Healing Hands Chiropractic

19009 Pineville Rd. Long Beach MS 39560

PATIENT INTAKE FORM

Name:_____ _____ _____ **Date:** _____
LAST FIRST M.I.

Date of Birth:_____ **Age:**_____ ❑ Male ❑ Female

Address: _____

City / State / Zip: _____

Telephone #:_____ **Cell phone #:**_____

e-mail address_____ **Work phone**_____

Occupation:_____ **Employer:** _____

Work Status: ❑ Full-time ❑ Part-time ❑ Self-Employed ❑ Unemployed ❑ Off-Work ❑ Other

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

Spouses Name: _____ **Telephone #:**_____

Spouses Employer: _____ **Work Telephone #:** _____

Emergency Contact :_____ **Telephone #:** _____

Primary Health Physician: _____

Address: _____ **Telephone #:** _____

How did you hear about our office? _____

I attest that the above information is true and correct. I further understand that any charges incurred by me in this office are my sole responsibility, regardless of any insurance plan, legal involvement or settlement.

Patient's Signature: _____ **Date:** _____

Parent or Legal Guardian: _____

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

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ **Date:** _____

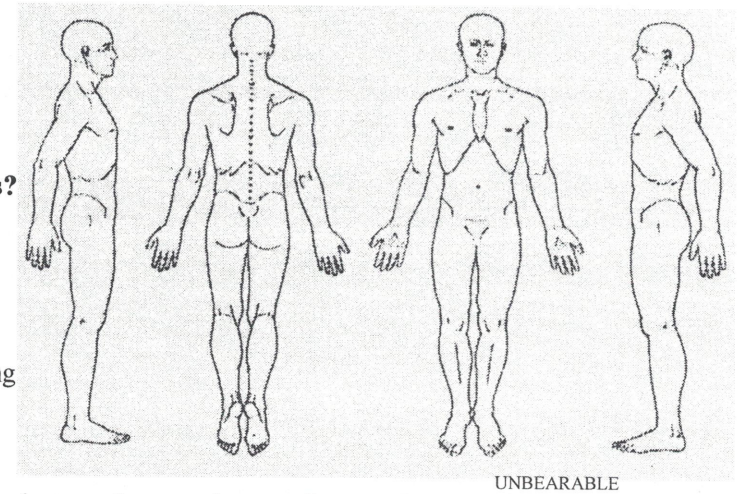
1. **Present Complaint:** _____
2. **When did your symptoms start?** _____
3. **How did your symptoms begin?** _____

_____

4. **How often do you experience your symptoms?**

   A. Constantly (76-100% of the day)
   B. Frequently (51-75% of the day)
   C. Occasionally (26-50% of the day)
   D. Intermittently (0-25% of the day)

Indicate below where you have pain or other symptoms



5. **What best describes the nature of your symptoms?**

   A. Sharp D. Shooting G. Dull Ache
   B. Stabbing E. Burning H. Soreness
   C. Numb F. Tingling I. Throbbing

6. **How are your symptoms changing?**

   A. Getting better B. Getting worse C. Not changing

7. **How bad are your symptoms?**

	NO PAIN									UNBEARABLE
A. At its WORST	0	1	2	3	4	5	6	7	8	9	10
B. At its BEST	0	1	2	3	4	5	6	7	8	9	10

8. **How do your symptoms affect your ability to perform your daily activities?**

   A. Not at all B. A little C. Moderately D. Quite a bit E. Severely

9. **What activity makes your symptoms worse?** _____
10. **What activity makes your symptoms better?** _____
11. **Who have you seen for your symptoms?**

    A. No One C. Medical Doctor E. Other
    B. Other Chiropractor D. Physical Therapist

    What treatments did you receive and when? _____

    What test have you had and when?

    A. Xrays _____ C. CT Scan _____
    B. MRI _____ D. Other _____

12. **Have you had similar symptoms in the past?** A. Yes B. No

    If yes, who did you see?

    A. This Office C. Medical Doctor E. Other
    B. Other Chiropractor D. Physical Therapist

13. **Are you currently seeing any health care providers for any other conditions?**

    List conditions and providers: _____

    _____

14. **What do you hope to get from your treatments? Circle all that apply**

    A. Reduced Symptoms D. Learn how to manage this condition
    B. Resume / Increase Activity E. How to prevent this from occurring again
    C. Understand my condition F. Other _____

Patient Signature _____

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Please check the box or boxes below if you have ever had a listed condition in the PAST or PRESENT. The information you provide concerning past and present conditions assists the doctor in thoroughly understanding your state of health.

Check ALL that apply:

PAST	PRESENT	
❑	❑	Headaches (784.0)
❑	❑	Neck Pain (719.41)
❑	❑	Jaw Pain (526.9)
❑	❑	Upper Back Pain (724.1)
❑	❑	Mid-Back Pain
❑	❑	Lower Back Pain (724.2)
❑	❑	Shoulder Pain (719.41)
❑	❑	Elbow / Upper Arm Pain (719.42)
❑	❑	Hand Pain (719.44)
❑	❑	Wrist Pain (719.43)
❑	❑	Hip / Upper Leg Pain (719.5)
❑	❑	Knee / Lower Leg Pain (729.5)
❑	❑	Ankle / Foot Pain (719.47)
❑	❑	Joint Swelling/Stiffness
❑	❑	Arthritis (716.9)
❑	❑	Rheumatoid Arthritis (714.0)
❑	❑	Dizziness (780.4)
❑	❑	Visual Disturbances (368.9)
❑	❑	Muscular Incoordination (781.3)
❑	❑	Fainting (780.2)
❑	❑	Nausea
❑	❑	High Blood Pressure (401.9)
❑	❑	Heart Attack (410.9)
❑	❑	Chest Pains (786.50)
❑	❑	Stroke (436)
❑	❑	Asthma (493.9)
❑	❑	Chronic Sinusitis (473.9)
❑	❑	Emphysema (492.8)
❑	❑	Kidney Stones (592.0)
❑	❑	Bladder Infection (595.9)
❑	❑	Loss of Bladder Control (788.30)
❑	❑	Painful Urination (788.41)
❑	❑	Frequent Urination (788.41)
❑	❑	Prostate Problems (601.9)

PAST	PRESENT	
❑	❑	Abnormal Weight Gain/Loss (783.1/2)
❑	❑	Loss of Appetite (783.0)
❑	❑	Abdominal Pain (789.0)
❑	❑	Ulcer (556.9)
❑	❑	Liver/Gall Bladder Problems (573.9/575.9)
❑	❑	Hepatitis (573.3)
❑	❑	IBS / Crohn's Disease
❑	❑	Constipation / Diarrhea
❑	❑	Loss of Bowl Control
❑	❑	Diabetes (250.0)
❑	❑	Excessive Thirst (783.5)
❑	❑	General Fatigue (780.7)
❑	❑	Cancer (199.1)
❑	❑	Tumor (229.9)
❑	❑	HIV / AIDS (042)
❑	❑	Epilepsy (349.58)
❑	❑	Systemic Lupus
❑	❑	Clinical Depression (311)
❑	❑	Smoking (305.1)
❑	❑	Drug/ Alcohol Dependence (303.9)
❑	❑	Corticosteroid Use
❑	❑	Osteoporosis
❑	❑	Birth Control Pills
❑	❑	Hormonal Replacement
❑	❑	Pregnancy
❑	❑	Breast Soreness / Lumps (611.72)

List ALL prescription medications:

_____

_____

_____

_____

Type of REGULAR exercise you perform:

❑None ❑Light ❑Moderate ❑Strenuous

Patients Signature: _____

Check if IMMEDIATE family members have/had any of the following:

❑ Cancer	❑ Epilepsy
❑ Lupus	❑ Chronic Back Problems
❑ Lung Problems	❑ Chronic Headaches
❑ Diabetes	❑ High Blood Pressure
❑ Heart Problems	❑ Rheumatoid Arthritis

List any known ALLERGIES:

_____ _____

List and date ALL surgical procedures/ hospitalizations:

_____

_____

_____

Present Weight: _____lbs. Height _____ft _____in.

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Informed consent for treatment

I hereby consent for Dr. Heidingsfelder to administer chiropractic procedures, including adjustments, physical therapy and examinations to me. I have had the opportunity to ask questions relating to my care in this office.

I understand that in the practice of chiropractic as well as medicine, there are risks and side effects related to most types of treatment. Some of the risks are included, but not limited to: sprains, bruises, fractures, dislocations, stroke. I do not expect the doctor to be able to explain all risks and complications that are possible for each type of care. I wish to rely on the doctor to exercise his judgment during the course of the procedures and attempt to avoid risks and alert me to any that in my best interest to be aware of.

I have read, or have been read to me, the above consent. I have also asked any questions that I may have about the procedures. By signing below, I give Dr. Heidingsfelder the consent to examine me and treat me based on his diagnosis.

Patient name: _____ date:_____

Patient signature: _____

Parent or Guardian Signiture(for minor): _____

Patient Health Information Consent Form

We want you to know how your patient health information is going to be used in this office and your rights concerning those records. Before we begin any health care procedures we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you'd like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information we encourage you to read the HIPPA notice that is available to you at the front desk before signing this consent form.

1. The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested patient health information to the health insurance company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all patient health information to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submitted in writing any further restrictions on the use of their patient health information. Our office is not obligated to agree to those restrictions.
3. The patient's written consent need only be obtained one time for all subsequent care given at this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records of the care given prior to the written request to revoke consent, but would only apply to any care given after the request has been presented.
5. For your security and right to privacy all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to ensure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the doctor has the right to refuse care.

I have read and understand how my patient health information will be used and I agree to these policies and procedures.

_____ _____

Signature of Patient Date

Healing Hands Chiropractic
19009 Pineville Rd.
Long Beach, MS 39560

Patient name:_____

Insurance company:_____

Insurance ID#:_____

Social Security Number (Car Wreck and Workers Comp. only):_____-____-_____

For and in consideration of value received, I, the above-named patient, do hereby assign and set over unto Adam Heidingsfelder, D.C., and Healing Hands Chiropractic, an amount equal to any bill for treatments which they may submit to me or to any third party payor of benefits. I further authorize such payor to make payment directly to Dr. Heidingsfelder at healing Hands Chiropractic.

I agree that I am ultimately responsible to Healing Hands Chiropractic for the cost of my treatment, and that any part of my bill not paid by a third-party payor will be paid by me in a timely manner.

I further authorize the staff of Healing Hands Chiropractic to communicate directly with any insurance company, which may have authorized treatment and/or any attorney whom I may retain to represent me in the matter of my injuries.

Patient Signature:_____ Date: _____