Patient Confidential Health Record—Intake Form

Please Take A Moment To Fill Out The Following:

Name _____ Social Security # _____ Date ____/____/_____

Gender: M / F Age _____ DOB _____ Email _____

Address _____ City _____ State _____ Zip _____

Mobile # _____ Home # _____ Work # _____

Occupation _____ Employer _____ Referred By _____

Marital Status: Married Single Widowed Divorced Partnered Spouse's Name _____

Emergency Contact Name _____ Emergency Contact Number _____

Have you been to a chiropractor before? Y / N If yes, how did you respond? _____

Medicare Yes_____ NO_____

Please Describe Your Presenting Condition And How It Began: Date Problem Began: ____/____/_____

_____

_____

In the scale below, indicate the current intensity of your symptom(s). If the symptom level varies, please indicate a range of levels:

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10

NO Symptoms — Worst Imaginable Symptoms

How often are your symptoms present?	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Intermittently
Describe your CURRENT pain/symptom(s):	☐ Sharp ☐ Dull ☐ Numb ☐ Other:	☐ Throbbing ☐ Sore ☐ Shooting	☐ Aching ☐ Weak ☐ Burning	☐ Stabbing ☐ Gripping ☐ Tingling
Since it began, is your symptom(s):	☐ Improving	☐ Getting Worse	☐ No Change	
What makes the symptom(s) better?	☐ Nothing ☐ Exercise ☐ Other:	☐ Lying Down ☐ Sitting	☐ Walking ☐ Movement	☐ Standing ☐ Inactivity
What makes the symptom(s) worse?	☐ Nothing ☐ Exercise ☐ Other:	☐ Lying Down ☐ Sitting	☐ Walking ☐ Movement	☐ Standing ☐ Inactivity
Can you perform your daily activities at home?	☐ Yes	☐ Yes, but with help	☐ Not at all	
Do you exercise?	☐ Intensely	☐ Frequently	☐ Occasionally	☐ Rarely/Never
Describe your job requirements:	☐ Sedentary	☐ Light labor	☐ Heavy labor	☐ Varies
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all	
Describe your stress level	☐ None to mild	☐ Moderate	☐ High	☐ Very High

Patient Signature: _____ Date: ____/____/_____

(Guardian must sign for all patients 17 years old or younger)

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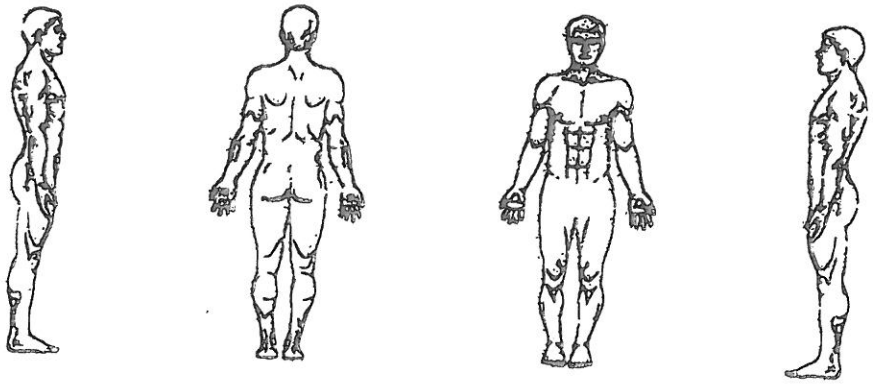
Pain Diagram: Please circle the area(s) where you have pain or other symptoms. Include symptoms of pain, numbness and/or tingling.



Review of Systems: If you have ever had a listed symptom in the past, please check that symptom in the *Past Column, "P"*. If you are presently troubled by a particular symptom, check that symptom in the *Current Column, "C"*. Knowledge of these conditions may influence the type of treatment/therapy you receive.

P	C	General
☐	☐	General Fatigue
☐	☐	Neck Pain
☐	☐	Shoulder Pain R / L
☐	☐	Pain in Upper Arm Or Elbow R / L
☐	☐	Hand Pain R / L
☐	☐	Wrist Pain R / L
☐	☐	Pain in Upper Leg Or Hip R / L
☐	☐	Pain in Lower Leg Or Knee R / L
☐	☐	Pain in Ankle Or Foot R / L
		Neurologic
☐	☐	Epilepsy
☐	☐	Tingling Sensation
☐	☐	Numbness
☐	☐	Weakness
☐	☐	Muscular Imbalance
		Muscle/Bone
☐	☐	Swelling/Stiffness
☐	☐	Muscle Ache
☐	☐	Fracture
☐	☐	Dislocation

P	C	G-I System
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Kidney/Gall Stone
☐	☐	Liver/Gallbladder Problems
☐	☐	Abdominal Pain
☐	☐	Kidney Disorders
☐	☐	Prostate Problems
☐	☐	Difficulty Swallowing
☐	☐	Heartburn Or Indigestion
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Irritable Bowel
☐	☐	Colitis
☐	☐	Excessive Thirst
		Skin
☐	☐	Dermatitis/Eczema
☐	☐	Rash
☐	☐	Brittle Nails
☐	☐	Changes In Moles
☐	☐	Peeling

P	C	Vascular
☐	☐	Aortic Aneurysm
☐	☐	Anemia
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Blood Disorder
☐	☐	Ankle Swelling
☐	☐	Cold Feet/Hands
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	High Cholesterol
		Female
☐	☐	Endometriosis
☐	☐	Profuse Menstrual Flow
☐	☐	Irregular Menstrual Flow
☐	☐	Breast Lumps
☐	☐	Breast Soreness
☐	☐	Birth Control Pills

P	C	Head
☐	☐	Jaw Pain
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headaches
☐	☐	Headache Unlike Ever Before
☐	☐	Tinnitus (Ear Ringing)
☐	☐	Head Trauma
☐	☐	Dentures
☐	☐	Migraines
		G-U System
☐	☐	Bladder Infection
☐	☐	Bladder Control Loss
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Constipation/Irregular Bowel Habits
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Blood in Stool

P	C	Conditions
☐	☐	Cancer/Tumor
☐	☐	Arthritis
☐	☐	Diabetes
☐	☐	Depression
☐	☐	HIV/AIDS
☐	☐	Thyroid Condition
☐	☐	Osteoporosis
☐	☐	Alcoholism
☐	☐	Polio
☐	☐	Parkinson's
☐	☐	Multiple Sclerosis
☐	☐	Gout
☐	☐	Psychiatric Care
		Lungs
☐	☐	Emphysema
☐	☐	Difficulty Breathing
☐	☐	Chronic Cough
☐	☐	Sinus Problems
☐	☐	Wheezing
☐	☐	Asthma

Patient Signature: _____ Date: ___/___/_____

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Family History: Please check the boxes of the conditions that apply to your family.

	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Mother	Father	Brother	Sister	Age of Onset	Description
Arthritis (type?)	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Cancer (type?)	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Heart Problems	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Lung Problems	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
Mental Disease	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	_____	_____

Lifestyle Factors: Please complete the following information regarding your lifestyle.

Tobacco: _____ packs/day for _____ years Alcohol: _____ glasses/day Coffee/Tea/Caffeinated Soft Drinks: _____ glasses/day

Recreational Drugs: _____ Exercise: _____ hours/week Water: _____ glasses/day

Average Sleep Quality: _____ hrs. sleep/night My Sleep Is: ☐ Restful ☐ Restless ☐ Wake up often ☐ Hard to get sleep

Present Weight: _____lbs. Present Height: _____ I have had recent ABNORMAL: ☐ Weight Gain ☐ Weight Loss

Do you have a permanent disability rating? Yes/No Location: _____ Rating: ____% Date Received: ___/___/_____

What treatment(s) have you had for this condition in the past (surgery, medications, injections, PT, chiropractic)?

_____

Have you had X-rays, MRI or other tests for this condition? What tests and when?

_____

Please list the medications you are currently taking:

_____

_____

Please list any reasons and dates for hospitalizations/surgeries: _____

_____

General Understandings:

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I, the undersigned, consent to chiropractic care in this office.

I clearly understand and agree that I am responsible for payment of any and all services rendered to me at the time of my visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. Patients with group or individual insurance are responsible for any unpaid balance in the event their insurance either does not cover chiropractic or is terminated during treatment.

Regarding the national Health Information Portability and Accountability Act (HIPAA): All information that is obtained from you by this office is protected and kept confidential in accordance with HIPAA mandated standards. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced. Our HIPAA policy is not a contract, authorization, release, or form of consent. A copy of our HIPAA policies is presented to you at the time of your initial evaluation. You may request a paper or electronic version of these policies at any time. The signature below acknowledges that you have read and been offered a copy of this office's Notice of Privacy Practices.

Patient Signature: _____ Date: ___/___/_____

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Pathways to Healing, LLC
Dr. Ramona D. Warren
1022 Founders Row
Greensboro, GA 30642
709-454-2040

Office Policy

Dr. Ramona Warren's practice is served by a highly dedicated staff. Our objective is to enhance health by providing unique and cost-effective care.

Clearly defining our office policies allows both patient and doctor to concentrate on regaining and maintaining optimal health.

Appointment Times: Appointments are required. This maximizes the time spent with the doctor. If you are late, you may have to wait for the next available opening ore reschedule. We do attempt to honor all appointments at the scheduled time. Multiple appointment scheduling is recommended to minimize waiting and facilitate incorporating these appointments into your daily routine.

Missed Appointments: Keeping your appointment schedule is extremely important. Frequency of visits counts. Therefore, it is your obligation to make-up missed appointments within 24 hours of any cancellation. Dr. Warren's practice reserves the right to charge for missed appointments if we are not notified within 24 hours of your scheduled appointment time.

Referrals: The greatest honor a patient can give their doctor is the referral of their family and friends so they experience the benefits of our Holistic Approach to Chiropractic and Health Care. We promise to give you family and friends the same quality of care, love and attention that you receive.

Financial Policy

Payment is expected when services are rendered. We accept cash, checks, Visa, Discover, MasterCard and Debit cards. There will be a $25 fee for any returned checks. We will provide you with a form that you can file with your insurance company. Wellness care quotes are available upon request. There is a fee charged for any reports required by any third-party members. Patients may not carry a balance at any time.

If through some set of circumstances a patient has an account balance: interest on the unpaid balance will be charged at the rate of one half of one percent per month and administrative expenses associated with account maintenance and collection will be charged.

I have read and understand the above policies and agree to abide by them.

Patient Signature:_____ Date:_____

Terms of Acceptance

Chiropractic:

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both the patient and the doctor to the working toward the same objective. Chiropractic has only one goal- remove nerve interference. It is important that each patient understand both the objective and the method that will be used to attain the objective. This will prevent any confusion or disappointment.

Analysis:

1. Vertebral Subluxation: A misalignment of one of the 24 vertebrae 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 it's maximum health potential.
2. Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of the vertebral subluxation.
3. Health: A State of optimal physical, mental, and social well-being, not merely the absence of disease or symptoms.

Diagnosis:

We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for these 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 the interference to the expression of the body's innate wisdom. This interference may be in the form of a structural, chemical, or energetic stress that must be removed for healing to take place.

Informed-Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures if necessary diagnostic x-rays on me by the doctor of chiropractic named below and/or anyone authorized by the same doctor I further understand and am informed that, as in all health care, there are some slight risks to treatment and do not expect the doctor to he able to anticipate or explain all risks. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. I have read the consent and intend this consent form to cover the entire course of my care this condition and any care in the future.

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._____ Date _____
(Signature)

WITNESS: _____ Date:_____

Consent to evaluate and adjust a minor child

I _____ 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 chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and her partners have permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period_____.

Signature_____ Date_____