Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Emergency Contact:_____

Phone number: _____

Name: _____ **Date:** _____

Insurance: _____ (dd/mm/yr)

Date of Birth: _____ ☐ **male** ☐ **female**

Address: _____

_____ **Marital status**

SSN#: _____ - _____ - _____

S	M	W	D	SEP

Phone #: home: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow

☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____ Length of cycle: _____

Date - 1st day last period: _____

Are you pregnant? ☐ yes, ☐ no

If yes, how many months? _____

How many children do you have? _____

Birth control method: _____

Date of last PAP test: _____

☐ normal, ☐ abnormal

Date of last mammogram: _____

☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

_____

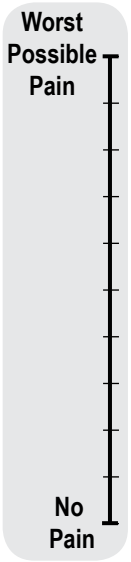
How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

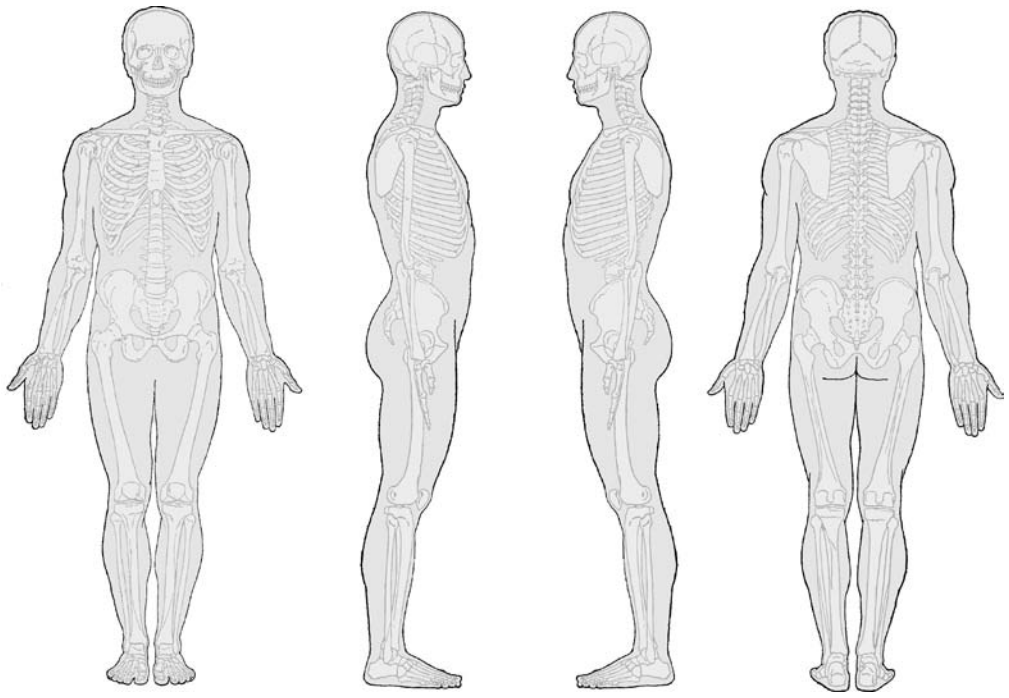
Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

Patient Signature: _____ Date: _____

Arctic Chiropractic and Physical Medicine
2050 Sea Level Dr Ste 106
907-225-7246

Consent to Treat:

I hereby request and consent to the performance of chiropractic examination, adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Tomcykoski, Dr. Grounds, and/or other licensed doctors of chiropractic who now or in the future work at Arctic Chiropractic and Physical Medicine Ketchikan.

I understand that I will have an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. By signing below, I agree to the examination and any procedures the chiropractic physician deems necessary. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient or Guardian _____ Date _____

Financial Responsibility:

I understand that I am responsible for payment to Arctic Chiropractic and Physical Medicine Ketchikan. If I am requesting for my insurance to be billed, I understand that Arctic Chiropractic and Physical Medicine Ketchikan will attempt to verify my coverage to inform me of my portion of the financial responsibility, however, they will not be able to obtain a guarantee of payment from the insurance company. If my insurance company does not pay, I will be financially responsible to pay for all services rendered by Arctic Chiropractic and Physical Medicine Ketchikan.

Signature of Patient or Guardian _____ Date _____

HIPAA Consent Form

HIPAA – Notice of Privacy Practices

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Arctic Chiropractic and Physical Medicine Ketchikan LLC may use or disclose your health information. The Notice also explains the rights that you are guaranteed under HIPAA regulations.

Though Arctic Chiropractic and Physical Medicine Ketchikan LLC has always taken great care to protect the integrity and confidentiality of your health information, we are now required by the HIPAA Privacy Rule to distribute the notice to you and obtain acknowledgement that you have received the notice.

Signing below indicates that you have received the Notice of Privacy Practice. If you have any questions, please contact our HIPAA Compliance Officer below:

Arctic Chiropractic and Physical Medicine Ketchikan
Attn: HIPAA Compliance Officer
2050 Sea Level Dr Ste 106
Ketchikan, AK 99901

I hereby acknowledge that I have received a copy of Arctic Chiropractic Ketchikan's Notice of Privacy Practices.

_____ _____

Signature of Patient/ Guardian (if Guardian, please provide relationship to patient) *Date*

I, _____ give permission to Arctic Chiropractic Ketchikan LLC to discuss the following medical information about me (check all boxes that apply):

☐ Scheduling/Appointment information

☐ Medical information, including my symptoms, diagnosis, medications and treatment plan

☐ Billing and Payment information

Arctic Chiropractic Ketchikan has my permission to discuss this information with:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Consent to bill Insurance plan(s)

By my signature below, I authorize Arctic Chiropractic Ketchikan LLC to bill my insurance company for the medical services provided to me. I authorize payment directly to my doctor and I permit this form to be used as "Signature On File" for all my insurance submissions. I understand that in order to obtain payment, my doctor may share exchange health information which may include diagnosis, service dates, types of services and other information that is necessary to process my claims. I understand that if payment is made directly to me for services provided by Arctic Chiropractic Ketchikan LLC, I am responsible for immediately sending such payments to the clinic. I am responsible to notify Arctic Chiropractic Ketchikan LLC of any changes in my health insurance coverage, as well as any denial information. I understand that I AM RESPONSIBLE for payments to Arctic Chiropractic Ketchikan LLC for charges regardless of my insurance coverage. I also understand that in the event my insurance company denies payment, I am responsible for the balance in full. I am aware that I am responsible for any co-payments and/or yearly deductible as specified under my insurance contract.

_____ _____

Signature of Patient/ Guardian (if Guardian, please provide relationship to patient) *Date*

Updated Massage Therapy Policies

As part of our commitment to provide the best service to our patients and out of consideration for our therapists' time, we have adopted the following policies, effective March 15, 2019.

Arrival Policy:

We ask that all massage therapy patients arrive at least 5 minutes prior to their scheduled appointments to complete any necessary paperwork, use the restroom, etc. Arrivals of more than 5 minutes after the scheduled appointment time will be considered a no-show and will need to be rescheduled.

Cancellation Policy:

Due to an increase in last-minute cancellations and no-shows, we are implementing a 24-hour cancellation limit. A $40 fee will be charged to patients who do not show up to their scheduled appointments and do not call ahead of time to cancel. For those who do not give 24 hours' notice prior to cancelling their appointment, we will do our best to fill that time slot, however, if we are unable to do so, a fee of $25 will be charged for the late cancellation. After 3 no-show appointments, we will no longer be able to schedule a patient for massage therapy.

The ONLY exception to these policies will be for medical emergencies, death in the family or severe weather. We apologize for any inconvenience this may cause as we realize emergencies do happen, however we value our massage therapists tremendously and late cancellations/no shows takes business away from them.

Perfume/heavy odors:

We have several patients and staff members with severe sensitivities to certain fragrances. We ask that any patient that is receiving treatment refrain from wearing perfume or any heavy fragrance to their appointments. In addition, we ask that patients refrain from smoking immediately before their scheduled appointment times.

We value and appreciate all our patients and hope that these policies will allow us to better serve them. Thank you for choosing Arctic Chiropractic and Physical Medicine for your health and wellness needs.

I have received a copy of the above policies and agree to comply with them.

Patient's Name: _____ Date: _____

Patient's (or Parent/Guardian's) Signature: _____

Arctic Chiropractic and Physical Medicine Ketchikan

Office Policies (effective 1/1/2020):

- Fragrance-free office: As we have patients and staff that are sensitive to odors, please refrain from wearing fragrance on days of appointments. In addition, please refrain from smoking immediately prior to visits, and assure that clothing has no excessive odor build-up. _____

- Promptness: Please arrive 5 minutes before your scheduled appointment time to fill out any necessary paperwork, use the restroom, etc. We value your time and strive to remain on schedule. As any late arrivals may result in an inability to stay on schedule, or insufficient time to accomplished. _____

- No cell phone usage in the office: We ask that all phones are placed in silent mode upon entering the office, and no phone calls are taken while in the waiting area or any treatment rooms. If tablets are being used, please use earphones. _____

I understand the above policies and agree to comply with them while in the office.

Signature: _____ Date: _____

Patient Name: _____