



Plasker Chiropractic & Functional Neurology

Adult Intake Form

Name _____
Date _____
Address _____
City _____ State ____ Zip _____
Phone: (H) _____ (W) _____
E-mail _____
Date of Birth _____ (Age _____)

Occupation _____
Employer _____
Marital Status S M D W
Spouse's Name _____
Spouse's Occupation _____

Whom may we thank for referring you to our office? _____
Our goal is to bring better health to our community. The best way for us to reach others is through word of mouth & satisfied patient referrals. The greatest compliment a patient can give us is a referral of friends and family.

Please tell us your top 3 health goals:

- 1. _____
- 2. _____
- 3. _____

Current Health Condition

What concerns/conditions do you feel we can address for you?

Pain or Problem started on _____
Pains are: Sharp Dull Constant Intermittent
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
Has this condition STAYED THE SAME GETTING BETTER GETTING WORSE
Other Doctors seen for this condition _____
Any home remedies? _____

Please check any other symptoms you have currently or have had in the past:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pins & Needles in legs/feet | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Numbness in legs/feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Jaw pain/TMJ | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Menstrual cramps |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Shldr/arm pain/tightness | <input type="checkbox"/> Cancer | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Facial twitch | <input type="checkbox"/> Pins & Needles in arm/hands | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Pain in legs/feet | <input type="checkbox"/> Nervousness | |
| <input type="checkbox"/> Ear ache | | | |

Please describe any previous care you have received for this condition?

Please list your current medications both prescription and over the counter:

What major and minor surgeries have you had? Include dates _____

What accidents have you had (ex. Motorcycle, car, bicycle, sports, slips/falls) at work or at home? Include dates: _____

Were you ever knocked unconscious? YES NO

What fractures or broken bones have you had? Include dates: _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>				
Mother's Side	<input type="checkbox"/>				

Your oldest grandparent on record lived to the age of _____.

Still living Deceased

Current Health:

How do you describe your current health? _____

How would you describe your family's health? _____

Describe your: Vision: _____ Hearing: _____ Coordination: _____

Do you consume any of the following? TOBACCO ALCOHOL COFFEE/TEA SODA MILK

Level of stress in your life: MILD MODERATE EXTREME Rating of stress: 1 2 3 4 5 6 7 8 9 10

Have you been exposed to any of the following on a regular basis, (past or present)?

TOXIC CHEMICALS SECOND HAND SMOKE RADIATION CHEMOTHERAPY DRUG THERAPY

Other: _____

Are you presently under any type of therapeutic care? _____ What type? _____

Have you ever received Chiropractic care? Y N

Name of D.C. _____

How long under care? _____

Date of last visit: _____ Why did you stop, if you did? _____

You deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of health can be interfered with. Through the examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

The information I have provided on this form is true and accurate to the best of my knowledge. I give Plasker Chiropractic & Functional Neurology permission to consult, program, and advise according to their expertise and experience.

Signature _____ Today's Date _____

Signature of Parent (for minor): _____ Today's Date _____

**Thank you for choosing Plasker Chiropractic & Functional Neurology.
We look forward to doing an evaluation and determining how we can best serve you.**

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Office Fee Schedule and Financial Policy

<u>Service</u>	<u>Fees</u>
Consultation	\$0
Initial Chiropractic Exam	\$195
Re-examination	\$35
Adjustment	\$55
Functional Neurology Exam	\$350
Functional Neurology Therapy (15 min)	\$90

Financial Policy and Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange an Active Life Plan in advance. These plans are designed to be the most cost-effective way to keep you and your family as healthy as possible. They include your Crisis Care, Critical Transition and Lifestyle Care Options. Details of these plans will be discussed with you during your Chiropractic Report. Please choose one of the following documentation options:

- Insurance:** If you have insurance that covers chiropractic, we will give you all of the information you need to get reimbursed quickly. This includes your diagnosis, prognosis and copies of your records or reports. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your first visit and then once a month after that. Just send your receipts with a copy of your claim form to your insurance company, and they will communicate with you about your reimbursement. Remember your agreement with your insurance company is between you and them. Please note that many insurance policies may not reimburse for Critical Transition or Lifestyle Care.

- No Insurance:** If you do not have health insurance, choose not to use your health insurance or are participating in Lifestyle Care, you may request a receipt for tax purposes or a Health Savings Account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

If a special situation arises, such as an auto accident or a worker's compensation injury, a new examination will need to be performed and you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims.

I, (name) _____ have read and I understand the above policies. I have initialed the option that applies to me.

Patient signature

Date

Cancellation Policy & Procedure

At Plasker Chiropractic, our goal is to provide you with quality care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of chiropractic and functional neurology care.

Please be courteous and notify us promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of care. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely care.

- Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, will be subject to a Cancellation fee of the full cost of the appointment. In the event of an actual emergency when prior notice cannot be given, consideration will be held, and a one-time exception may be granted.
- These fees are not covered by insurance and is therefore the sole responsibility of the patient.

To cancel or reschedule appointments call our office at (458) 206-3461. If we are unable to answer the phone, you can leave a message with your name, appointment date and cancellation reason or request for rescheduling.

Patient Signature _____

Date _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____



Plasker Chiropractic and Functional Neurology, LLC

Patient Name: _____ Date of Birth: _____

I acknowledge that I received and/or reviewed a copy of Plasker Chiropractic and Functional Neurology's Notice of Privacy Practices.

I give permission to communicate messages in the following manner:

____ You may leave a message on my answering machine located at this number _____

____ You may leave a message on my cell phone _____

____ You may leave a message with my spouse, _____ at this number _____

____ You may leave a message with another person, _____ at this number _____

____ You may email me regarding my health care at _____

I give permission to communicate messages about the following via phone or email:

____ X-rays, and other test results

____ Billing or insurance matters

Patient Signature

Date