

New Patient Intake

NAME			DATE			
ADDRESS	·					
HOME PHONE		WORK PHONE	CELL F	PHONE		
EMAIL		MALE [F		Y # s, if you don't have your insurance card)		
BIRTHDATE		AGE		ON		
EMPLOYER NAME &	ADDRESS					
SINGLE MARRI	ED SPOU	JSE'S NAME				
HAVE YOU SEEN A C	HIROPRACTOR BE	FORE? YES NO	IF YES, WHEN?			
W II O M M A A Y IM E THA I	NE COD DEFENDIN	C VOIL TO OUR OFFICE?				
WHOM MAI WE THAT	NK FOR REFERRIN	G TOO TO OUR OFFICE: _				
PLEASE CHECK ALL	SYMPTOMS YOU H.	AVE EVER HAD, EVEN IF 1	THEY DO NOT SEEM RELATEDTO	YOUR CURRENT PROBLEM:		
HEAD	ACHES	LOSS OF SMELL	LOSS OF TASTE	LOSS OF BALANCE		
PINS 8	NEEDLES IN ARMS	PINS & NEEDLES IN LEGS	BACK PAIN	NECK PAIN		
DIZZIA	IESS	BUZZING IN EARS	RINGING IN EARS	☐ NERVOUSNESS		
NUMB	NESS IN FINGERS	NUMBNESS IN TOES	FAINTING	UPSET STOMACH		
FATIGI	JE	DEPRESSION	IRRITABILITY	TENSION		
SLEEP	ING PROBLEMS	STIFF NECK	COLD HANDS	COLD FEET		
DIARR	HEA	CONSTIPATION	FEVER	HOT FLASHES		
COLD	SWEATS	LIGHTS BOTHER EYES	PROBLEM URINATING	HEARTBURN		
wood	SWINGS	MENSTRUAL PAIN	MENSTRUAL IRREGULARITY	ULEERS		
LIST ANY MEDICATIO	ONS YOU ARE TAKI	NG				
			YOU MAY REQUEST A COPY OF			
	DE ON THIS FORM	A ARE ACCURATE TO THE	BEST OF MY RECOLLECTION AN			
PATIENT SIGNATURE			DATE			
GUARDIAN SIGNATU	R E		DATF			

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly 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 choice which most closely describes your condition right now.

1. Pain I	ntensity					6. Rec	reation			
No pain	Mild pain	Mode pair	1	Severe pain	Worst possible pain	No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
2. Sleepi	ng					7. Free	quency of Pa	ain		
Perfect sleep	Mildly disturbed sleep		Ioderately sturbed sleep	Greatly disturbed sleep	Totally disturbed sleep	No (Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day
3. Person	al Care (1	vashi	ng, dress	sing, etc.)		8. Lift	ing			
No pain no restrictions	Mild pain no restriction	pair to go	derate n; need slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance	No pain w/hea weigh	Increased pain with vy heavy t weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
4. Travel	(driving, e	etc.)				9. Wal	king			
No pain on long trips	Mild pain on long trips	p	oderate ain on ig trips	Moderate pain on short trips	Severe pain on short trips	No pair any distance	pain afte		pain after	Increased pain with all walking
5. Work						10. Sta	nding			
Can do usual work plus unlimit extra work		ork ra	Can do 50% of usual work	Can do 25% of usual work	Cannot work	No pain after several hours	Increased pain after several hours	Increased pain l after l hour	Increased pain after 1/2 hour	Increased pain with any standing
Name								Total S	core	
			PRIN	ITED						
***************************************	*		Signat	ııre		· · · · · · · · · · · · · · · · · · ·			Date	

BASS CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

- 1. Treatment purposes discussion with other health care providers involved in your care.
- 2. Inadvertent disclosures open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
- 3. For payment purposes to obtain payment from your insurance company or any other collateral source.
- 4. For workers compensation purposes to process a claim or aid in investigation.
- 5. Emergency in the event of a medical emergency we may notify a family member.
- 6. For Public health and safety in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
- 7. To Government agencies or Law enforcement to identify or locate a suspect, fugitive, material witness or missing person.
- 8. For military, national security, prisoner and government benefits purposes.
- 9. Deceased persons discussion with coroners and medical examiners in the event of a patient's death.
- 10. Telephone calls or emails and appointment reminders we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
- 11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

- 1. To receive an accounting of disclosures.
- 2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
- 3. To request mailings to an address different than residence.
- 4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
- 5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
- 6. To request amendments to information. However, like restrictions, we are not required to agree to them.
- 7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

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BASS CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I have received a copy of Bass Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name	DOB	HR#
Patient's Signature	 Date	
Witness	 Date	

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Bass Chiropractic

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Bass Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

REGARDING: Open Door Adjusting Environment, Travel Card Use; and Patient Record of Disclosures:

Our office uses travel cards and provides care in an "open door" adjusting environment. Adjustments and rehabilitation are done in open areas, separated by pony walls. As a result, patients are in sight of each other and some ongoing routine details of care may be in earshot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations or presenting reports of findings. These procedures are done in a private, confidential setting, and all of your health information is kept secure, safe and confidential.

If you ever have matters to discuss with our doctors or staff that you would prefer to be discussed in private, this will be arranged for you. Your signature below indicates your authorization for receiving treatment in this environment. In addition, your signature below authorizes us to contact you at all the phone numbers/addresses you have listed in your application. If you do not wish to be contacted at any listed numbers/addresses, please let us know.

			Witness Initials
Patient or Authorized Person's Signature	Date		