BASLER
FAMILY CHIROPRACTIC
The place for families

ADULT INTAKE FORM

Date: _____

PERSONAL INFORMATION

First Name: _____ M.I: _____ Last Name: _____

Preferred Name: _____ Social Security Number: _____

Birth Date: _____ Age: _____ Sex: ○M ○F

Address: _____

Email: _____ Cell Phone: ( ) _____

Cell Phone Provider (For Text Reminders): _____

May we send you occasional cards, letters, or emails to you as an extension of care in this office? ○Y ○N _____ Initial

Occupation: _____ Employer's Name: _____

Marital Status: ○S ○M ○D ○W ○Other Spouse's Name: _____

# of Children: _____ Children's Names & Ages: _____

_____

Emergency Contact Name: _____ Phone #: ( ) _____

Who can we thank for referring you or how did you hear about Basler Family Chiropractic?

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Basler Family Chiropractic?

_____

When did this begin? (If applicable) _____

Are there any major injuries, hospitalizations, and/or surgeries we should know about?

_____

What is this affecting that is MOST important in your life? (List all that apply)

_____

Have you seen any other providers for this condition? (List all that apply)

_____

Have you seen a chiropractor before? ○Yes ○No

How long ago? _____ Clinic/Doctor Name: _____

What is your reason for the change? (If applicable) _____

What is your level of commitment to yourself and your health? 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

Explain: _____

What health goal, if you were to complete of accomplish it, would have the greatest impact on your life?

_____

_____

Please Turn Over

Name:_____ D.O.B._____

HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Digestive Troubles
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Hypertension
- ☐ Arthritis
- ☐ Loss of Balance
- ☐ Neck/Back Pain
- ☐ Pain in Arms/Legs
- ☐ Irritability
- ☐ ADD/ADHD
- ☐ Fatigue/Sleep Issues
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Sensitivity to Light
- ☐ Loss of Concentration
- ☐ Memory Problems
- ☐ Headaches
- ☐ Stiffness/Flexibility
- ☐ Sinus Troubles/Allergies
- ☐ Cold Hands/Feet
- ☐ Other/Explanation: _____

_____

_____

Did You Know . . .

Each health concern relates to a specific area of the spine and nervous system? Your doctor will review each area in your doctor's report.

FAMILY HISTORY

Does anyone in your family suffer with the same conditions?

☐ Yes ☐ No

If yes, whom: ☐ Grandmother ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Son(s) ☐ Daughter(s)

Have they ever been treated for their condition?

☐ Yes ☐ No ☐ I don't know

Any other hereditary conditions the doctor should be aware of?

☐ No ☐ Yes

CURRENT MEDICATIONS & VITAMINS/SUPPLEMENTS

Current Medications: _____

Vitamins/Supplements: _____

REVIEW OF SYSTEMS

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have**.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck Pain	○	○	Back Problems
○	○	Hip Disorders	○	○	Knee Injuries	○	○	Foot/Ankle Pain	○	○	Shoulder Problems	○	○	Elbow/ Wrist Pain
○	○	TMJ Issues	○	○	Poor Posture									

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and Needles
○	○	Numbness												

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	High Blood Pressure	○	○	Low Blood Pressure	○	○	High Cholesterol	○	○	Poor Circulation	○	○	Angina
○	○	Excessive Bruising												

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay Fever	○	○	Shortness of Breath
○	○	Pneumonia												

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anorexia/Bulimia	○	○	Ulcer	○	○	Food Sensitivities	○	○	Heartburn	○	○	Constipation
○	○	Diarrhea												

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Blurred Vision	○	○	Ringing in Ears	○	○	Hearing Loss	○	○	Chronic Ear Infection	○	○	Loss of Smell
○	○	Loss of Taste												

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Skin Cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair Loss
○	○	Rash												

Name:_____ D.O.B._____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Caring for Families	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Grocery Shopping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting to Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bending Over	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving Car	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

X-RAY CONSENT FOR WOMEN OF CHILDBEARING AGE

X-ray examination of the abdomen and pelvis expose the uterus to radiation. The last ten days following onset of the menstrual cycle are generally considered safe for x-ray examination.

Date of onset of last menstrual period: _____

I am pregnant: ○Yes ○No

I had a hysterectomy: ○Yes ○No

I use an IUD: ○Yes ○No

I recognize that if I am pregnant and have radiation to the abdomen, there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this examination is important to my health. I therefore wish to have this x-ray examination performed now.

Patient signature: _____ Date: _____

Guardian signature: _____ Date: _____

Witness signature: _____ Date: _____

Please Turn Over

INFORMED CONSENT

I hereby authorize doctors and staff at Basler Family Chiropractic to treat my condition as deemed appropriate. At Basler Family Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Basler Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per million to one per two million, have been associated with chiropractic adjustments. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Basler Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Also, it is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private confidential setting.

Date: _____ Signature :_____

FINANCIAL POLICY

Our goal is to provide the highest quality of healthcare possible of our patients. In order to achieve this goal, we need your commitment as well. We urge our patients to follow the doctor's recommendations for care. Please keep your appointments as scheduled or call our office within 24 hours to make any changes. In order to attain the level of achievement we both desire, care must be followed.

- In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it doesn't.
- Late payment of non-coverage, deductible, and co-payment may be subject to an 18% annual finance charge, which will be added monthly to that account.
- If you have any questions about our financial policies, please ask to speak to our financial officer. If you need to make special arrangements, please ask. We will never deny care to anyone based solely on ability to pay.
- I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. This chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all service rendered to me are charged directly to me and that I am personally responsible for payment.

Date: _____ Signature:_____

Basler Family Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, **or as dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPPA'** on tables in the reception.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction..
5. To request amendments to information. However, like restrictions, we are not required to agree to them.
6. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Heather at 406-257-3004. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Basler Family Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Basler Family Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name D.O.B.

_____ _____

Patient's Signature Date

_____ _____

Witness Date

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FAMILY CHIROPRACTIC
The place for families

RESTRICTION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, understand and agree to the following points:

1. At any time if I elect to pay cash for all services rendered in this office and restrict this office/provider from sharing my Protected Health Information with my health plan, such as information to include but not be limited to my diagnosis, history, and other medical record documentation necessary for third-party payment.

2. By electing to self-pay for services, any payments I make to this office will NOT be credited toward satisfying any deductible I may be subject to under my health plan.

3. By electing to self-pay, I also understand that it is inappropriate for me to attempt to send in my receipts to my health plan for reimbursement of what I have paid, and agree not to submit them on my own.

4. I have read and understand this Restriction of Use and Disclosure of PHI, and freely choose to self-pay rather than use my health benefits. I choose to exercise my rights under the Health Insurance Portability and Accountability Act (HIPPA) to restrict this information from my health plan and pay for my services out of pocket.

Patient Name: (print) _____

Patient Signature: _____ Date: _____