CTintake

Bountiful Spinal Care

535 W 500 S #1 , Bountiful, UT 84010

Phone: 801-335-7288

Patient Information:

Date		SSN		Birthday	
First Name		Middle Name		Last Name	
Sex	○ Male ○ Female	Height		Weight	
Married/Civil Union:		Spouse Name		# of Children	
Home #		Cell #		Work #	
Address					
City		State		Zip	
Emergency Contact		Emergency Relation		Emergency Phone	
Email					

Patient Social

Alcohol:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Caffeine:	○ Daily	○ Weekly	○ Occasionaly	○ Never
Diet Food Products:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Drugs:	○ Daily	○ Weekly	○ Occasionaly	○ Never
OTC Stimulants:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Exercise:	○ Daily	○ Weekly	○ Occasionaly	○ Never
Homemade Food:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Processed:	○ Daily	○ Weekly	○ Occasionaly	○ Never
Soft Drinks:	○ Daily	○ Weekly	○ Occasionaly	○ Never	Tobacco:	○ Daily	○ Weekly	○ Occasionaly	○ Never
Water:	○ Daily	○ Weekly	○ Occasionaly	○ Never					

Chiropractic Experience:

Who referred you to our office: _____

Where did you hear about us? ☐ Newspaper ☐ Sign ☐ Yellow Pages ☐ Mailing ☐ Community Event ☐ Other _____

Have you been adjusted by a chiropractor before? ○ Yes ○ No If yes, Why? _____

Doctor's Name: _____ Approximate Date of Visit _____

Employer Information:

Employed:		Employer Name			
Employer Address:					
Employer City:		Employer State:		Employer Zip:	
Occupation:		Work Supervisor:		Supervisor #:	
Work Duties:					

Reason for this Visit:

Describe the reason for this visit?

When did this concern begin? _____ Has this concern: ○ Gotten Worse ○ Stayed Constant ○ Come and Gone

Does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain: _____

Has this concern occurred before? ○ Yes ○ No

Briefly Explain: _____

Have you seen other doctor's for this concern? ○ Yes ○ No Doctor's name: _____

Type of Treatment: _____

For Women Only:

Are you pregnant? ○ Yes ○ No Are you taking birth control? ○ Yes ○ No Do you take HRT? ○ Yes ○ No

Are you nursing? ○ Yes ○ No Do you experience painful periods? ○ Yes ○ No Do you have irregular cycles? ○ Yes ○ No

Do you perform a regular self breast examination? ○ Yes ○ No Do you have breast implants? ○ Yes ○ No

Do you take oral contraceptives? ○ Yes ○ No

Date of last PAP/pelvic exam? _____ Date of last mammogram? _____ Date of Last Menstrual Period? _____

Personal Health History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: ○ Yes ○ No Date: _____ Condition(s) treated: _____

Chance Pregnant: ○ Yes ○ No Planning: ○ Yes ○ No

Medications: _____

Supplements: _____

Personal Incident History:

Broken Bones: ○ Yes ○ No Treatment: ○ Yes ○ No Explain _____

Sprains/Strains: ○ Yes ○ No Treatment: ○ Yes ○ No Explain _____

Hospitalized: ○ Yes ○ No Explain: _____

Surgery: ○ Yes ○ No Explain: _____

Auto Accident: ○ Yes ○ No Treatment: ○ Yes ○ No Explain _____

Struck Unconscious: ○ Yes ○ No Treatment: ○ Yes ○ No Explain _____

Eating Disorder: ○ Yes ○ No Explain: _____

Stroke: ○ Yes ○ No Explain: _____

Health Checklist:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Back Pain
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cataracts
- ☐ Chest Pain
- ☐ CHF
- ☐ Cold Extremities
- ☐ Constipation
- ☐ COPD/emphysema
- ☐ Cramps
- ☐ CVA (stroke/TIA)
- ☐ Dementia/Alzheimer's
- ☐ Depression
- ☐ Diabetes
- ☐ Diagnosed emotional/mental
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Gallbladder disease/stones
- ☐ Glaucoma
- ☐ Gout
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Menstrual Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Liver disease/cirrhosis
- ☐ Loss of Balance
- ☐ Loss of Memory
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Lung disease
- ☐ Macular Degeneration
- ☐ Migraines
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Retinal Disease
- ☐ Sciatica
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinus Infection
- ☐ Skin Sensitivity
- ☐ Sleep Problems/Insomnia
- ☐ Smoked
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other

_____

Have you had any of these Cardiovascular Diseases? Please select all that apply.

- ☐ Myocardial infarction
- ☐ Hypertension
- ☐ Hypercholesterolemia
- ☐ Bypass surgery
- ☐ Coronary artery disease

Do you have Diabetes? If so what type?

○ Type I ○ Type II ○ Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

- ☐ Ulcers
- ☐ Reflux
- ☐ IBS

Family Health History:

Family Health History

EHR Information:

Pefered Language _____ Smoking Status _____ Smoking Start Date _____

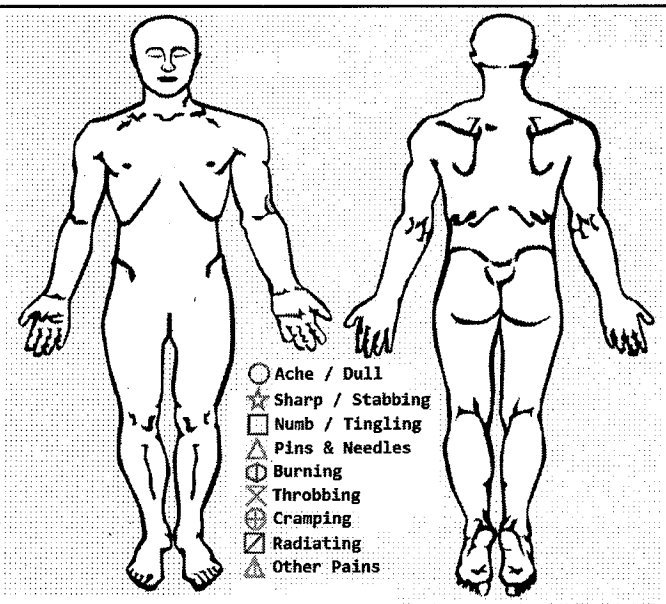
Ethinicty _____ Race _____

☐ I choose to decline receipt of my clinical summary after every visit

Current Medications And Dosage

Medication Allergies

Patient Symptoms:



TERMS OF ACCEPTANCE

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

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease, symptoms, or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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 its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than a vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual 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 a major interference of the expression of the body's innate wisdom. Our only method is specifically adjusting to correct vertebral subluxation.

INSURANCE & FINANCIAL NOTICE

I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me with payment due at the time of service unless other arrangements are made.
The doctor must bill Medicare if Medicare-covered services are provided. Reimbursement checks will then come directly to the patient. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. A SUPERBILL RECEIPT will be provided by request along with statements, reports, or other documents to help me receive reimbursement from a third party, but the doctor will not become legally involved with my insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information.
I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. Fees are subject to change. Outstanding balances will be billed monthly and considered past due 10 days after the invoice date. Returned check fees will be passed on to the patient. Balances beyond 30 days will be assessed interest at an 18% APR plus any legal or collection fees.

HIPPA NOTICE

The Practice's Privacy Notice has been made available to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law. The Practice's "Notice of Privacy Practices" is also provided in the reception area of the office. I may also request a copy from this office at any time via US Mail. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information. By signing below I have read and understand this notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

CONSENT TO TREAT & X-RAY AUTHORIZATION

I certify that I am the patient or legal guardian of the patient listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and give CONSENT TO TREAT my condition as the doctors see fit, including x-ray examination. If female, I certify that to the best of my knowledge I am not pregnant and the doctor and associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. If pregnant, I will notify the doctor and/or staff before proceeding with an x-ray exam.

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

As parent or legal guardian I have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Print Name _____ Signature _____ Date _____

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