

# Confidential Patient Intake Form

## Welcome To Spinal Health Associates

### Patient Data

Name \_\_\_\_\_ Date \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Referred By \_\_\_\_\_ Family Medical Doctor \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_  Male  Female

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

Emergency Contact/ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Have you ever received chiropractic care?  Yes  No If yes, when? \_\_\_\_\_

Name of most recent Chiropractor \_\_\_\_\_

### 1. Reason for Seeking Treatment

Nature of injury:  Automobile\*  Work  Other

Primary complaint: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Complaints and health concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***\*If an auto accident please provide:***

Insurance company / Attorney name \_\_\_\_\_

Contact person \_\_\_\_\_ Phone \_\_\_\_\_

Date of Accident: \_\_\_\_\_

**2. Previous Interventions, Treatments, Medications, Surgery or Care You've Received for Your Condition:**

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**3. Past Health History**

A. Previous illness you've had in your life: \_\_\_\_\_  
\_\_\_\_\_

B. Previous injury or trauma: \_\_\_\_\_  
\_\_\_\_\_

Have you ever broken any bones? Which? \_\_\_\_\_  
\_\_\_\_\_

C. Allergies: \_\_\_\_\_  
\_\_\_\_\_

D. Medications and reason for taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E. Surgeries:  
Date \_\_\_\_\_ Type of Surgery \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. Females/ Pregnancies and outcomes:  
Pregnancies/ Date of Delivery \_\_\_\_\_ Outcomes \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. Family Health History**

Associated health problems of relatives: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Death in immediate family/ Cause of death and age at death: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 5. Check All Symptoms You've Experienced:

### Cervical Spine (Neck)

- Neck Pain
- Headaches
- Sinusitis
- Pain into your shoulders/arms/hands
- Dizziness
- Allergies/Hay fever
- Numbness/tingling in arms/hands
- Visual disturbances
- Recurrent colds/Flu
- Hearing disturbances
- Coldness in hands
- Low energy/Fatigue
- Weakness in grip
- Thyroid Conditions
- TMJ/Pain/Clicking

### Thoracic Spine (Upper Back)

- Heart Palpitations
- Heart Murmurs
- Tachycardia
- Heart Attacks/ Angina
- Recurrent lung infections/Bronchitis
- Asthma/Wheezing
- Shortness of breath
- Pain on deep inspiration/Expiration

### Thoracic Spine (Mid Back)

- Mid back pain
- Pain into your ribs/chest
- Indigestion/Heartburn
- Reflux
- Nausea
- Ulcers/Gastritis
- Hypoglycemia
- Tired/Irritable after eating  
or when you haven't eaten for awhile

### Lumbar Spine (Low Back)

- Pain into your hips/legs/feet
- Numbness/tingling into your legs/feet
- Coldness into your legs/feet
- Muscle cramps into your legs/feet
- Constipation/Diarrhea
- Weakness/injuries in your hips/knees/ankles
- Recurrent bladder infections
- Frequent/difficulty urinating
- Menstrual irregularities/cramping (Females)
- Sexual dysfunction
- Low back pain

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing:

A=Ache

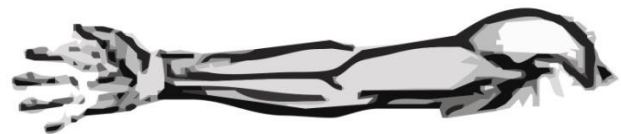
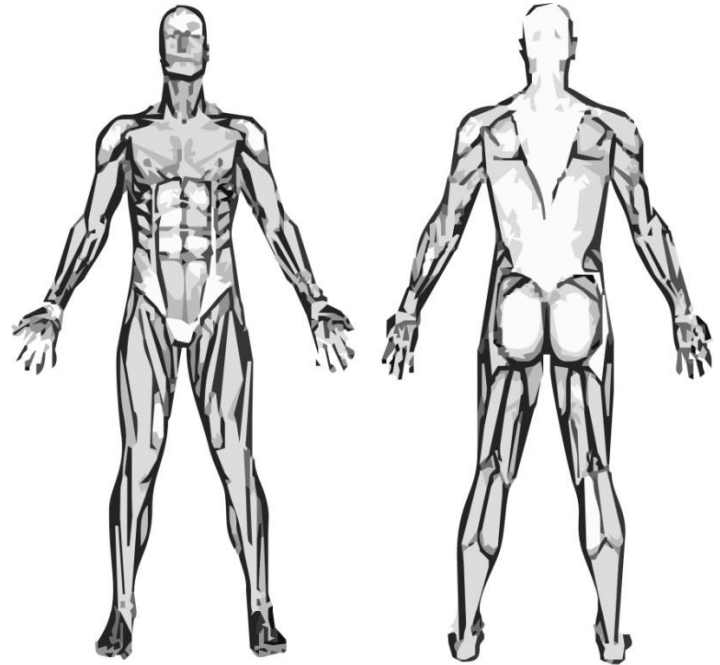
B=Burning

N=Numbness

O=Other

P=Pins & Needles

S=Stabbing



**6. Social and Occupational History**

- A. Job responsibilities: \_\_\_\_\_  
\_\_\_\_\_
- B. Work schedule: \_\_\_\_\_  
\_\_\_\_\_
- C. Recreational activities: \_\_\_\_\_  
\_\_\_\_\_
- D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): \_\_\_\_\_

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I have read the above information and certify it to be true and correct to the best of my knowledge. I understand that Pesale Chiropractic, LLC, (dba Spinal Health Associates) will rely on the above information while treating me and hereby authorize this office to provide me with treatment in accordance with all applicable federal, state and local law.

I hereby assign to Pesale Chiropractic, LLC, (dba Spinal Health Associates) all payments for any and all treatments and/or services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Patient Name (Please Print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Parent or Guardian Signature (If minor): \_\_\_\_\_

Date: \_\_\_\_\_

## HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

### **Use and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name