Hastings Chiropractic Wellness & Center

Office: 830-755-9109
Fax: 830-755-9114
E-mail: southpawchiro@gvtc.com
www.BoerneChiropractors.com

Welcome

Thank you for choosing our practice for your needs. Please complete this form in ink.
We will be happy to help you with any questions or concerns, so please do not hesitate to ask for assistance.

(Please Print)

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. Patient's Name: _____ Date: _____ SS#: _____

Street Address: _____ City: _____ State: ____ Zip: _____

❑ Male ❑ Female Home Phone: _____ Work Phone: _____ Cell phone: _____

E-mail: _____ DL#: _____ DOB: _____ Age: ___

Would you like to sign up to receive: (Please initial to indicate your permission for us to contact you.)

Initials _____ E-mail ❑ Appointment reminders ❑ Coupons ❑ Newsletters ❑ Birthday cards ❑ Thank you's

_____ Text ❑ Appointment reminders ❑ Specials

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No preference

Your employer (school): _____ Occupation/Type of Work: _____

Work address: _____ City: _____ State: ____ Zip: _____

Name of local friend or relative: _____ Relationship to patient: _____ Phone: _____

How did you choose us? (please check one box): ❑ referral from Dr. _____ ❑ Family _____

❑ Close to home/work ❑ Yellow Pages ❑ Website _____ ❑ Friend _____

Other family members seen here: _____

FINANCIAL RESPONSIBILITY:

Person responsible for bill (if different): _____

Address if different from patient: _____ Phone: _____

DOB: _____ Relationship to patient: _____ Work Phone: _____

INSURANCE INFORMATION: (PLEASE GIVE YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST.)

Is this patient covered by insurance? ❑ Yes ❑ No Primary Insurance : _____

Subscriber's name: _____ Subscriber's SS#: _____ DOB: _____

Group #: _____ Policy #: _____ Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

Name of secondary insurance (if applicable): _____ Group #: _____ Policy #: _____

Subscriber's name: _____ Subscriber's SS#: _____ DOB: _____

AUTO OR WORK INJURY?:

Date of Accident: _____ Insurance Co: _____ Adjustor: _____ Claim #: _____

Brief description of the accident: _____

_____

The above information is complete and true to the best of my knowledge.

Patient/Guardian signature: _____ *Date:* _____

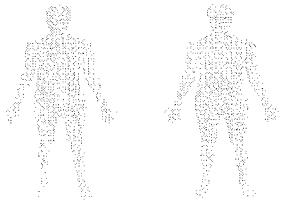
CONFIDENTIAL

Wellness. Your goal, *our mission...*

PATIENT INTAKE FORM

1. **Is today's problem caused by:** ❑ Auto Accident ❑ Workman's Compensation
2. **Indicate on the drawings below where you have pain/symptoms**

Back Front



3. **How often do you experience your symptoms?**

❑ Constantly (76-100%) ❑ Frequently (51-75%) ❑ Occasionally (26-50%) ❑ Intermittently (1-25%)

4. **How would you describe the type of pain?**

❑ Sharp ❑ Dull ❑ Diffuse ❑ Achy ❑ Burning ❑ Shooting ❑ Stiff
❑ Numb ❑ Tingly ❑ Sharp with motion ❑ Shooting with motion ❑ Stabbing with motion

5. **How are your symptoms changing with time?**

❑ Getting Worse ❑ Staying the Same ❑ Getting Better

6. **Using a scale from 0-10 (10 being the worst), how would you rate your problem?**

0 1 2 3 4 5 6 7 8 9 10

7. **How much has the problem interfered with your work/daily living?**

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

8. **What other specialist have you seen for this problem?**

❑ Chiropractor ❑ ER Physician ❑ Massage Therapist ❑ Neurologist ❑ Orthopedist
❑ Physical Therapist ❑ Primary Care ❑ No One ❑ Other:_____

9. **How long have you had this problem?** _____
10. **How do you think your problem began?** _____
11. **Do you consider this problem to be severe?** ❑ Yes ❑ Yes, Sometimes ❑ No
12. **What aggravates your condition?** _____
13. **What concerns you most about your current problem; what does it prevent you from doing?**

_____

14. **How do you rate your overall Health?** ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor
15. **What is your: Height**_____ **Weight**_____ **Age:**_____

Occupation:_____

Do you exercise regularly? ❑ No ❑ Yes

Frequency: (1-2x/week) (3-5x/week) (6-7x/week) **Intensity:** ❑ Low ❑ Moderate ❑ Heavy

Do you take Vitamins? ❑ No ❑ Yes

Do you take Nutritional Supplements? ❑ No ❑ Yes _____

16. Indicate if any immediate family members have any of the following: ❑ Cancer ❑ Diabetes ❑ Rheumatoid Arthritis ❑ Heart Problems ❑ ALS ❑ Lupus

17. For each of the conditions listed below, indicate if it is a "Past" condition or "Current" condition

Use "P" for Past condition---"C" for Current condition

❑ Headaches
❑ Neck Pain
❑ Upper Back Pain
❑ Mid Back Pain
❑ Low Back Pain
❑ Shoulder Pain
❑ Elbow/Upper Arm Pain
❑ Wrist Pain
❑ Hand Pain
❑ Hip Pain
❑ Upper Leg Pain
❑ Knee Pain
❑ Ankle/Foot Pain
❑ Jaw Pain
❑ Joint Pain/Stiffness
❑ Migraine Headaches
❑ Arthritis
❑ Rheumatoid Arthritis
❑ Cancer
❑ Asthma
❑ High Blood Pressure
❑ Heart Attack
❑ Chest Pain
❑ Stroke
❑ Angina
❑ Kidney Stones
❑ Kidney Disorders
❑ Bladder Infection
❑ Painful Urination
❑ Loss of Appetite
❑ Abdominal Pain
❑ Ulcer
❑ Hepatitis
❑ Liver/Gall Bladder Disorder
❑ General Fatigue
❑ Muscular Incoordination
❑ Visual Disturbances
❑ Dizziness
❑ Tumor
❑ Chronic Sinusitis
❑ Diabetes
❑ Excessive Thirst
❑ Frequent Urination
❑ Smoking/Tobacco Use
❑ Drug/Alcohol Dependence
❑ Allergies
❑ Depression
❑ Systemic Lupus
❑ Epilepsy
❑ Dermatitis
❑ Eczema/Rash
❑ HIV/AIDS ❑ STD
❑ Herniated Disk

For Females Only
❑ Birth Control Pills
❑ Hormonal Replacements
❑ Pregnancy_____

❑ Other:_____

18. List of prescription medications currently taking:

_____

19. List of Over-The-Counter medications currently taking:

_____

20. List of surgical procedures:

_____

21. Describe the frequency of the following activities?

Sit:	❑ Most of the Day	❑ Half the Day	❑ A little of the Day
Stand:	❑ Most of the Day	❑ Half the Day	❑ A little of the Day
Computer Work:	❑ Most of the Day	❑ Half the Day	❑ A little of the Day
On the Phone:	❑ Most of the Day	❑ Half the Day	❑ A little of the Day
Cell/Device Use	❑ Most of the Day	❑ Half the Day	❑ A little of the Day

22. What other activities do you engage in outside of work:

_____

23. Have you ever been hospitalized? If so, explain-

_____

24. Have you had past traumas? ❑ auto ❑ sports ❑ physical ❑ mental/emotional ❑ other_____

Provide anything additional that is pertinent to your visit today?

PATIENT SIGNATURE: **DATE:** _____

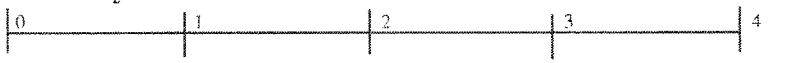
CONFIDENTIAL

Functional Rating Index

For use with **Neck and/or Back Problems** only.

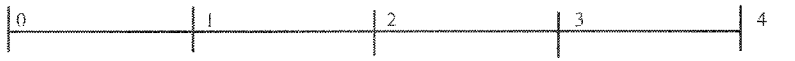
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



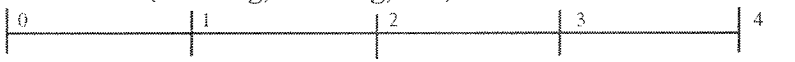
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

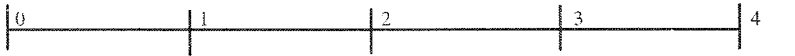


0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

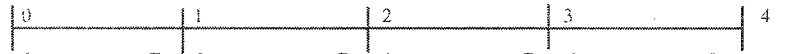
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



0	1	2	3	4
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

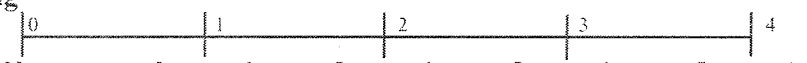


0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

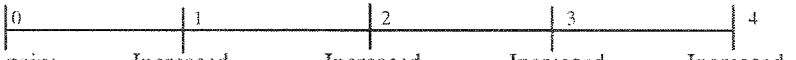
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



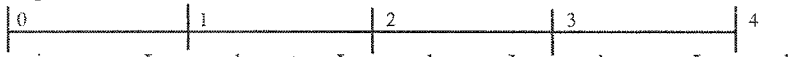
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
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



0	1	2	3	4
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 _____
PRINTED

Total Score _____

_____
Signature

_____
Date

Hastings Chiropractic & Wellness Center

Consent to Treatment

I certify I have read and I understand the information provided by Hastings Chiropractic & Wellness Center (HCWC). I completed the requested medical information to the best of my knowledge, and I have responded accurately to the questions. I understand if I withhold information or provide inaccurate information it would not be in my best interest to improve my condition or health. I understand it is in my best interest for the Doctor to be aware of my conditions and health history to receive accurate and effective health and medical care. I hereby authorize Dr. David Hastings and the Staff at Hastings Chiropractic & Wellness Center to treat my condition, or my child's condition, as he deems appropriate through the use of manipulation, mobilization throughout the spine, and therapeutic procedures.

_____ _____

Patient Signature Date

_____

Relationship to Patient

X-RAY Agreement

It is understood Hastings Chiropractic & Wellness Center will be reimbursed for radiographs completed, and these films will be used for examination and services provided. These x-ray films will remain the property of this office where they may be viewed at any time for the purpose of treatment. If I need these x-rays for any medical reason, I understand I may check out the films; however, they are under my responsibility once signed out of this office.

_____ _____

Patient Signature Date

Hastings Chiropractic & Wellness Center

ACKNOWLEDGEMENT RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have been notified Hastings Chiropractic & Wellness Center is compliant with HIPAA regulations. The HIPAA Privacy Rule establishes national standards to protect individual medical records and personal health information. HIPPAA requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions to the uses and disclosures that may be made of such information without patient authorization.

_____ _____

Patient Signature Date

_____

Relationship to Patient

HIPAA Authorization to Release Medical Information

Due to HIPAA Regulations and our promise to provide you with the utmost privacy, this HIPAA Authorization to Release Medical Information Form is designed to allow only certain people whom you select to have access to your medical information. (example: spouse, children, family friend, medical facility)

I hereby authorize the following people to have access to my medical information:

(This includes but is not limited to: sitting in during my consultations with the physician, and calling the office to check my medical status. This authorization will hold in effect until I submit a written notice of any changes.)

Name	Relationship	Authorization Date	Date Authorization Revoked
1.			
2.			
3.			
4.			

_____ _____

Patient Signature Date

Hastings Chiropractic & Wellness Center

Insurance and Payment Contract

Our office will accept your insurance on assignment. It must be fully understood that your insurance policy is a contract between you and your insurance company and does not imply a guarantee that our charges will be covered. Our office **will not** enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. **All charges incurred are your responsibility.**

1. At the beginning of your treatment, or if your insurance changes, our office will make every attempt to verify your policy benefits. However, this office DOES NOT guarantee your insurance policy or payments. In addition, this office is not responsible for inaccurate information quoted by your insurance company.

2. Your insurance will be filed as a **courtesy** to you. We file insurance claims on a weekly basis.

3. If your policy requires a referral from your Primary Care Physician, you are responsible for obtaining that referral. If your policy requires pre-certification or prior authorization, we will make every effort to obtain that for you if we know in advance of that requirement.

4. Patient is responsible for the annual deductible and /or co-payments **at the time of service** unless other arrangements are made.

5. In some instances, your insurance company may require additional information before they will process your claim. It is your responsibility to contact your insurance company with any requested information in a timely manner.

6. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for approximately 60 days from the date on which the claim was filed. In the event your insurance company does not pay on a timely basis, the amount will become patient responsibility and patient will be billed.

7. If the insurance company mails a check directly to you for our services, patient must bring the misdirected check to our office within 48 hours.

8. If the insurance company overpays in error, the refund will be to your insurance company.

I have read and understood the policy regarding insurance assignments and payment obligations. I authorize that payment be made directly to Dr. Hastings/ Hastings Chiropractic & Wellness Center for any insurance benefits or reimbursement for services rendered by the doctor. I authorize the release of any information necessary to secure this payment. I also understand that there is no guarantee that my insurance company or pre-paid health plan will cover or pay for all of my charges and I am responsible for all remaining charges. I understand all responsibility for payment is mine for myself and/or my dependents when services are provided. I agree to pay any attorney fees if this account is turned over to collection.

Appointment N0-SHOWS: Due to the new changes of our scheduling requirements resulting from COVID-19, any patient who fails to arrive for a scheduled appointment without cancelling the appointment **24 hours prior** to the scheduled time is considered a "no-show." **A no-show patient will be charged $40.00, as set by the practice, for failure to show.** A patient who is a no-show more than 3 times may be restricted to schedule future visits. Our office regrets having to implement this policy; however, we value and protect our scheduled appointments and to allow all our patients to have access to an appointment.

Patient/ Guardian/ Insured Signature: _____ Date: _____

Smoking Status:

Smokes every day	Smokes some days	Former Smoker	Never Smoked

If you smoke, how many cigarettes do you smoke per day?_____

PRESCRIBED MEDICINES

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	**# of MD refills issued:**	**Quantity of Pills:**	**Strength:** i.e. 10 mg	**MD's instruction:** i.e. 1 per day

Are you allergic to any medicines? If so, Please list each drug allergy:

Check here if you do not have any medical allergies: ☐

Name of Drug: i.e. penicillin	**Symptom:** i.e. headache	**Severity:** i.e. Mild, Moderate, Severe, Fatal

OFFICE USE ONLY

Vitals: In EZnotes, complete by 1) Going to "Exam" screen
2) "Select by region"
3) Then select "Vitals"

Blood Pressure: _____/_____ **Height:** _____ Weight: _____

OFFICE USE ONLY

"
"

Entered into EZnotes by (name): Date & Time: Completed?