5 ☐ >10

Is your current condition the result of a **recent**: ☐ auto accident? ☐ work injury Date of injury? _____

If so, please inform the front desk staff immediately to obtain additional necessary paperwork.

Please describe below, in the following 2 sections, your primary, secondary and additional reasons, if any, for seeking care in our office:

Primary Complaint (List one only): _____

When did you first experience this problem? _____

How did this problem first begin? _____

How often do you experience this problem? ☐ **<25% (Int.)** ☐ **26-50% (Occ.)** ☐ **51-75% (Freq.)** ☐ **>76% (Const.)**

Please grade the severity of this problem (with 10 being worst): **Now 1 2 3 4 5 6 7 8 9 10**

On Average 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?

☐ Burning ☐ Stabbing ☐ Aching ☐ Sharp ☐ Tingling ☐ Numb ☐ Other: _____

Please describe the location of the pain: _____

Does this problem cause pain to travel to any other area? ☐ Y ☐ N If yes, where? _____

_____

Is this problem: In the AM: ☐ worse? ☐ better? In the PM: ☐ worse? ☐ better?

Doctor Initials: _____

Patient Name: _____ DOB:_____ Date: _____

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)?

_____

Have you seen any other doctors for this problem? ☐ Y ☐ N If yes, who? _____

What treatment was given? _____

How effective was the care? _____

Secondary Complaint - if any (List ALL): _____

_____

Lifestyle/Social History

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

Do you smoke? ☐ Y ☐ N If yes, how much? _____

Do you drink alcohol? ☐ Y ☐ N If yes, how much? _____

Do you drink coffee? ☐ Y ☐ N If yes, how much? _____

Do you drink tea? ☐ Y ☐ N If yes, how much? _____

Do you drink water? ☐ Y ☐ N If yes, how much? _____

How regularly do you exercise? ☐ daily ☐ ____x/week ☐ occasionally ☐ never

What kind of EXERCISE do you do? _____

How many hours of SLEEP do you get on average? _____

What position do you regularly sleep in? ☐ Back ☐ Side ☐ Stomach

On a scale of 1-10 please rate your stress level (1=none and 10=extreme):

Occupational _____

Personal _____

Women Only

Pregnancies and outcomes:

Date of pregnancy	Outcome
_____	_____
_____	_____
_____	_____

When was your last period? _____

Are you pregnant? ☐ Yes ☐ No ☐ Not sure

Patient Name: _____ DOB:_____ Date: _____

Medical History

Please list the cause of death and age of any immediate family members (parents or siblings):

Relationship	Cause of Death	Age of death

Surgeries:

Date	Type	Reason for surgery

Previous injuries or trauma (please give type and date): _____

_____

Medications (including over the counter drugs):

Medication & Dosage	Reason for taking

Nutritional Supplements you are currently taking:

Supplement & Dosage	Reason for taking

Allergies: _____

Stress History

Please indicate whether you have **ever** experienced stress in any of the following areas.
Your answers will enable us to determine which factors have contributed to your present health condition/concerns.

Childhood

Repeated/Prolonged Antibiotic Use	☐ Y ☐ N	Inhaler Use	☐ Y ☐ N	Car Accident.	☐ Y ☐ N
Prescription Medications	☐ Y ☐ N	Childhood Illness	☐ Y ☐ N	Surgery	☐ Y ☐ N
Fall/Jump from a Height < 3 feet	☐ Y ☐ N	Fall/Jump from a Height > 3 feet	☐ Y ☐ N		
Vaccinations	☐ Y ☐ N	Youth Sports	☐ Y ☐ N		
Head Trauma	☐ Y ☐ N	Other Traumas (physical or emotional) _____			

Adulthood

Alcohol Consumption	☐ Y ☐ N	Inhaler Use	☐ Y ☐ N
Repeated/Prolonged Antibiotic Use	☐ Y ☐ N	Prescription Medications	☐ Y ☐ N
Car Accident	☐ Y ☐ N	Smoker	☐ Y ☐ N
Coffee Drinker	☐ Y ☐ N	Surgery	☐ Y ☐ N
Drug Use/Abuse	☐ Y ☐ N	Contact Sports	☐ Y ☐ N
Fall/Jump from a Height	☐ Y ☐ N	Extreme Sports	☐ Y ☐ N
Head Trauma	☐ Y ☐ N	Workplace Stress	☐ Y ☐ N
Home Environment Stress	☐ Y ☐ N	Other Traumas (physical or emotional) ____	

Please check any of the following you have had in the last 12 MONTHS AND/OR EVER RECEIVED TREATMENT FOR:

Patient Name: _____ DOB:_____ Date: _____

MUSCULO-SKELETAL

☐ Low Back Pain ☐ Pain Between Shoulders ☐ Neck Pain ☐ Arm Pain ☐ Joint Pain/Stiffness ☐ Walking Problems
☐ Difficult Chewing/Clicking Jaw ☐ General Stiffness ☐ Scoliosis

Symptom	Date Last Experienced	Treatment Received

GENITO-URINARY

☐ Painful/Excessive Urination ☐ Discolored Urine ☐ Bladder Trouble

Symptom	Date Last Experienced	Treatment Received

CARDIO-VASCULAR- RESPIRATORY

☐ Chest Pain ☐ Short Breath ☐ Blood Pressure Problems ☐ Irregular Heartbeat ☐ Heart Problems
☐ Lung Problems/Congestion ☐ Varicose Veins ☐ Ankle Swelling ☐ Stroke

Symptom	Date Last Experienced	Treatment Received

NERVOUS SYSTEM

☐ Nervous ☐ Numbness ☐ Paralysis ☐ Dizziness ☐ Forgetfulness ☐ Confusion/Depression ☐ Fainting
☐ Convulsions ☐ Cold/Tingling Extremities ☐ Stress ☐ Hearing Difficulty

Symptom	Date Last Experienced	Treatment Received

EYES, EARS, NOSE, THROAT

☐ Vision Problems ☐ Dental Problems ☐ Sore Throat ☐ Ear Aches ☐ Stuffed Nose

Symptom	Date Last Experienced	Treatment Received

GENERAL

☐ Fatigue ☐ Allergies ☐ Headaches ☐ Fever

Symptom	Date Last Experienced	Treatment Received

MALE / FEMALE

☐ Menstrual Irregularity ☐ Menstrual Cramps ☐ Vaginal Pain/Infection ☐ Breast Pain/Lumps ☐ Prostate/Sexual Dysfunction
☐ Other: _____

Symptom	Date Last Experienced	Treatment Received

Patient Name: _____ DOB:_____ Date: _____

GASTRO-INTESTINAL

☐ Poor/Excessive Appetite ☐ Excessive Thirst ☐ Frequent Nausea ☐ Vomiting
☐ Diarrhea. ☐ Constipation ☐ Hemorrhoids ☐ Liver Problems
☐ Gall Bladder Problems ☐ Weight Trouble ☐ Abdominal Cramps ☐ Gas/Bloating after Meals
☐ Heartburn ☐ Black/Bloody Stools ☐ Colitis

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

Please check any of the following illnesses you have ever had:

☐ Cancer ☐ Diabetes ☐ Mental Disorders ☐ Pneumonia ☐ Heart Disease
☐ Rheumatic Fever ☐ Small Pox ☐ Pleurisy ☐ Polio ☐ Chicken Pox
☐ Arthritis ☐ Tuberculosis ☐ Epilepsy ☐ Whooping Cough. ☐ Anemia
☐ Mumps ☐ Measles ☐ Thyroid Disorder

Symptom	Date Last Experienced	Treatment Received
_____	_____	_____
_____	_____	_____

Consent for Purposes of Treatment, Payment & Healthcare Operations (01/22)

In this document, "I" and "my" refer to the patient, and the "Chiropractor" refers to Blackstone Health Associates, PC.

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

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

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

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Practices prior signing this document. 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 healthcare operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is available at the front desk of Blackstone Health Associates, PC. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. 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.

Printed Name of Patient _____ Date: _____

Signature of Patient or Personal Representative _____

Doctor Initials: _____

Patient Name: _____ DOB:_____ Date: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment
An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health
A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation
A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend you seek the services of another healthcare provider.

We do not offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(Print Name)

Consent to evaluate and adjust a minor child
I, _____ being the parent of legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. All questions regarding the doctor's objectives pertaining to my/ my child's care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient/Guardian Signature _____ Date _____

Patient Name: _____ DOB:_____ Date: _____

Authorization to Release Medical Information

I authorize the release of medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature _____ **Date** _____

Patient Name: _____ DOB:_____ Date: _____

Informed Consent

The nature of the chiropractic adjustment: I will either use my hands, an instrument or both to move the joints of your body; this may result in an audible "pop" or "click".

The material risks inherent in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic adjustment. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fracture is rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Ancillary treatments recommended: Ice, heat, massage, STIM, TENS, .

Other treatment options for your condition can include: Medical care with prescription drugs, self management with over-the-counter drugs, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to drugs, side effects of drugs, improper self dosages, and surgical risks including complications from either the procedure and/or the anesthesia.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient's Printed Name _____ **Date** _____

Patient's Signature _____

The Patient had the following questions and was supplied the following answers: _____

_____

It is my clinical opinion this patient is oriented to time and space: ☐ **Yes** ☐ **No**
It is my clinical opinion this patient was able to understand the language involved: ☐ **Yes** ☐ **No**

Patient Name: _____ DOB:_____ Date: _____

Agreement for Payment of Services

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY REPSONSIBLE FOR THE PAYMENT OF MY ACCOUNT.** It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

Patient Signature _____ Date _____

E-Practice Form/SOCIAL MEDIA Release Form

In the modern practice, we strive to inform our practice members, as well as those like-minded individuals in our local community that might benefit from useful information or demonstrations. In signing this form, you expressly authorize Blackstone Health Associates, PC and it's employees to post a picture or story to social media platforms(maintaining your privacy/ HIPAA rights, in the process. We will not post anything before obtaining your verbal consent as well.
We are constantly updating our database and requesting current information. By providing this information it will allow you to take advantage of and have access to our on-line scheduling, online class/lecture registration and receive up to the minute information about all the events occurring at Blackstone Health Associates, PC (including schedule changes, current events, and newsletters). This data will never be released to anyone! Our efforts are to provide you with unparalleled service. We look forward to continuing our tradition of exceeding all your expectations.

Name: _____ *E-Mail Address*: _____

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Spine & Health