MANA CHIROPRACTIC

NEW PATIENT INTAKE

Name_____ Date _____

Address _____ City _____

State _____ Zip_____ Cell phone #_____ Home #_____

Work#_____ DOB_____ E-Mail _____

Text/Email Reminders (please circle text, e-mail, or both) YES NO

Occupation _____ Employer _____

Emergency Contact/Phone_____

Please circle: SINGLE MARRIED PARTNER DIVORCED WIDOWED

Who referred you to our practice? _____

Inform staff if this is a work or auto injury

Primary Health Complaint _____

How long have you experienced this primary complaint? _____ Any prior episodes? _____

What do you believe is causing this? _____

How often do you experience this? (circle): CONSTANTLY FREQUENT DAILY RANDOM

Circle type of pain: SHARP DULL LOCAL REFERRING RADIATING **When is it worse? (circle):** A.M. P.M.

What makes it better _____

What makes it worse _____

Who have you seen for this? (circle): CHIROPRACTOR NATUROPATH PHYSICAL THERAPIST MD LMT

OTHER _____ Results _____

List other health complaints _____

_____

What health goals are you seeking? (circle) injury treatment wellness care range of motion mobility/ flexibility body alignment strengthening/exercise pain management healthy lifestyle education massage therapy ergonomic/posture assessment

Other _____

Lifestyle

STRESS LEVEL AND PRESCRIPTIONS

Rate your stress (circle) Low Moderate High Cause of your stress _____

Prescription drugs _____

_____

HEALTH & FITNESS

Describe your exercise program _____

Frequency _____ **Overall health (circle)** POOR FAIR GOOD GREAT

How satisfied are you with your level of health? (circle) poor 1 2 3 4 5 6 7 8 9 great 10

Comment _____

Have you been diagnosed with any health conditions _____

_____

Female Chiropractic Patients

X-rays are contraindicated during pregnancy. Mana Chiropractic does not knowingly x-ray women who may be or who are, regardless of stage of pregnancy. If there is a chance that you are pregnant, let the doctor or the Chiropractic assistant know at this time.

Are you pregnant?_____
What date did your last period begin?_____

Do you want to take a pregnancy test now?_____
Office Use Only - Result of clinic pregnancy test - +

Circle if the following conditions are of significant concern for you in the last 12 weeks:

General _____

weight gain, weight loss, fainting, headache, vertigo, fatigue, fever, night sweats, convulsions, insomnia, anxiety, depression

Gastro-intestinal _____

constipation, rectal bleeding, nausea, diarrhea, vomiting, stomach pain, gall bladder issues, liver problems, eating disorder, hemorrhoids, poor digestion, jaundice

Eye/Ear/Nose/Throat _____

ringing in ears, ear ache, asthma, sore throat, nose bleeds, sinus congestion, frequent colds, hearing loss, flu or pneumonia, hay fever, thyroid issues

Cardiovascular _____

ankle swelling, poor circulation, rapid heart rate, slow heart rate, low blood pressure, high blood pressure, pain in chest, heart trouble, stroke, angina

Muscles/joints/bones _____

neck, upper back, mid back, low back, sacroiliac, hip, thigh, leg, foot, toes, shoulder, ribs, arms, hands, stiffness, weakness, tingling, numbness, fingers

sprain/strains_____ Fractures _____

Respiratory _____

chest pain, chronic cough, spitting blood, spitting phlegm, difficulty breathing

Skin or Allergies _____

bruise easily, sensitive skin, dryness, hives, eczema

Women _____

cramps, excessive flow, hot flashes, irregular cycle, painful periods

Patient Name: _____ **Date:** _____

Circle the number representing your dysfunction or pain.

Rate the dysfunction or pain you have right ***NOW***:

0 1 2 3 4 5 6 7 8 9 10
None Unbearable

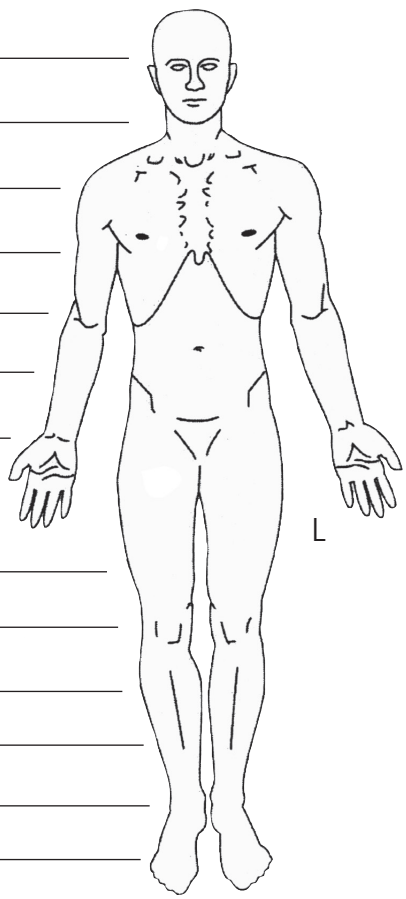
Rate your dysfunction or pain at its ***WORST*** in the past week:

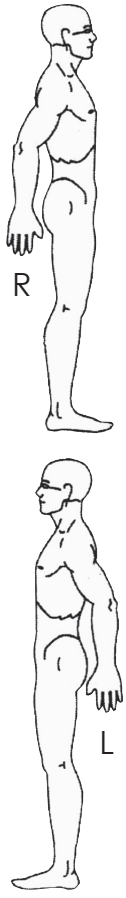
0 1 2 3 4 5 6 7 8 9 10
None Unbearable

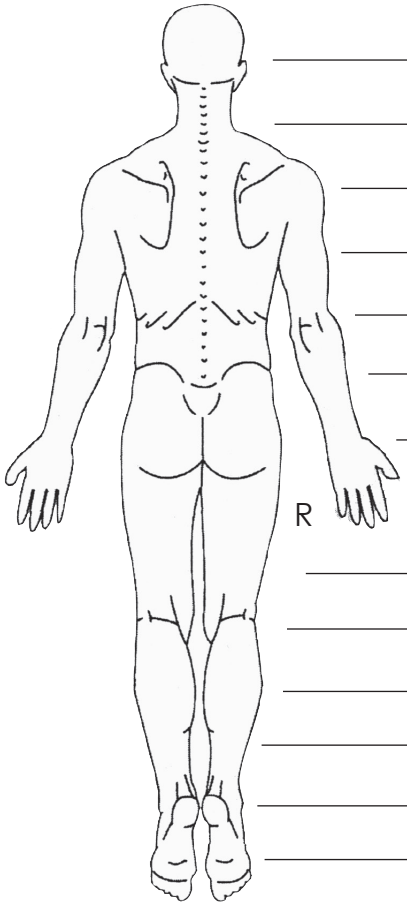
***Circle* the location** of your pain or dysfunction on the images below. Using the letters listed to indicate the type of dysfunction or pain.

B = Burning
C = Cramping
D = Dull
S = Stabbing/Sharp
T = Tingling (pins & needles)
N = Numb
SP = Spasm
ST = Stiff

DC/LMT notes:







DC/LMT notes:

Office Use Only: _____

F	EX	RR	LR	RLF	LLF

F	EX	RR	LR	RLF	LLF

Patient Name: _____ **Date:** _____

412 Girard St • Bellingham, WA 98225 • P (360) 734-9525 • F (360) 734-9505

Terms of Acceptance

The intention of this form is to ensure that patients are well informed about treatment procedures, including the potential benefits and risks. Please read the documentation and have all questions answered prior to signing.

Treatment Agreement

Chiropractic, massage and other clinical procedures used in our practice seldom cause any problems and the majority of patients experience improvement. Stiffness or discomfort may occur during the adjustment, post adjustment, after soft tissue procedures, or with prescribed self-care activities. This typically resolves in a few days. If it does not, please inform your provider.

Our treatments have extremely low risk of complications. In rare cases, underlining physical defects, deformities, pathologies, surgeries or medication used may increase risk factors for dislocations, spinal disc injury, fractures, neurovascular complications, or aggravations of pre-existing conditions. Inform your provider of your health history, current conditions and medications. The incidence of neurovascular conditions associated with treatment is exceedingly rare. Please inform your provider if you feel any of the above listed pertains to you.

I, (print name) _____ have read and fully understand the above statements. All questions regarding the provider's objective pertaining to my care in this office have been answered to my complete satisfaction. I, therefore accept care on this basis.

_____ _____

Signature Date

Authorization to treat a minor

I, (print name) _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive care at Mana Chiropractic.

_____ _____

Signature Date

Notice of Privacy Practice Summary

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To That Information. Please Review This Notice Carefully.

Mana Chiropractic P.S., in accordance with applicable federal and state law, is committed to maintaining the privacy of your protected health information (PHI). In other words, the private information about your health condition and the care and treatment you receive. We will use and disclose elements of your PHI the following ways:

- *Treatment*
- *Payment*
- *Health Care Operations*
- *When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement*
- *In emergency situations or to avert serious health/safety situations*
- *To medical examiners, coroners or funeral directors to aid in identifying you or to help them in their duties*
- *To organ, tissue and other donation organizations, upon or proximate to your death, if we have no indication on hand about your donation preferences*

Special Cases:

- *Appointment reminders, treatment alternatives and other health related benefits and services*
- *Sponsor of your health plan*

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your Rights: You have the following rights concerning your PHI:

- ***Restrictions:*** *To request restricted access to all or part of your PHI. To do this, please make the request in writing. We are not required to grant your request.*
- ***Confidential Communications:*** *To receive correspondence of confidential information by alternative means or location. To do this, please make a request in writing.*
- ***Access:*** *To inspect or receive copies of your PHI. To do this, please make a request in writing.*
- ***Amendments:*** *To request changes to be made to your PHI. To do this, please make a request in writing.*
- ***Accounting:*** *To receive an accounting of the disclosures by us of your PHI in the six years prior to your request. To do this, please make a request in writing.*
- ***This Notice:*** *To get updates or re-issue of this notice, at your request.*
- ***Complaints:*** *To complain to your office or the U.S. Department of Health and Human Services if you feel your privacy rights have been violated. To register a complaint with us, please submit your request in writing. The law forbids us from taking retaliatory action against you if you complain.*

Our Duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy Contact: To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Dr. Dylan Semu, Mana Chiropractic P.S., 412 Girard Street, Bellingham, WA 98225.

Effective Date: This notice is in effect as of June 1, 2006. A complete copy of the Notice of Privacy Practice is available at the reception desk.

Patient Acknowledgment: By subscribing my name below, I acknowledge receipt of a copy of the Notice offered, and my understanding and my agreement to its terms.

_____	_____	_____
Patient Name (Print)	*Signature*	*Date*

Payment, Cancellation & No Show Policy

Payment

All payments including co-pays and deductibles are due at the time of service. Please see your financial agreement provided by us for details. For your convenience we accept MasterCard, Visa, American Express, CareCredit, cash or checks. If you are unsure if we take a payment option you prefer, please ask the front desk. You may also choose to keep a payment card securely on file with our office for your visits.

We will gladly bill your insurance provider, but it is not a guarantee of payment. Any remaining balance from insurance will be your responsibility.

Cancellation/No Show Policy

Mana Chiropractic requires 24 hour cancellation notice. There will be a $50 charge for missed, no-show or less than 24 hour cancellation notice for chiropractic appointments and $80 charge for massage. Please note we are unable to bill insurance for any services not rendered. We understand your health goals and know the value in following your treatment plan.

We appreciate you choosing Mana Chiropractic for your health care needs.

I certify that I have read and understand the above financial policy.

_____ _____

Print Name *Date*

_____

Signature