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: _____

_____

_____

_____

_____

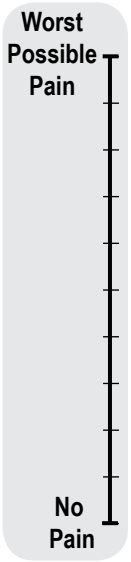
How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

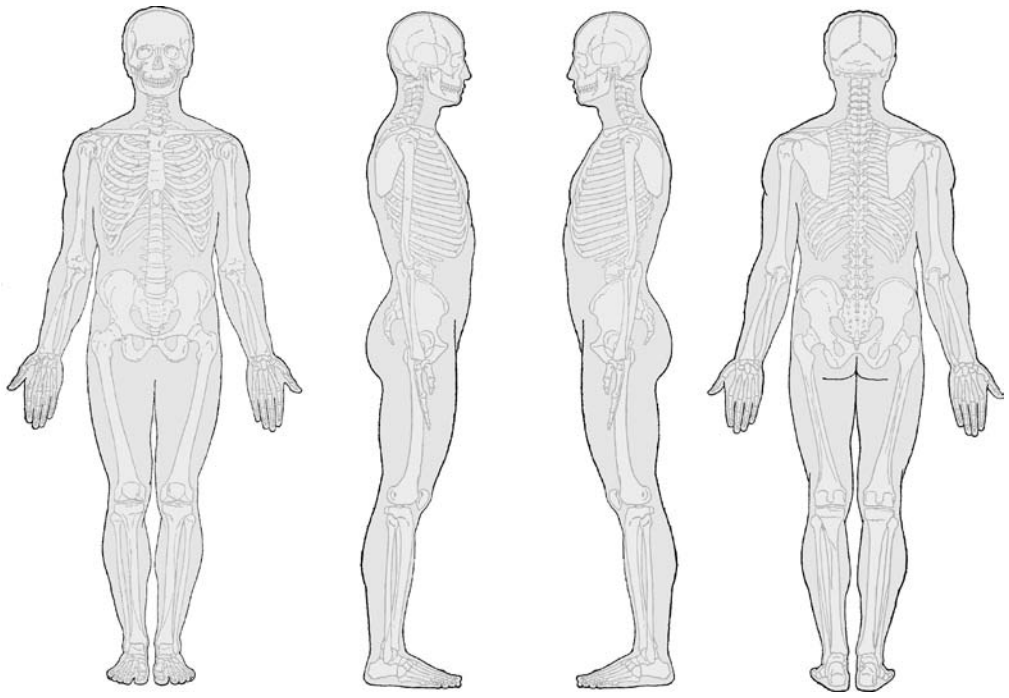
Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

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: _____

Physical Therapy Consent Form

For PT services rendered by Arctic Chiropractic and Physical Medicine Ketchikan

Patient Name: _____ Date of Birth: _____

First MI Last

Address: _____

Street Address/Apt.# City State Zip Code

Home Phone Number: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Referring Physician: _____

1. I, the patient, (or, _____, parent/guardian for the patient) do hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatments sought by myself and/or as ordered by a physician or their assistants.
2. I understand that I have the opportunity to discuss with the doctor of physical therapy and/or the other office personnel the nature and purpose of physical therapy treatments and other procedures.
3. I understand that results are not guaranteed.
4. I understand that I am responsible for understanding my insurance plan's policy on co-pays, deductibles, or provider information that pertain to my physical therapy treatment at ARCTIC CHIROPRACTIC AND PHYSICAL MEDICINE KETCHIKAN.
5. I authorize payment directly to ARCTIC CHIROPRACTIC AND PHYSICAL MEDICINE KETCHIKAN of the benefits otherwise payable to me but not to exceed the regular charges for this treatment period. If I have sought litigation due to my injury and refuse to provide adequate insurance information, I understand that I am required to pay ARCTIC CHIROPRACTIC AND PHYSICAL MEDICINE KETCHIKAN at the time of each treatment. I also understand that if I have filed a worker's compensation claim and that claim is denied, I will then be responsible for payment of services provided at ARCTIC CHIROPRACTIC AND PHYSICAL MEDICINE KETCHIKAN, including all charges not covered by my insurance
6. I hereby authorize ARCTIC CHIROPRACTIC AND PHYSICAL MEDICINE KETCHIKAN to release medical information regarding myself and my current condition to my insurance company for purpose of payment and/or quality reviews, as well as referring, consulting, treating physicians or other medical providers as needed to support continuity of care. This authorization will remain valid until revoked in writing.
7. I consent to the use of still photography and/or video analysis as a component of my physical therapy services. These will be used only as necessary for my plan of care, and I will be made aware that these photos or videos are being taken. These photos, video tapes, or CDs are part of my medical record and cannot be reproduced or used otherwise, without my written consent.
8. I have seen or can receive a copy of the ARCTIC CHIROPRACTIC AND PHYSICAL MEDICINE KETCHIKAN Note of Privacy Practices upon request. In addition to my insurance company and referring physician, the following individuals may have access to my medical information: _____.
9. I have read this form and certify that I understand its contents as of this date.

_____

Signature of patient or parent/guardian Date

_____

Witness if patient is a minor 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*

Physical Therapy Policies

As part of our commitment to provide the best service to our patients and out of consideration for our providers' time, we have adopted the following policies, effective April 18th, 2024.

Arrival Policy:

We ask that all physical 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. After three no-show/cancellations have been accumulated, the patient will be placed on the waitlist for scheduling, and a new referral from their doctor may be required. Should a patient accumulate further no-shows/cancellations after resuming care with us, the patient will be released from care.

The ONLY exception to these policies will be for medical emergencies, death in the family, severe weather, or other emergency situations. We apologize for any inconvenience this may cause as we realize emergencies do happen, however late cancellations/no shows reduces our availability to help other patients.

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: _____