New Patient Intake Form

Patient Information

Date_____

Patient Name_____

Address_____

City_____State_____ Zip Code_____

Phone #_____

Email_____DOB_____

Sex_____ Age_____ Marital Status_____ Occupation_____

Employer Information

Employer_____

Address_____

City_____ State_____ Zip Code_____

Phone #_____

In Case Of Emergency

Name_____

Relationship_____ Phone Number_____

Insurance Information

Insurance Company_____

Insurance ID #_____

Insurance Group #_____

Insurance Subscriber Information

Name_____

Birthdate_____Relationship to Patient_____

Secondary Insurance

Insurance Company_____

Insurance ID #_____

Insurance Group #_____

Secondary Insurance Subscriber Information

Name_____

Birthdate_____Relationship to Patient_____

Accident Information

Is this condition due to an accident?_____

If Yes, Type of Accident (circle) Auto Work Personal Injury Other

Attorney Name_____

Phone #_____

Description of Presenting Symptoms

Reason for Visit_____

Where are your symptoms?_____

When did your symptoms begin?_____

How did you injure yourself?_____

Type of Pain (circle)

Aching Burning Cramping Dull Inflamed Numbness Sharp Shooting Stiffness Throbbing Tingling

On a Scale from 0-10, with 10 being the worst, what is your pain level?_____

Is the Pain/Injury stopping you from doing anything?_____

What are your goals from care_____

Who has treated you for this condition?_____

_____

Have you had an X-Ray, MRI, CT Scan, or EMG in the last year?_____

If yes, Where?_____

Health History

Injuries/Surgeries	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Hospitalizations		

Please List Current:

Medications

Supplements

Allergies

Are you pregnant?_____If yes, due date_____

Review of Systems

Do you have/have you experienced any of the following? Circle and explain all that apply.

	(Current:Last 6 Months)	(Past)	Explain/Details
Family History			
Diabetes	C	P	_____
Thyroid Disease	C	P	_____
Muscle/Joint Disease	C	P	_____
Cancer	C	P	_____
Inflammatory Arthritis	C	P	_____
Autoimmune Disorder	C	P	_____
Other	C	P	_____
General History			
Height Change	C	P	_____
Weight Change	C	P	_____
Fever/Chills	C	P	_____
Night Sweats	C	P	_____
Autoimmune Disorder	C	P	_____
Malaise/Fatigue	C	P	_____
Weakness	C	P	_____
Cardiovascular System			
Shortness of Breath	C	P	_____
Chest Discomfort	C	P	_____
Calf Pain	C	P	_____
High Blood Pressure	C	P	_____
Respiratory System			
Difficulty Breathing	C	P	_____
Cough	C	P	_____
Blood in Sputum	C	P	_____
Wheezing/Asthma	C	P	_____
Exposure to Chemical/Asbestos	C	P	_____
Lung Infection/Disease	C	P	_____
Skin / Hair / Nails			
Changes in Skin	C	P	_____
Rashes/Itching	C	P	_____
Skin Growths/Lesions/Cancer	C	P	_____
Change in Hair Quality/Growth	C	P	_____
Change in Nails	C	P	_____
Dry Skin	C	P	_____
Endocrine System			
Heat/Cold Intolerance	C	P	_____
Thyroid Condition	C	P	_____
Diabetes	C	P	_____

Eyes / Ears / Nose / Throat

Blurred/Double Vision	C	P	_____
Difficulty Hearing/Deaf	C	P	_____
Ringing in Ears/Dizziness	C	P	_____
Ear Pain/Growth/Discharge	C	P	_____
Nose Bleeds	C	P	_____
Change in Smell	C	P	_____
Nose Pain/Growth/Discharge	C	P	_____
Sinusitis	C	P	_____

Gastrointestinal System

Change in Apetite	C	P	_____
Food Intolerance	C	P	_____
Nausea/Vomiting	C	P	_____
Indigestion/Heart Burn	C	P	_____
Abdominal Pain	C	P	_____
Diarrhea/Constipation	C	P	_____
Gas/Bloating	C	P	_____
Hemorrhoids	C	P	_____
Gall Bladder Disease	C	P	_____
Pancreatitis	C	P	_____

Breast

Pain/Tenderness	C	P	_____
Change in Color/Size/Shape	C	P	_____
Nipple Discharge	C	P	_____

Urinary System

Frequent Urination	C	P	_____
Pain upon Urination	C	P	_____
Change in Color/Smell of Urine	C	P	_____
Difficulty Urinating	C	P	_____
Discharge	C	P	_____
Flank/Kidney/Pelvic Pain	C	P	_____
Urinary Tract Infection	C	P	_____
Night Urination	C	P	_____

Neurological System

Headaches	C	P	_____
Seizures/Ticks/Spasm/Tremor	C	P	_____
Weakness	C	P	_____
Numbness/Tingling	C	P	_____
Dizziness	C	P	_____

Psychological History

Anxiety	C	P	_____
Depression	C	P	_____
Other Psychological Diagnosis	C	P	_____

Patient Name_____ Date_____

Patient/Guardian Signature_____

Bournemouth Questionnaire for Low Back Pain

The following scales have been designed to find out about your **Low Back** pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel and fill in description when asked:

1. Over the past week, on average how would you rate your **Low Back** pain?
No pain **0 1 2 3 4 5 6 7 8 9 10** Worst pain possible

2. Over the past week, how much has your **Low Back** pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry out activities
Please Describe:_____

_____

3. Over the past week, how much has your **Low Back** pain interfered with your ability to take part in recreational, social, and family activities?
No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry out activities
Please Describe:_____

_____

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?
Not at all anxious **0 1 2 3 4 5 6 7 8 9 10** Extremely anxious

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?
Not at all depressed **0 1 2 3 4 5 6 7 8 9 10** Extremely depressed

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your **Low Back**?
Made it no worse **0 1 2 3 4 5 6 7 8 9 10** Made it much worse
If worse, which activities?_____

_____

7. Over the past week, how much have you been able to control (reduce/help) your **Low Back** pain on your own?
Completely control it **0 1 2 3 4 5 6 7 8 9 10** No control whatsoever
What have you done?_____

Patient Name_____ Date_____
Patient/Guardian Signature_____

Bournemouth Questionnaire for Neck Pain

The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel and fill in description when asked:

1. Over the past week, on average how would you rate your **Neck** pain?
No pain **0 1 2 3 4 5 6 7 8 9 10** Worst pain possible

2. Over the past week, how much has your **Neck** pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?
No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry out activities
Please Describe_____

_____

3. Over the past week, how much has your **Neck** pain interfered with your ability to take part in recreational, social, and family activities?
No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry out activities
Please Describe:_____

_____

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?
Not at all anxious **0 1 2 3 4 5 6 7 8 9 10** Extremely anxious

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?
Not at all depressed **0 1 2 3 4 5 6 7 8 9 10** Extremely depressed

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your **Neck** pain?
Made it no worse **0 1 2 3 4 5 6 7 8 9 10** Made it much worse
If worse, which activities?_____

_____

7. Over the past week, how much have you been able to control (reduce/help) your **Neck** pain on your own?
Completely control it **0 1 2 3 4 5 6 7 8 9 10** No control whatsoever
What have you done?_____

Patient Name_____ Date_____
Patient/Guardian Signature_____

Savino Chiropractic PLLC HIPAA Notice

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/**.** We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: share information with your family, close friends, or others involved in your care, share information in a disaster relief situation

We never share your information unless you give us written permission for marketing purposes or sale of your information.

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

Treat you: We can use your health information and share it with other professionals who are treating you.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective: January 1, 2017

Privacy Official: Alicia Savino DC, LMT

alicia.savino@gmail.com

518-439-1100

Authorization for Records Release

Signing below will allow Savino Chiropractic PLLC to furnish and/or receive your medical records from:
Chiropractor:
Primary Care Physician:
Orthopedist
Neurologist:
OBGYN/Midwife:
Radiologist:
Dentist:
Other:

_____

Signature (Patient or Legal Guardian) Date

_____

Printed Name

Acknowledgement of Receipt of Health Insurance Portability and Accountability Act (HIPAA) Policies and Practices Notice

Signing below acknowledges that Savino Chiropractic PLLC has furnished you with a copy of their HIPAA policies and practices.

_____

Signature (Patient or Legal Guardian) Date

_____

Printed Name

Financial Policy

I _____ (patient name), am insured by _____ (insurance company). I authorize and assign Savino Chiropractic PLLC and Dr Alicia Savino all insurance benefits. I understand that I am financially responsible for all charges whether or not paid for by my insurance. I authorize the use of my signature on all insurance submissions. The above named Dr may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits. I understand that if I do not make timely payments that late fees may occur and my account will be forwarded to a collections agency.

_____

Signature (Patient or Legal Guardian) Date

_____

Printed Name

Cancellation Policy

If you are unable to keep a scheduled appointment, 24 hours advanced notice is required for both canceling or rescheduling appointments. If less than 24 hours notice is given or you miss your appointment, you will be charged $40.

Thank you for understanding our policy.

Patient Signature_____

Printed Name_____

Date_____