NEW PATIENT INTAKE

Name: _____ Age: _____

Today's Date: _____ Birthday: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Home Phone: _____ Cell#: _____

Email: _____

Sex: (Male or Female) Single or Married: _____ Occupation: _____

Employer Name and Phone #: _____

Have you seen a Chiropractor before? Yes No If yes, whom? _____

Who is your Primary Physician? _____ Phone _____

Who can we thank for referring you to our office? _____

CMS (Centers for Medicare and Medicaid Services) requires providers to report both race and ethnicity

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

Preferred Language: _____

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

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

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Please list any medications you are taking:

_____

Please check all conditions you have currently or have had in the past, even if they do not seem related to your current problem.

☐ AIDS/HIV	☐ Allergies	☐ Anemia	☐ Anorexia/Bulimia
☐ Appendicitis	☐ Arthritis	☐ Asthma	☐ Autoimmune
☐ Bleeding Disorder	☐ Bowel Disease (IBS, Crohn's, etc)	☐ Bronchitis	☐ Cancer: _____
☐ Depression	☐ Diabetes	☐ Emphysema	☐ Epilepsy
☐ Fractures	☐ Heart Disease	☐ Hernia	☐ Herniated Disc
☐ High Cholesterol	☐ Kidney Disease	☐ High Blood Pressure	☐ Low Blood Press.
☐ Migraine Headache	☐ Miscarriage	☐ Multiple Sclerosis	☐ Osteoporosis
☐ Pacemaker	☐ Liver Disease/Hepatitis	☐ Pneumonia	☐ Prostate Problems
☐ Rheumatoid Arthritis	☐ Scoliosis	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Ulcers	☐ Urinary Tract Infections	☐ Whiplash
☐ STD	☐ Psychiatric Problems	☐ Alcoholism/Chemical Dependency	

Please check all conditions all conditions for which you have an IMMEDIATE (parent, sibling, child) family history, even if they do not seem related to your current problem. Please list the family member.

☐ AIDS/HIV	☐ Allergies	☐ Anemia	☐ Anorexia/Bulimia
☐ Appendicitis	☐ Arthritis	☐ Asthma	☐ Autoimmune
☐ Bleeding Disorder	☐ Bowel Disease (IBS, Crohn's, etc)	☐ Bronchitis	☐ Cancer:_____
☐ Depression	☐ Diabetes	☐ Emphysema	☐ Epilepsy
☐ Fractures	☐ Heart Disease	☐ Hernia	☐ Herniated Disc
☐ High Cholesterol	☐ Kidney Disease	☐ High Blood Pressure	☐ Low Blood Press.
☐ Migraine Headache	☐ Miscarriage	☐ Multiple Sclerosis	☐ Osteoporosis
☐ Pacemaker	☐ Liver Disease/Hepatitis	☐ Pneumonia	☐ Prostate Problems
☐ Rheumatoid Arthritis	☐ Scoliosis	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Ulcers	☐ Urinary Tract Infections	☐ Whiplash
☐ STD	☐ Psychiatric Problems	☐ Alcoholism/Chemical Dependency	

List any non-medication allergies you currently have:

_____

List any surgeries you have had and the date:

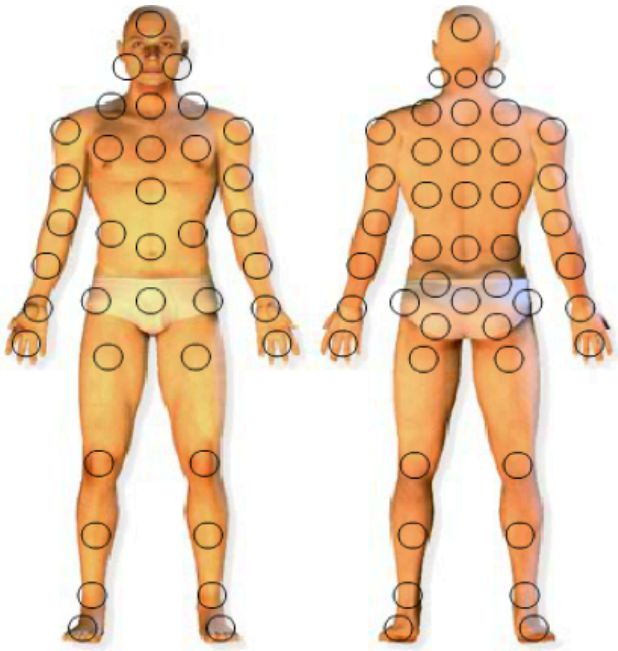
_____

Your Health Summary

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins and Needles in legs	☐ Fainting
☐ Pins and Needles in arms	☐ Loss of smell	☐ Back Pain
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste
☐ Sleeping problems	☐ Depression	☐ Irritability
☐ Fatigue	☐ Lights bother eyes	☐ Cold hands
☐ Diarrhea	☐ Neck stiff	☐ Fever
☐ Cold sweats	☐ Constipation	☐ Problem urination
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual irregularity
☐ Neck Pain	☐ Loss of Balance	☐ Nervousness
☐ Stomach upset	☐ Tension	☐ Cold Feet
☐ Hot Flashes	☐ Heartburn	☐ Ulcers

Mark an X on your areas of discomfort.



Front Back

How would you rate the level of discomfort right now on a scale of 0-10 with 0 being no pain and 10 being the worst possible pain (Circle One)?

No Pain Extreme Pain

0 1 2 3 4 5 6 7 8 9 10

What is the frequency of the discomfort you are feeling? (Circle One)

None of the time All of the time

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How would you rate the discomfort at its worst? (Circle One)

No pain Extreme Pain

0 1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best? (Circle One)

No pain Extreme Pain

0 1 2 3 4 5 6 7 8 9 10

When did the discomfort begin?

☐ Years ago. Roughly? _____ ☐ Months ago ☐ Days ago

Since the problem began, have the symptoms been getting better, worse, or have they been relatively unchanged? (Circle One)

Better Worse Unchanged

What makes the discomfort worse? (Check all that apply)

☐ Bending ☐ Carrying ☐ Chewing ☐ Cleaning ☐ Cooking ☐ Coughing ☐ Driving
☐ Exercising ☐ Gardening ☐ Lifting ☐ Lying Down ☐ Medications ☐ Pulling ☐ Pushing
☐ Running ☐ Sitting ☐ Sleeping ☐ Sneezing ☐ Standing ☐ Stretching ☐ Turning
☐ Twisting ☐ Typing ☐ Walking ☐ Working ☐ Other _____

What relieves the discomfort? (Check all that apply)

☐ Adjustments ☐ Bending ☐ Eating ☐ Exercising ☐ Medications ☐ Lying Down ☐ Ice
☐ Resting ☐ Running ☐ Sitting ☐ Sleeping ☐ Standing ☐ Stretching ☐ Turning
☐ Twisting ☐ Walking ☐ Working ☐ Other _____

How would you describe the discomfort? (Check all that apply)

☐ Aching ☐ Burning ☐ Deep ☐ Dull ☐ Frequent ☐ Intense ☐ Numb
☐ Random ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Tightness
☐ Mild ☐ Moderate ☐ Severe ☐ Other _____

When is the discomfort at its worst? (Check One)

☐ In the morning ☐ In the afternoon ☐ In the evening ☐ Just before bed

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This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

These statements made on this form are accurate to the best of my recollection and I agree to have this office and physician examine me for further evaluation.

- I authorize payment of medical benefits to this office. I also assign benefits to this office.
- I understand that I am fully responsible for any and all charges that are brought on behalf of the care received in this office. Irregardless of any medical insurance coverages. Contractual obligations with insurance will remain intact.
- Our office policy is that payment for services is collected up front or we use auto debit. Auto debit authorization will be signed and placed in your chart.
- I allow this office to contact me via email, text message, or phone for scheduling, promotional, and clinical need.
- This office may from time to time be in contact with office promotions and events. You may opt out with in the email itself.
- I give this office the right to use my name for any office promotions or publications (within HIPAA guidelines).
- Authorization may be denied or retracted by notifying our office in writing.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

It's not about the *pain*. It's all about what you will do when the pain is gone.

What do you have planned?

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Gateway Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

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.

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 Treatment in Open or Common Areas
Treatment is given in semi-private areas. Private rooms 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.

Authorized Contact
Authorized contacts are people with whom we may discuss appointments, medical care, account/billing information, etc. Please list your authorized contacts below. These authorized contacts remain in effect until revoked in writing.

Contact Name:	Phone #:	Relationship:
___E.g. Susie Smith_____	__999-555-9999_____	__Mother_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Office Policies

1. Cell Phone Policy – Please help us to keep a peaceful, relaxing environment by refraining from cell phone use in our office. If you must take a call, please step either outside the building or into the hallway. Please use headphones or silence your device while watching videos or playing games. _____ (Initials)

2. Image Consent – Pictures and video are periodically taken during patient hours. In the event you are in the background or subject of one of these images, you give consent to Gateway Chiropractic to use that video or picture without further authorization. Often we use these images in our Instagram or Facebook feed as a patient showcase. In the event that you are the featured subject, verbal consent will be requested before proceeding. _____ (Initials)

3. Insurance – Verification of your insurance benefits is not a guarantee of payment. You will be responsible for any unpaid balance. If we submit your insurance claims, the amount due, as discussed at your report of findings, will be based upon our best estimate according to the information provided us by your insurance company. If claims process differently than expected, we will update your amount due according to the information provided on your insurance company's Explanation of Benefits. All payments are due at the time of service or by other signed arrangement. You will be refunded any overpayments. _____ (Initials)

4. Payment - All attempts to collect your open balance for treatment rendered will be utilized. This includes but, not limited to, credit card, debit card or any other form of payment that you may have used with our office. In the event the patient defaults and the outstanding balance is referred to a collection agency for collections, the customer agrees to pay a collection fee of 50%, reasonable attorney fees, and interest to be accrued at the annual rate of 10% per annum. _____ (Initials)

5. Accepting Assignment - While our office/billing company will do the submission of claims on your behalf, often they will send payment directly to you instead of our office. We will do our best to inform you when to expect those payments and paperwork from your insurance company. We also ask that you bring in any and all paperwork attached so that we can apply those payments appropriately.

   There are 2 ways that we can handle those visits paid directly to you for services rendered in our office.

   1. Keep the checks that the insurance has made out to you. Then pay directly with a personal check or card you may have used with our office for those sums/visits to our office
   2. Bring in the checks and endorse them directly to our office.

   If insurance payments, directly paid to you/your household, are not brought in. You authorize our office to charge your card/account for those amounts. _____ (Initials)

By my signature below I give my permission to use and disclose my health information and agree to office policies.

Patient Name (please print): _____

Signature: _____ Date: ____/____/____

Gateway Chiropractic

Phone: 314-909-9000 • Fax: 314-334-0946
9560 Watson Road, Ste G, Crestwood, MO 63126

Informed Consent

Patient Name: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
(Initial the statement below OR initial each procedure to which you are consenting)

__*I consent to all of the procedures listed below*

If not consenting to all procedures, initial each procedure below to indicate consent:

__*spinal manipulative therapy*	__*palpation*	__*vital signs*
__*range of motion testing*	__*orthopedic testing*	__*basic neurological testing*
__*muscle strength testing*	__*postural analysis*	__*electrical muscle stimulation*
__*hot cold therapy*	__*x-rays*	__*Other (please explain)*
__*therapeutic exercises*	__*active and passive therapy*	

_____

_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications including but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers of remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

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

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Dated: _____

Joseph D. Sas
Doctor's Name

_____
Signature