Patient Intake Information | Erin K. Simpson, DC

Name:_____ Home Phone:_____

Address:_____ Work/Cell Phone:_____

City, State:_____ E-mail Address:_____

Zip:_____ Birthdate:_____

Emergency Contact Name & Relationship to You:_____

Emergency Contact Phone:_____

Who referred you to our office?_____

Financial Responsibility

Who is responsible for paying health care bills in your family? (circle one)
You Spouse Parent Other:_____

- Patients are responsible for all charges that insurance companies do not pay for (i.e. deductibles, co-payments, non-covered services).
- Payments are due at the time of services unless special arrangements have been made.

I agree to be responsible for any balance due.

Signature:_____ Date:_____

Insurance Information (if applicable)

Name of Insured:_____ Birthdate of Insured:_____

Insurance Company:_____ ID:_____

I authorize my insurance company to pay Erin K. Simpson, D.C., directly. I understand that there is no guarantee that my insurance will pay for any bills, and that I must pay directly for any unpaid balances.

Dr. Simpson is authorized to provide my health care information to my insurance company in order for them to process the claims. This signature may be used for submitting all insurance claim bills.

Signature:_____ Date:_____

Health Information

Below is a list of diseases & conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of treatment.

Check any of the following diseases you have had:

- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ Polio
- ❑ Tuberculosis
- ❑ Mental Disorder
- ❑ Measles
- ❑ Mumps
- ❑ Small Pox
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Anemia
- ❑ Thyroid
- ❑ Influenza
- ❑ Pleurisy
- ❑ Arthritis
- ❑ Whooping cough
- ❑ Heart Disease
- ❑ Eczema
- ❑ Hepatitis
- ❑ HIV/Aids
- ❑ Epilepsy
- ❑ Cancer
- ❑ Lumbago

Check any of the following you have had in the past six months:

MUSCULO-SKELETAL CODE

- ❑ Low back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm pain
- ❑ Joint pain/stiffness
- ❑ Walking problems
- ❑ Difficulty chewing/clicking jaw
- ❑ General stiffness

NERVOUS SYSTEM CODE

- ❑ Nervousness
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness/confusion
- ❑ Depression
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold/tingling extremities
- ❑ Stress

GENERAL CODE

- ❑ Fatigue
- ❑ Allergies:_____
- ❑ Loss of sleep
- ❑ Fever
- ❑ Headaches

GASTRO-INTESTINAL CODE

- ❑ Poor/excessive appetite
- ❑ Excessive thirst
- ❑ Frequent nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver problems
- ❑ Gall bladder problems
- ❑ Weight problems
- ❑ Abdominal cramps
- ❑ Gas/bloating after meals
- ❑ Heartburn
- ❑ Black/bloody stool
- ❑ Colitis

GENITO-URINARY CODE

- ❑ Bladder trouble
- ❑ Painful/excessive urination
- ❑ Discolored urine

EENT CODE

- ❑ Vision problems
- ❑ Dental problems
- ❑ Sore throat
- ❑ Earaches
- ❑ Hearing difficulty
- ❑ Stuffed nose

C-V-R CODE

- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Blood pressure problems
- ❑ Irregular heartbeat
- ❑ Heart problems
- ❑ Lung problems/congestion
- ❑ Varicose veins
- ❑ Ankle swelling
- ❑ Stroke

MALE/FEMALE CODE

- ❑ Menstrual irregularity
- ❑ Menstrual cramping
- ❑ Vaginal pain/infections
- ❑ Breast pain/lumps
- ❑ Prostate/sexual dysfunction
- ❑ Genital herpes

Females Only:

When was your last period?

_____

Are you pregnant? (circle one)

Yes No Unsure

PLEASE DO NOT WRITE BELOW THIS LINE

Diagnosis:

Patient accepted: ( ) Yes ( ) No ( ) Referred

Doctor's signature:_____

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 _____

When does it bother you? € Work € Sleep €
Other:_____

What seemed to be the initial cause?_____

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

Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Shoulder, Arm Pain
0 1 2 3 4 5 6 7 8 9 10

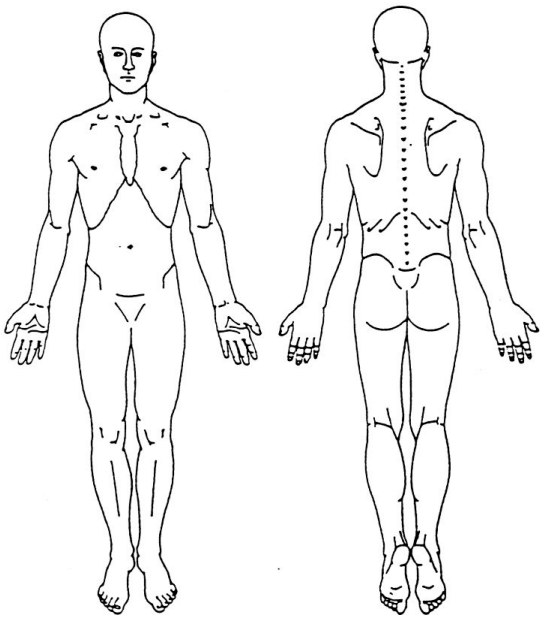
Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back Pain
0 1 2 3 4 5 6 7 8 9 10

Hip, Leg Pain
0 1 2 3 4 5 6 7 8 9 10

Foot, Ankle Pain
0 1 2 3 4 5 6 7 8 9 10

Please mark your areas of pain on the figure below:



Past Health History

Have you…	Yes	No	If yes, explain briefly:
…been hospitalized in the last 5 years?	€	€	_____
…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	€	€	€	€
Salt	€	€	€	€
Water	€	€	€	€
Sugar	€	€	€	€

Family History

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

€ Alcoholism € Bleed easily € Glaucoma € Osteoporosis
€ Anemia € Cancer € Heart disease € Stroke
€ Arteriosclerosis € Diabetes € High blood pressure € Thyroid disease
€ Arthritis € Emphysema € High cholesterol € Any other health issues we should be aware of?
€ Asthma € Epilepsy € Multiple Sclerosis _____

Patient Advisory

Physicians, chiropractors, osteopaths, and physiotherapists are required to advise their patients of the following:

In chiropractic, as in all health care, there are some slight risks, including but not limited to: muscle strains, sprains and disc injuries. There have also been incidents of injury to the vertebral artery during the course of treatment. This has caused stroke or stroke-like occurrences which are usually temporary in nature. The chances of this happening are approximately one in a million. Tests, with or without x-rays, will be performed on you to determine if you are in a risk group, and you will be informed if you are. Treatment will be amended accordingly.

Chiropractic is considered one of the safest and most effective treatments for neuro-musculoskeletal problems. If you have any questions about this, please ask your chiropractic doctor.

I have read the above statement, and consent to examination and treatment.

_____ _____

Patient's Name Signature of Patient/Guardian

Personal Health Information Consent for Purposes of Treatment, Payment and Health Care Operations

Patient's Name:_____

I have read the Practitioner's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations by Dr. Erin K. Simpson. This Notice of Privacy Practices has been provided to me.

I consent to the use or disclosure of my protected health information for the above-named purposes and those contained within the Notice of Privacy Practices.

_____ _____

Signature of Patient/Guardian Date