BENTIN CHIROPRACTIC

7545 W. Boynton Beach Blvd., Suite 102
Boynton Beach, FL 33437
Telephone: (561) 736-9355

PATIENT INTAKE FORM - CHIROPRACTIC

Patient Name:_____ Birth Date ___/___/_____

Age:_____ Gender: ☐Female ☐Male Email:_____

Address:_____ City:_____ Postal code:_____

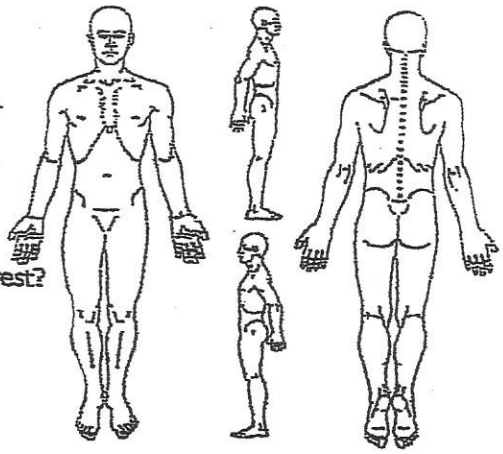
Phone (Home):_____ Phone (Cell):_____

Occupation:_____ Family Doctor:_____

How did you hear about our clinic? _____ Referred By:_____

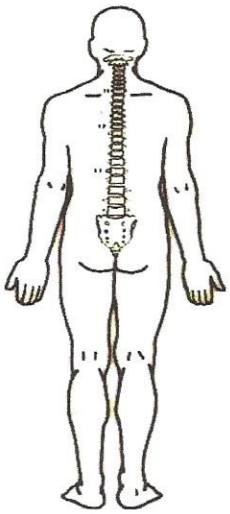
Marital Status_____

Please mark where the pain is located.



1. What is your major symptom/problem?_____
2. When did your symptoms begin?_____
3. Have you had this problem before? ☐Yes ☐No
4. Is the problem there — ☐constant ☐comes & goes ☐with use ☐at rest?
5. Is the problem getting – ☐worse ☐no change ☐better?
6. What makes it worse?_____
7. What makes it better?_____
8. How does it feel? ☐Burning ☐Sharp ☐Shooting ☐Dull ☐Stiff ☐Aching ☐Tingling ☐Throbbing ☐Swelling Other:_____
9. How would you rate the sensitivity of your pain (0=no pain, 10=severe pain)?_____
10. Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation?
11. What test have you had for this condition?: ☐Spinal Exam ☐X—ray ☐MRI ☐CT Scan
12. Have you received any treatment for this condition? ☐Orthopedic ☐Physiotherapy ☐Massage Therapy ☐Acupuncture ☐Surgery (Date D/M/Y:_____) Other:_____

Please circle the number of pain's severity and indicate type(s) of pain:
Burning • Stabbing • Sharp • Constant



EXAMPLE: *NECK* ___*SHARP*___
1 2 3 (4) 5 6 7 8 9 10

NECK _____
1 2 3 4 5 6 7 8 9 10

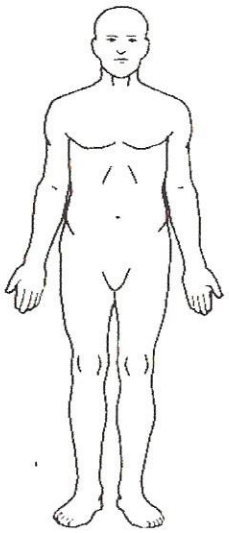
MID BACK _____
1 2 3 4 5 6 7 8 9 10

LOW BACK _____
1 2 3 4 5 6 7 8 9 10

HIPS _____
1 2 3 4 5 6 7 8 9 10

ARMS _____
1 2 3 4 5 6 7 8 9 10

LEGS _____
1 2 3 4 5 6 7 8 9 10



Please draw on the figures where you have any of the following:
A= Ache **SF**= Stiffness **SH**= Sharp **S**= Soreness **N**= Numbness **P**= Pain **C**= Constant **XX**= Other

Please check if you currently have or have previously had any of these conditions:

GENERAL
- □ Convulsions
- □ Headaches
- □ Loss of sleep
- □ Fatigue
- □ Nervousness
- □ Loss of weight
- □ Excessive urination
- □ Painful urination
- □ Bed-wetting
- □ Diabetes I / II
- □ Cancer
- □ Anemia
- □ Arthritis
- □ Depression
- □ Thyroid/Goiter
- □ Spine trauma
- □ Whiplash
- □ Scoliosis
- □ Ulcers

MUSCULOSKELETAL
- □ Low back pain
- □ Mid back pain
- □ Shoulder pain
- □ Neck pain/stiffness
- □ Swollen joints
- □ Painful joints
- □ Arm problems
- □ Leg problems
- □ Sore muscles
- □ Foot problems
- □ Walking problems
- □ Weak muscles
- □ Muscle spasm

GASTROINTESTINAL
- □ Poor appetite
- □ Excessive hunger
- □ Difficulty chewing
- □ Difficulty swallowing
- □ Nausea
- □ Vomiting blood
- □ Abdominal pain
- □ Diarrhea
- □ Constipation
- □ Bloody stools
- □ Liver trouble
- □ Gall Bladder problems
- □ Excessive thirst
- □ Hemorrhoids

EYE/EAR/NOSE & THROAT
- □ Eye inflammation
- □ Vision problems
- □ Ear pain
- □ Hearing loss
- □ Dental problems
- □ Hoarseness
- □ Difficult speech
- □ Sinus
- □ Allergy
- □ Jaw pain

NERVOUS SYSTEM
- □ Numbness/Tingling
- □ Paralysis
- □ Dizziness
- □ Fainting
- □ Muscle jerking
- □ Convulsions
- □ Insomnia

CARDIOVASCULAR
- □ Chest pain
- □ Difficulty breathing
- □ Persistent cough
- □ Coughing phlegm
- □ Coughing blood
- □ Rapid heartbeat
- □ Slow heartbeat
- □ High blood pressure
- □ Low blood pressure
- □ Swelling ankles
- □ Poor circulation
- □ Varicose veins
- □ Stroke
- □ Pacemaker
- □ Palpitations
- □ Lung problems

FEMALES ONLY
- □ Breast pain
- □ Cramps
- □ Irregular cycle

Date of last menstrual cycle:
_____

Please list if any of the following have affected a family member:
Diabetes • Heart issues • Cancer • Kidney issues • Back issues

Father: _____ Living: Yes _____ No _____
Mother: _____ Living: Yes _____ No _____
Brother(s): _____ How many? _____
Sister(s): _____ How many? _____

Activities of Daily Living

Patient's Name: _____ **Date of Birth:** _____

Please identify how your current condition is affecting your ability to carry out activities that may be routinely part of your life. Check one box for each activity.

ACTIVITY	EFFECT			
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Doing chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Rolling over	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Watching T.V.	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Playing sports	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Sitting to standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Computer work	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Sexual activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform
Recreation	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to perform

Patient's Signature: _____ **Today's Date:** _____

BENTIN CHIROPRACTIC

7545 W. Boynton Beach Blvd., Suite 102
Boynton Beach, FL 33437
Telephone: (561) 736-9355

Consent For Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Social Security: _____

Section B: To the Patient – Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a reversed Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Bentin Chiropractic Wellness Center

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice fo your revocation submitted to the Contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

ACKNOWLEDGMENTS

1. *I instruct the chiropractor to deliver the care that, in his or her professional judgment can best help me in the restoration of my health, I understand that the care offered at Bentin Chiropractic is based on evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct health art form from medicine and does not proclaim to cure any named disease or entity.*
2. *I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.*
3. *I grant permission to be called to confirm or reschedule an appointment and to be sent occasion cards, letters, email or health information as an extension of my care in the office.*

INSURANCE POLICY/FINANCIAL POLICY AND RELEASE OF AUTHORIZATION

Insurance is a contract between you and your insurance company. As a courtesy to you, we will verify and file claims to your PRIMARY insurance only. Verification is not a guarantee of benefits or payment. Your insurance company will make the final determination of eligibility and subsequent payment.

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits be paid directly to Bentin Chiropratic. I agree that this authorization will cover all services rendered until I revoke the authorization. I understand that I am financially responsible for any charge not covered by this assignment.

Copayments are due at the time of service unless other written arrangements have bee approved. If unpaid balances are more than 60 days delinquent, you may be referred to a collection agency.

Returned Checks-There will be a $12 fee for any returned checks.

Patient or Responsible Party Signature_____

Date:_____