Backworks Chiropractic

1311 W. Business Highway 60, Suite B • PO Box 678 • Dexter, MO 63841
Ph (573) 624-1935 • Fax (573) 624-9131
www.BackworksChiro.com

Patient Intake Information

PERSONAL INFORMATION

Patient Name: _____ Today's Date: ____ / ____ / 20____

Address: _____ City: _____ State: _____ Zip:_____

Cell Phone: _____ Work Phone: _____

Email: _____

Sex: M F Married Single Widowed Divorced Separated Birth Date: _____ / _____ / _____

Social Security #: _____ - _____ - _____ Occupation: _____

Who is your Primary Care Doctor? _____ Can we send them notes about your care? Y N

Are you disabled? Y N If yes, what for and when? _____

Describe the reason for your visit: _____ □ Wellness/Prevention (skip to medical history at bottom of page)

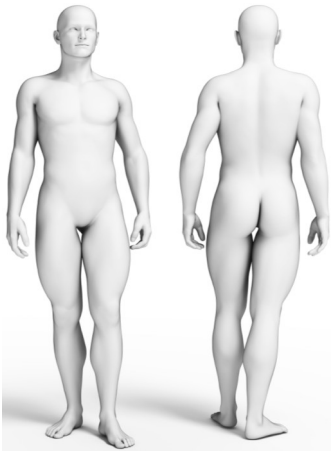
What caused your problem? _____ □ I don't know

Is your problem □ new □ recurring? If new, when did the problem begin? _____ □ I don't know

If recurring, when is the first time it happened? _____ □ I don't know When did it flare up this time? _____

INFORMATION ABOUT YOUR CONDITION

Circle the area of complaint on the diagram to the right. → → →



Since the pain began, has it gotten □ better □ worse □ same

Did your symptoms come on □ suddenly □ gradually

Is your pain worse with coughing, sneezing or laughing? □ yes □ no

Is your problem worse in the: □ morning □ afternoon □ night □ depends on what I do □ doesn't change

In your arms/hands, do you have any: □ pain □ numbness □ tingling and/or weakness □ no pain

In your legs/feet, do you have any: □ pain □ numbness □ tingling and/or weakness □ no pain

What is your pain RIGHT NOW? (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

What is your TYPICAL pain? (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

What is your pain AT ITS BEST? (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

What is your pain AT ITS WORST? (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Is your pain: □ sharp □ dull/achy □ tingling □ stabbing □ burning □ no pain □ other: _____

What motions/positions/activities make your problem worse? _____

What motions/positions/activities make your problem better? _____

MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY OR HAVE APPLIED TO YOU IN THE PAST

Condition	None	Past	Present
Fever	□	□	□
HIV/AIDS	□	□	□
Diabetes	□	□	□
Trauma	□	□	□
Osteoporosis	□	□	□
Back Pain	□	□	□
Neck pain	□	□	□
Arthritis	□	□	□
Cancer/Tumor	□	□	□

Condition	None	Past	Present
Prostate problems	□	□	□
Frequent Urination	□	□	□
Epilepsy/Seizures	□	□	□
High blood pressure	□	□	□
Stroke	□	□	□
Dizziness/Fainting	□	□	□
Visual disturbances	□	□	□
Urinary retention	□	□	□
Aortic Aneurysm	□	□	□

Condition	None	Past	Present
Fractures/Dislocations	□	□	□
Numbness in groin/buttocks	□	□	□
Abnormal weight gain/loss	□	□	□
Birth control pills	□	□	□
Pregnancy	□	□	□
Alcohol Use	□	□	□
Tobacco Use	□	□	□
History of recent infection	□	□	□

Family History: □ *Cancer* □ *Diabetes* □ *High Blood Pressure* □ *Cardiovascular Problems/Stroke*

List all surgeries: _____

List all medications: _____

I certify the above information to be complete and accurate. _____

Patient Signature

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Functional Rating Index

1. Pain Intensity at Worst

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Pain

2. Sleeping at Worst

0	1	2	3	4
Perfect Sleep	Mildly Disturbed	Moderatly Disturbed	Greatly Disturbed	Totally Disturbed

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

0	1	2	3	4
No Pain; No Restrictions	Mild Pain; No Restrictions	Moderate Pain; need to go slow	Moderate Pain; Need some assistance	Severe Pain; Need 100% assistance

4. Travel (driving, etc)

0	1	2	3	4
No Pain - 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
Usual work plus extra work	Usual work; no extra work	50% of usual work	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; 25% of the day	Intermittent; 50% of the day	Frequent; 75% of the day	Constant; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with mod-erate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain	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

_____ _____ ____/____/____ _____

Patient Name | Signature | Date | Score

dob / /

Rendering Provider: Dr Kelly Hutson 1891866042

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Informed Consent, PHI & Payment

INFORMED CONSENT TO TREATMENT

I do hereby give my consent to conservative, noninvasive treatment to the joints and soft tissues. I understand that treatments in this office may consist of manipulations, therapeutic and rehabilitative exercise, electrical therapy, muscle/soft tissue release, and other therapeutic modalities may also be used.

I understand that patient care takes place in an open area. Any conversations I have with the doctor could be overheard by other patients. If I have a confidential matter I wish to discuss, time will be scheduled for me to speak to the doctor privately.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective treatments for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:
Soreness: Like exercise, it is common to experience muscle soreness in the first few treatments. In some cases, symptoms may get worse for a short period before they get better.
Dizziness: Temporary symptoms like dizziness, headache, and nausea can occur but are relatively rare.
Fractures/Joint Injury: In isolated cases underlying deformities or pathologies (ie: osteoporosis) may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormalities are detected, this office will proceed with extra caution.
Stroke: Strokes from chiropractic adjustments are extremely rare. I am aware that stroke occurs once in 1-10 million adjustments.

If non-chiropractic or unusual findings are encountered, I will be referred to another healthcare provider.

I understand that there are beneficial effects associated with the treatment procedures used in this office, however, as with any medical procedure or therapy, there is no certainty that I will achieve these benefits. I agree to the use of these procedures. Reasonable alternatives to these procedures include rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

PROTECTED HEALTH INFORMATION (PHI)

I understand this office cannot release my PHI without my written consent and cannot be shared with anyone else unless I give prior written authorization. Occasionally my PHI *could* be overheard by other patients in the office. I understand I can request a copy of my records. My PHI may be shared in consultation with another healthcare provider. My PHI is required for billing and payments for and by third party payers. A full HIPAA manual is available to me to review in this office, at any time. All staff have been trained in the importance of patient record privacy. Information will only be available to those who need it and properly request it.

PAYMENTS, INSURANCE & IDENTIFICATION

I understand: I am fully responsible for all fees for services and goods. I request payment from my insurance company to be made to this office. I am responsible for all deductibles, copayments and any charges not covered by my insurance company. All payments are due at time of service. My insurance is billed by this office as a courtesy to me and the benefits they quote are not a guarantee of payment. Any outstanding unpaid balance on my account may be turned over to a collection agency and I am further responsible for all costs and fees for such. This office will keep a copy of my insurance card and drivers license which will be used strictly for insurance and identification purposes.

CONSENT TO EVALUATE & TREAT A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care by the doctor and/or staff.

I have read, or have had read to me, the above explanation of chiropractic treatment and office policies, and have had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician, I also understand said policies. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

_____ Print Name

_____ Signature

_____/_____/_____ Date

dob / / Rendering Provider : Dr Kelly Hutson 1891866042