# New Patient Intake

Name:______________________________________________________________Date: __________________

Mailing Address: _____________________________________________________________________________

City_____________________________________State________________Zip ________________

Email address: _______________________________________________________________________________

Phone # (H)___________________________(W)_________________________(Other)_______________________

Date of Birth:________________________________ Sex: ❑ Male ❑ Female SS#: ______________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation:__________________________________Employer: ____________________________________________

Employer Address:_________________________________________Phone: _________________________________

Emergency contact:_____________________________________Relation:________________________________

Phone #: (H)___________________________(W)____________________________(C) _______________________

**Would you prefer email _________ or text message__________ reminders for upcoming appointments?**

**Circle your cell phone carrier:** Verizon AT&T T-Mobile Sprint Other:_____________

How did you hear about our practice? _________________________________________________________________

**What is your chief complaint today?** _______________________________________________________________

Please list any additional health complaints ______________________________________________________

Please list any surgeries (with dates) and/or medical conditions (past & present) ________________________________
_______________________________________________________________________________________________

Family History: Please specify members of your family including extended family who have these illnesses.
Cancer:_____________________________________________Hypothyroidism:__________________________________
Heart Disease:_______________________________________High Blood Pressure: ____________________________
Hypoglycemia:_______________________________________Obesity: ________________________________________
Back Problems: _________________________________ Scoliosis:____________________________________

| Current Medications/Supplements | | |
|---|---|---|
| Medication/Dose/How often | Reason for taking | Prescribing M.D. |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please list any allergies ____________________________________________________________________________

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time. Are You Pregnant? Yes ❑ No ❑

Signature:_______________________________________________________Date: __________________

## Review of Systems

Name:________________________________________________Date of Birth:______/____/_____Date:______/____/_____

Please mark if you have experienced any of these symptoms within the ***last month***:

**Neurological**

- ____ Migraines
- ____ Headaches
- ____ Slurring of speech
- ____ Ringing in ear
- ____ Dizziness
- ____ Pins/Needles Arms
- ____ Pins/Needles Legs
- ____ Cold Feet
- ____ Fainting
- ____ Fever

**Ear/Nose/Throat**

- ____ Altered taste/smell
- ____ Night Blindness
- ____ Sore Throat
- ____ Gingivitis
- ____ Nose bleeds
- ____ Blurred Vision
- ____ Light bothers eyes

**Cardiovascular**

- ____ Chest pain
- ____ Palpitations- racing heart beat
- ____ Swelling in hands/feet
- ____ Anemia

**Respiratory**

- ____ Recurrent respiratory infections
- ____ Asthma
- ____ Chest congestion
- ____ Wheezing
- ____ Frequent sneezing
- ____ Shortness of breath

**Gastrointestinal**

- ____ Stomach pains or cramping
- ____ Constipation
- ____ Reflux or heartburn
- ____ Bloating
- ____ Gas
- ____ Nausea or vomiting
- ____ Bowel/ bladder changes

**Musculoskeletal**

- ____ Joint pain
- ____ Arthritis
- ____ Chronic pain
- ____ Muscle aches
- ____ Neck pain
- ____ Back pain
- ____ Arm pain
- ____ Knee/leg pain
- ____ Night pain
- ____ Jaw problems

**Skin**

- ____ Eczema
- ____ Dermatitis
- ____ Excessive sweating
- ____ Rashes
- ____ Brittle nails
- ____ Hair loss
- ____ Increased bleeding
- ____ Easy bruising
- ____ Numbness/tingling
- ____ Cold sweats

**Genitourinary**

- ____ Uterine fibroids
- ____ Ovarian cysts
- ____ Cancer (breast, ovarian, prostate,uterine)
- ____ Prostate problems

**Emotional/Mental**

- ____ Depression
- ____ Anxiety
- ____ Mood swings
- ____ Irritability
- ____ Memory loss
- ____ Confusion
- ____ Nervousness

**Energy**

- ____ Fatigue
- ____ Hyperactivity
- ____ Restlessness
- ____ Insomnia
- ____ Decreased libido
- ____ Stress
- ____ Tension

**Weight**

- ____ Decreased appetite
- ____ Weight gain
- ____ Inability to lose weight
- ____ Food cravings
- ____ Binge eating
- ____ Water retention
- ____ Sudden weight loss

**Allergies**

- ____ Hives
- ____ Runny nose
- ____ Itchy/Watery eyes
- ____ Congestion

____ **None of the above**

# Functional Rating Index

In order to assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one which most closely describes your condition ***right now***.

Pain Intensity

| | | | | |
|---|---|---|---|---|
| *No pain* | *Mild pain* | *Moderate pain* | *Severe pain* | *Worst possible pain* |

Sleeping

| | | | | |
|---|---|---|---|---|
| *Perfect sleep* | *Mildly disturbed sleep* | *Moderately disturbed sleep* | *Greatly disturbed sleep* | *Totally disturbed sleep* |

Personal Care (washing, dressing, etc.)

| | | | | |
|---|---|---|---|---|
| *No pain with no restrictions* | *Mild pain with no restrictions* | *Moderate pain; need to go slowly* | *Moderate pain; need some assistance* | *Severe pain; need 100% assistance* |

Travel (Driving, etc.)

| | | | | |
|---|---|---|---|---|
| *No pain on long trips* | *Mild pain on long trips* | *Moderate pain on long trips* | *Moderate pain on short trips* | *Severe pain on short trips* |

Work

| | | | | |
|---|---|---|---|---|
| *Can do usual work plus unlimited extra work* | *Can do usual work with no extra work* | *Can do 50% of usual work* | *Can do 25% of usual work* | *Cannot work* |

Recreation

| | | | | |
|---|---|---|---|---|
| *No pain* | *Mild pain* | *Moderate pain* | *Severe pain* | *Worst possible pain* |

Frequency of pain

| | | | | |
|---|---|---|---|---|
| *No pain* | *Occasional pain; 25% of the day* | *Intermittent pain; 50% of the day* | *Frequent pain; 75% of the day* | *Constant pain; 100% of the day* |

Lifting

| | | | | |
|---|---|---|---|---|
| *No pain with heavy weight* | *Increased pain with heavy weight* | *Increased pain with moderate weight* | *Increased pain with light weight* | *Increased pain with any weight* |

Walking

| | | | | |
|---|---|---|---|---|
| *No pain with any distance* | *Increased pain after 1 mile* | *Increased pain after 1/2 mile* | *Increased pain after 1/4 mile* | *Increased pain with all walking* |

Standing

| | | | | |
|---|---|---|---|---|
| *No pain after several hours* | *Increased pain after several hours* | *Increased pain after 1 hour* | *Increased pain after 1/2 hour* | *Increased pain with any standing* |

## HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

**Patient Signature**_________________________________________________________________**Date**__________________

## Authorization and Assignment

*Please initial next to each line that applies to you. Thank you.*

__**AUTHORIZATION TO RELEASE INFORMATION (*if applicable):*** You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

__**ASSIGNMENT OF PAYMENT (*if applicable*):** My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any money due to him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that is not covered by my policy or if for any other reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

__**MEDICARE ASSIGNMENT (*if applicable*):** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

__**ACKNOWLEDGEMMENT AND UNDERSTANDING:** I hereby acknowledge;

A. That there is no insurance company obligated to pay for the services, or if the insurance company involved, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or
B. If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Total Heath Systems P.C., will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

**Patient Signature**_________________________________________________________________**Date**__________________

## Consent to Treat

**THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, ACUPUNTURE, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE.**
I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Northwest Health Center DBA: Momentum Health Center. I understand and am informed that, while extremely rare, there are some risks to treatment, including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

**Patient Signature**_________________________________________________________________**Date**__________________

**Parent/Legal guardian name (please print)**__________________________________________________________________

**Guardian Signature**_______________________________________________________________**Date**___________________

Insurance Responsibility of Payment Agreement

I, ____________________, agree that Momentum Health Center is helping me by billing my insurance for me. It has been explained that if the service of acupuncture is not covered, even after prior benefits confirmations, I will be held responsible for any remaining balance. Also, I will reimburse Momentum Health Center if the insurance company decides at a later date that acupuncture is considered experimental of some other reason, and they decide they want the money back from the office. If this happens, I know I am responsible for the services I have already received. Non-insurance rates for acupuncture services are $100 for the first visit and $80 for an hour for visits after. There is a **$55 cancelation fee i**f you do not cancel your appointment within 24 hours. If you do not call/text to cancel your appointment or do not show up for your appointment **you will be charged the full visits amount.** (non-insurance prices apply).

Patient Name-Printed_____________________

Patient Name-Signed______________________

Date: _____________

Office Manager-Printed__________________

Office Manager –Signed__________________

Date: ______________