Cashin Chiropractic Healing and Wellness Center **Adult Intake Form**

Name: Nickname: Age Date of Birth:

Address City State Zip

Phone (h) Phone (w) Cell

Occupation Employer

Marital Status(circle one) Single Married Divorced Widow Domestic Partner Email:

Partner's Name & Occupation

Number of Children: Children's Names & Ages:

Have you ever received Chiropractic Care? Yes No If yes, doctor's name/location

Referred by Hobbies:

About Your Health The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

Yes	**No**		If Yes, Please Comment	Dr. Zach's Comment
		1. Birth Process		
O	O	Do you know any history of your birth?		
O	O	Was it difficult? Breech?		
O	O	Caesarean?		
		Home birth? Hospital birth? (Circle one)		
		2. Growth and Development		
O	O	Were you breast fed?		
O	O	Childhood sicknesses or accidents?		
O	O	Drugs?(Prescriptive and non-prescriptive)		
O	O	Childhood vaccinations?		
O	O	Exposure to toxins?		
O	O	Did you have any other traumas? What? When?		
		(examples: divorce, death, loss of job in household)		
Yes	**No**	**3. Current Health Habits**		
O	O	Did/do you smoke?		
O	O	Did/do you drink alcohol?		
O	O	Diet (Do you eat healthy foods)?		
O	O	Have you been in accidents?		
O	O	Have you had surgery?		
O	O	organs removed/replaced?		
O	O	Use recreational drugs?		
O	O	Exercise Regularly?		
O	O	Have you ever had a concussion?		
O	O	Are you a caregiver for someone?		

Circle to rate your STRESS level based on a frequency scale of 1-5. 1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly

Work: 1 2 3 4 5 Financial: 1 2 3 4 5 Family: 1 2 3 4 5 Mental & Emotional Stress: 1 2 3 4 5

Chemical: 1 2 3 4 5 Physical Stress: 1 2 3 4 5 Other: 1 2 3 4 5

(Comment)

Sleeping Posture: O Side O Stomach O Back (Comment)

Circle to rate each: **1= Very Poor 2= Poor 3= Fair 4= Good 5= Excellent**

Sleep Quality	1	2	3	4	5	Energy Level	1	2	3	4	5
Life Enjoyment	1	2	3	4	5	Motivation	1	2	3	4	5

Symptoms and Ill Health (Present State of Ill Health)

Finally, the years of continuing damage show up as acute or chronic symptoms. What brought you here?

Present Complaint_____

This started on _____

It feels like: (circle) Sharp Dull Aching Burning Radiating Itching Stabbing Other: _____

Is condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse or better? _____

Other Doctors seen for this condition? _____Any home remedies? _____

⇨ Please note **ANY** of the following signals that have presented, even if you feel they are unrelated:

<Under-Aroused>	*<Un-Stable>*	*<Over –Aroused>*
O Poor Attention	O Migraines	O Cold hands
O Impulsive	O Headaches	O Cold feet
O Easily Distracted	O Seizures	O Tight Muscles
O Disorganized	O Sleepwalking	O Teeth grinding
O Depressed	O Hot flashes	O Anxiety
O Lacking motivation	O PMS	O Heart Palpitations
O Poor Concentration	O Food sensitivities	O Restless Sleep
O Spaciness	O Bed wetting	O Poor expression of emotions
O Constipation	O Eating Disorder	O poor immune system
O Low Pain Threshold	O Bipolar Disorder	O Racing Mind
O Difficulty waking up	O Mood Swings	O High Blood Pressure
O Worry	O Panic Attacks	O Accelerated Aging
O Irritable		O Irritable Bowel
O Low Energy		

<Exhausted>

O Cancer	O Rheumatoid Arthritis	O Diabetes
O Multiple Sclerosis	O Depression	O Chronic Fatigue Syndrome
O Fibromyalgia	O ALS (Lou Gehrig Disease)	O Epstein-Barr Syndrome

O Eczema or Skin problems	O Pins & Needles in Legs or Arms	O Buzzing in Ears	O Vision Problems
O Low Blood Pressure	O Loss of Smell or Taste	O Dyslexia	O Loss of Memory
O Numbness in Fingers & Toes	O Diarrhea	O Dizziness or Fainting	O Sinus Problems
O Shortness of Breath	O Loss of Balance	O Face Flushed	O Bladder Problems
O Ear Infections	O Urinary Infections	O Speech Difficulty	O ADHD or ADD

Have you been under drug and medical care?_____

What medications are you taking?(use back of page if needed)_____

How long have you been taking them? What side effects have you experienced ?_____

Is there a family history of : Heart Disease O Arthritis O Cancer O Diabetes O Other _____

On a Scale of 1 – 10, Rate the importance for you to achieve the following:	**1 = Not Important**									**10= Necessary**
Eat Better	1	2	3	4	5	6	7	8	9	10
Reduce Stress	1	2	3	4	5	6	7	8	9	10
Stop smoking	1	2	3	4	5	6	7	8	9	10
Increase my mobility	1	2	3	4	5	6	7	8	9	10
Improve my sleep	1	2	3	4	5	6	7	8	9	10
Learn about wellness and natural health care	1	2	3	4	5	6	7	8	9	10
Improve immune function	1	2	3	4	5	6	7	8	9	10
Improve mental function	1	2	3	4	5	6	7	8	9	10

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

_____ _____

(Signature) (Date)

CHIROPRACTIC PC

HIPAA: PATIENT CONSENT

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby state that by signing this consent, I acknowledge and agree as follows:

1. I am aware that the full Cashin Chiropractic, P.C. Privacy Notice is available to me at any time upon request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Cashin chiropractic, P.C. to provide treatment to me, and also necessary for Cashin Chiropractic, P.C. to obtain payment for that treatment and to carry out its health care operations. Cashin Chiropractic, P.C. explained to me that the Privacy Notice will be available to me in the future at my request. Cashin Chiropractic, P.C. has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. Cashin Chiropractic, P.C. reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that might be used by Cashin Chiropractic, P.C.:

    a. Telephoning me at the number I provide and leaving a message on my answering machine or with the individual answering the phone
    b. Sending me a text on the mobile phone number that I provide
    c. Sending me an email at the email address I provide

4. Cashin Chiropractic, P.C. may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Cashin Chiropractic, P.C. to treat me and obtain payment for that treatment, and as necessary for Cashin Chiropractic, P.C. to conduct its specific health care operations.

5. I understand that I have a right to request that Cashin Chiropractic, P.C. restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Cashin Chiropractic, P.C. is requested restriction, and then the restriction is binding on Cashin Chiropractic, P.C.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that Cashin Chiropractic, P.C. has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, Cashin Chiropractic, P.C. has the right to refuse to treat me.

_____/ _____
Signature Date

CHIROPRACTIC PC

OFFICE POLICY

AUTOMOBILE ACCIDENT INSURANCE

If you currently have Medical Payments Coverage (Med Pay) as a part of your car insurance, we will bill Med Pay for you. Please remember that you are personally responsible to pay your bill timely regardless of actions taken by your automobile insurer.

GENERAL

If you are unable to pay your account in full at the time services are rendered, you should be aware that the following rules apply to your account:

1. A finance charge of one and one half percent (1.5%) per month (18% A.P.R.) will be charge with a minimum of $5.00 on all accounts which are more than thirty (30) days old.
2. Sometimes it may become necessary to utilize a payment schedule (only on approval of the Doctor). If so, such a schedule must be strictly adhered to. In the event any payment is not made when due, the account will be turned over to a collection agency.
3. Should this office be required to turn your account over for collections, you will be required to pay all collection costs, attorneys' fees, and court costs.

CONSENT TO TREATMENT

A chiropractic manipulation or adjustment is a passive manual maneuver during which a three joint complex is suddenly carried beyond the normal range of motion without exceeding the boundaries of anatomical integrity. The usual characteristic is a thrust accompanied by an audible or cracking noise (Sandoz, 1976, 1981). Material risks inherent in the chiropractic adjustment include stroke, paralysis and even death. The risk of serious complication is one in 1,562,500 manipulations and the risk of death is one in 3,703,703 manipulations (Rand, 1995). As a matter of comparison, the risk of serious complication or death attributed to the use of non-steroid anti-inflammatory drugs is 100-400 times greater than for cervical manipulation in the treatment of similar conditions (JMPT, 1995).

AUTHORIZATION TO RELEASE INFORMATION & PAYMENT OF MEDICAL BENEFITS

By signing this form, you are hereby authorizing the release of any medical information necessary to process your insurance claims. You are also authorizing payment of medical benefits to CASHIN CHIROPRACTIC for services or products rendered. I certify that I have read and understand the above agreement/policy/explanation of the chiropractic adjustment(s) and related treatments and freely accept the terms. I further agree to abide by the terms/policies of CASHIN CHIROPPRACTIC as stated above to do whatever is necessary to effectuate them. By signing below, I have accepted the risk and consent to the treatment recommended.

Date: The _____ day of _____, 20 ____

Patient's (or Guardian's) Signature_____
Witness Signature _____