



# 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 RELATED TO YOUR CURRENT PROBLEM:

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

### 6. Recreation

|         |           |               |             |                     |
|---------|-----------|---------------|-------------|---------------------|
| 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 |
|---------------|------------------------|----------------------------|-------------------------|-------------------------|

### 7. Frequency of Pain

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

### 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 |
|-------------------------|---------------------------|----------------------------------|-------------------------------------|-----------------------------------|

### 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 |
|------------------------|----------------------------------|-------------------------------------|----------------------------------|--------------------------------|

### 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 |
|-----------------------|-------------------------|-----------------------------|------------------------------|----------------------------|

### 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 |
|----------------------|-----------------------------|-------------------------------|-------------------------------|---------------------------------|

### 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 |
|---|---------------------------------|--------------------------|--------------------------|-------------|

### 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 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 apprise 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

