BASS CHIROPRACTIC

New Patient Intake

NAME _____ DATE _____

ADDRESS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL _____ MALE ☐ FEMALE ☐ SOCIAL SECURITY # _____
(used to verify medical benefits, if you don't have your insurance card)

BIRTHDATE _____ AGE _____ OCCUPATION _____

EMPLOYER NAME & ADDRESS _____

SINGLE ☐ MARRIED ☐ SPOUSE'S NAME _____

HAVE YOU SEEN A CHIROPRACTOR BEFORE? YES ☐ NO ☐ IF YES, WHEN? _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PLEASE CHECK ALL SYMPTOMS YOU HAVE EVER HAD, EVEN IF THEY DO NOT SEEM RELATEDTO YOUR CURRENT PROBLEM:

☐ HEADACHES	☐ LOSS OF SMELL	☐ LOSS OF TASTE	☐ LOSS OF BALANCE
☐ PINS & NEEDLES IN ARMS	☐ PINS & NEEDLES IN LEGS	☐ BACK PAIN	☐ NECK PAIN
☐ DIZZINESS	☐ BUZZING IN EARS	☐ RINGING IN EARS	☐ NERVOUSNESS
☐ NUMBNESS IN FINGERS	☐ NUMBNESS IN TOES	☐ FAINTING	☐ UPSET STOMACH
☐ FATIGUE	☐ DEPRESSION	☐ IRRITABILITY	☐ TENSION
☐ SLEEPING PROBLEMS	☐ STIFF NECK	☐ COLD HANDS	☐ COLD FEET
☐ DIARRHEA	☐ CONSTIPATION	☐ FEVER	☐ HOT FLASHES
☐ COLD SWEATS	☐ LIGHTS BOTHER EYES	☐ PROBLEM URINATING	☐ HEARTBURN
☐ MOOD SWINGS	☐ MENSTRUAL PAIN	☐ MENSTRUAL IRREGULARITY	☐ ULEERS

LIST ANY MEDICATIONS YOU ARE TAKING _____

_____

THIS OFFICE CONFORMS TO THE CURRENT HIPAA GUIDELINES. YOU MAY REQUEST A COPY OF OUR HIPAA POLICY AT THE FRONT DESK. PLEASE INITIAL TO INDICATE YOU HAVE BEEN MADE AWARE OF ITS AVAILABILITY _____

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.

PATIENT SIGNATURE _____ DATE _____

GUARDIAN SIGNATURE _____ DATE _____

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 Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

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

4. 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

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. 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

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

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

10. 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

Name _____ Total Score _____
PRINTED

_____ _____
Signature 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 **P**ersonal **H**ealth **I**nformation. 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.

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

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