New Patient Intake

Name:_____Date: _____

Mailing Address: _____

City_____State_____Zip _____

Email address: _____

Phone # (H)_____(W)_____(Other)_____

Date of Birth:_____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation:_____Employer: _____

Employer Address:_____Phone: _____

Emergency contact:_____Relation:_____

Phone #: (H)_____(W)_____(C) _____

Would you prefer email _____ or text message_____ reminders for upcoming appointments?

Circle your cell phone carrier: Verizon AT&T T-Mobile Sprint Other:_____

How did you hear about our practice? _____

What is your chief complaint today? _____

Please list any additional health complaints _____

Please list any surgeries (with dates) and/or medical conditions (past & present) _____

_____

Family History: Please specify members of your family including extended family who have these illnesses.
Cancer:_____Hypothyroidism:_____
Heart Disease:_____High Blood Pressure: _____
Hypoglycemia:_____Obesity: _____
Back Problems: _____ Scoliosis:_____

Current Medications/Supplements		
Medication/Dose/How often	Reason for taking	Prescribing M.D.

Please list any allergies _____

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time. Are You Pregnant? Yes ❑ No ❑

Signature:_____Date: _____

Review of Systems

Name:_____Date of Birth:_____/____/____Date:_____/____/____

Please mark if you have experienced any of these symptoms within the ***last month****:*

Neurological
- ___ Migraines
- ___ Headaches
- ___ Slurring of speech
- ___ Ringing in ear
- ___ Dizziness
- ___ Pins/Needles Arms
- ___ Pins/Needles Legs
- ___ Cold Feet
- ___ Fainting
- ___ Fever

Ear/Nose/Throat
- ___ Altered taste/smell
- ___ Night Blindness
- ___ Sore Throat
- ___ Gingivitis
- ___ Nose bleeds
- ___ Blurred Vision
- ___ Light bothers eyes

Cardiovascular
- ___ Chest pain
- ___ Palpitations- racing heart beat
- ___ Swelling in hands/feet
- ___ Anemia

Respiratory
- ___ Recurrent respiratory infections
- ___ Asthma
- ___ Chest congestion
- ___ Wheezing
- ___ Frequent sneezing
- ___ Shortness of breath

Gastrointestinal
- ___ Stomach pains or cramping
- ___ Constipation
- ___ Reflux or heartburn
- ___ Bloating
- ___ Gas
- ___ Nausea or vomiting
- ___ Bowel/ bladder changes

Musculoskeletal
- ___ Joint pain
- ___ Arthritis
- ___ Chronic pain
- ___ Muscle aches
- ___ Neck pain
- ___ Back pain
- ___ Arm pain
- ___ Knee/leg pain
- ___ Night pain
- ___ Jaw problems

Skin
- ___ Eczema
- ___ Dermatitis
- ___ Excessive sweating
- ___ Rashes
- ___ Brittle nails
- ___ Hair loss
- ___ Increased bleeding
- ___ Easy bruising
- ___ Numbness/tingling
- ___ Cold sweats

Genitourinary
- ___ Uterine fibroids
- ___ Ovarian cysts
- ___ Cancer (breast, ovarian, prostate,uterine)
- ___ Prostate problems

Emotional/Mental
- ___ Depression
- ___ Anxiety
- ___ Mood swings
- ___ Irritability
- ___ Memory loss
- ___ Confusion
- ___ Nervousness

Energy
- ___ Fatigue
- ___ Hyperactivity
- ___ Restlessness
- ___ Insomnia
- ___ Decreased libido
- ___ Stress
- ___ Tension

Weight
- ___ Decreased appetite
- ___ Weight gain
- ___ Inability to lose weight
- ___ Food cravings
- ___ Binge eating
- ___ Water retention
- ___ Sudden weight loss

Allergies
- ___ Hives
- ___ Runny nose
- ___ Itchy/Watery eyes
- ___ Congestion

___ **None of the above**

Functional Rating Index

In order to 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 one which most closely describes your condition ***right now***.

Pain Intensity

No pain	*Mild pain*	*Moderate pain*	*Severe pain*	*Worst possible pain*

Sleeping

Perfect sleep	*Mildly disturbed sleep*	*Moderately disturbed sleep*	*Greatly disturbed sleep*	*Totally disturbed sleep*

Personal Care (washing, dressing, etc.)

No pain with no restrictions	*Mild pain with no restrictions*	*Moderate pain; need to go slowly*	*Moderate pain; need some assistance*	*Severe pain; need 100% assistance*

Travel (Driving, etc.)

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*

Work

Can do usual work plus unlimited extra work	*Can do usual work with no extra work*	*Can do 50% of usual work*	*Can do 25% of usual work*	*Cannot work*

Recreation

No pain	*Mild pain*	*Moderate pain*	*Severe pain*	*Worst possible pain*

Frequency of pain

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*

Lifting

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*

Walking

No pain with any distance	*Increased pain after 1 mile*	*Increased pain after 1/2 mile*	*Increased pain after 1/4 mile*	*Increased pain with all walking*

Standing

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*

HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Patient Signature_____ **Date**_____

Authorization and Assignment

Please initial next to each line that applies to you. Thank you.

___**AUTHORIZATION TO RELEASE INFORMATION (*if applicable):*** You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

___**ASSIGNMENT OF PAYMENT (*if applicable*):** My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any money due to him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that is not covered by my policy or if for any other reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

___**MEDICARE ASSIGNMENT (*if applicable*):** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

___**ACKNOWLEDGEMMENT AND UNDERSTANDING:** I hereby acknowledge;

A. That there is no insurance company obligated to pay for the services, or if the insurance company involved, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or
B. If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Total Heath Systems P.C., will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

Patient Signature_____ **Date**_____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, ACUPUNTURE, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE. I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Northwest Health Center DBA: Momentum Health Center. I understand and am informed that, while extremely rare, there are some risks to treatment, including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient Signature_____ **Date**_____

Parent/Legal guardian name (please print)_____

Guardian Signature_____ **Date**_____

momentum
health center

Insurance Responsibility of Payment Agreement

I, _____, agree that Momentum Health Center is helping me by billing my insurance for me. It has been explained that if the service of acupuncture is not covered, even after prior benefits confirmations, I will be held responsible for any remaining balance. Also, I will reimburse Momentum Health Center if the insurance company decides at a later date that acupuncture is considered experimental of some other reason, and they decide they want the money back from the office. If this happens, I know I am responsible for the services I have already received. Normal cash amounts for acupuncture services are $100 for the first visit and $80 for an hour for visits after. There is a $35 cancelation fee if you do not cancel your appointment within 24 hours.

Patient Name-Printed_____

Patient Name-Signed_____

Date: _____

Office Manager-Printed_____

Office Manager –Signed_____

Date: _____