Form Title

Patient Name

Chiropractic Intake Form Packet

Patient First Name | **Patient Middle Name** | **Patient Last Name** | **Patient Preferred Name**

Cell Phone

Sex

☐ Male ☐ Female ☐ Other

Age | **Date of Birth** | **Email Address**

Explain

Address | **City** | **State** | **Zip**

SPOUSE DATA (If applicable)

First Name | **Last Name** | **Primary Phone** | **Email**

Relationship to patient | **Date of Birth**

Address | **Address 2** | **City** | **State** | **Zip**

Occupation | **Position**

Employment Type

☐ Full - Time ☐ Part - Time

EMERGENCY CONTACT

Emergency Contact First Name | **Emergency Contact Last Name** | **Emergency Contact Phone** | **Emergency Contact Reletionship**

Review of Symptoms

What would you like to be seen for today? Please include all regions that are bothering you.

When did your symptoms begin?

Since my symptoms started, they have become:

☐ Worse ☐ Better ☐ Stayed the same

Are your symptoms a result of

☐ Motor Vehicle Accident ☐ Work related Accident ☐ Other

Other

How often do you experience your symptoms?

☐ Constantly (76-100% of the day)
☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day)
☐ Intermittently (0-25% of the day)

Does the pain radiate?

☐ Yes ☐ No

Are you pregnant?

☐ Yes ☐ No ☐ N/A

If yes, Explain

Are any of the following negatively impacted by your pain? Select all that apply:

☐ Sitting ☐ Standing ☐ Walking ☐ Driving ☐ Sleeping

☐ Lifting ☐ Twisting ☐ Turning ☐ Rising from a seated position ☐ Other

Please Describe the nature of your symptoms below, check that that apply:

☐ **Sharp** ☐ **Dull ache** ☐ **Numb** ☐ **Shooting**

☐ **Burning** ☐ **Tingling** ☐ **Stabbing** ☐ **Other**

Describe Other

Please rate your level of pain on a scale from 1-10:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Are you experiencing numbness or tingling?

☐ Yes ☐ No

Has anything at home helped your symptoms such as icing, heat, stretching, self massage?

Health History

What treatment have you already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None

Are your currently under the care of a Healthcare Provider or any other doctor?

☐ Yes ☐ No

If yes, for what

Provider's Name/Phone Number

Date of last Physical Exam

Date of last Spinal Exam

Date of last Blood Test

Date of last MRI, CT Scan Bone Scan

Date of last Spinal Xray

Please Select if you have had any of the following

- ☐ **Diabetes**
- ☐ **Epilepsy**
- ☐ **Migraine Headaches**
- ☐ **Anemia**
- ☐ **Fractures**
- ☐ **Stroke**
- ☐ **Multiple Sclerosis**
- ☐ **Thyroid Problems**
- ☐ **Arthritis**
- ☐ **Gout**
- ☐ **Osteoperosis**
- ☐ **Bleeding Disorders**
- ☐ **Heart Disease**
- ☐ **Pacemaker**
- ☐ **Tumors**
- ☐ **Growths**
- ☐ **Hernia**
- ☐ **Herniated Disk**
- ☐ **Cancer**
- ☐ **Polio**
- ☐ **High Blood Pressure**
- ☐ **Lupus**
- ☐ **Rheumatoid Arthritis**
- ☐ **High Cholesterol**
- ☐ **Prosthesis**
- ☐ **Kidney Disease**
- ☐ **Other**

Other

Exercise

☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work Activity

☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Habits

Smoking

☐ Light ☐ Moderate ☐ Heavy

Alcohol

☐ Light ☐ Moderate ☐ Heavy

Coffee/Caffeine Drinks

☐ Light ☐ Moderate ☐ Heavy

Stress Level

☐ Light ☐ Moderate ☐ Heavy

Injuries you have had

- ☐ **Dislocations**

Description

- ☐ **Head Injuries**

Description

- ☐ **Broken Bones**

Description

- ☐ **Surgeries**

Description

- ☐ **Falls**

Description

Explain:

Medications

Allergies

Vitamins/Herbs/Supplements

Do you have any other health problems/concerns not listed?

Assignment and Release

ASSIGNMENT AND RELEASE FOR INSURANCE BENEFITS

I certify that I, and or my dependent(s) have insurance coverage with and assign benefits directly to .I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office, will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable.

Name

Date of Birth

Patient's Signature

Doctor's Signature

Consent

Patients Informed Consent

I hereby give my consent to the performance of diagnostic tests and chiropractic treatment of my condition(s) on myself or on the patient named on this form, for whom I am legally responsible, by Dr. Daniel Klope, DC a licensed chiropractor at Daniel W. Klope, DC, PLLC, DBA Klope Chiropractic. Chiropractic management and treatment of conditions almost always include the delivery of a chiropractic adjustment. The doctor will use their hands or a mechanical device to place mechanical force through the tissues of your body. This may result in an audible 'pop' or 'click' and/or movement of joint surfaces. Various procedures such as soft tissue mobilization, therapeutic exercise, postural recommendations, or others may also be used as apart of your treatment. Chiropractic treatment is one of the safest methods of treating spinal problems. Still, unexpected issues can occur such as soreness/stiffness immediately after treatments and especially at the initiation of a treatment plan. Serious injuries such as fractures, sprains/disc injuries, and stroke are extremely rare with a stroke occurring less than 1 per million treatments. Bruising can also be a symptom after treatment as well, though less common, with both chiropractic or soft tissue manipulation. Dizziness, nausea, and flushing are also rare symptoms as well. It is always important to communicate with your doctor if you are having such symptoms pre, during or post treatment. Bony or soft tissue spinal conditions such as herniations, bulges or others may worsen with chiropractic treatment. I hereby give my consent for examination and treatment. --Required

Name **Date of Birth**

Patient’s Signature

Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Privacy & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health insurance. I understand that this information can and will be used to :

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.
- I acknowledge that I have reviewed your Notice of Privacy Practices of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices. I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its health professionals to communicate to other health professional such as family doctors, primary care, PT, referring physicians if deemed necessary for my treatment. I also understand that my personal and medical information is confidential and will only be disclosed with my permission.

Patient Signature

Date

OFFICIAL USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date
Initials
Reason

Patient Consent

PATIENT CONSENT FOR USE AND DISCLOSE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Klope Chiropractic, to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Klope Chirorpactic's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to singing this consent. Klope Chiropractic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Klope Chiropractic,

With this consent form myself the signed , may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory results, among others.

With this consent form, Klope Chiropractic, may mail, to my home or other alternative location, any items that assist in carrying out treatment, payment or healthcare operations such as appointment reminder cards and patient statements as long as they are marked personal and confidential. With this consent form, Klope Chiropractic, may email, to my home or other alternative location, any items that assist the practice in carrying out treatment, payments or healthcare operations such as appointment reminders. I have the right to request that Klope Chiropractic, restrict how it uses or discloses my protected health information (PHI) to carry out treatments, payments and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Klope Chiropractic ,use and disclosure of PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Klope Chiropractic, may decline to provide treatment for me.

Name

Signature

Date

Neck Pain

Neck Pain Disability Index Questionnaire

Please read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by selecting the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may apply to you but just select one.

Pain Intensity

☐ 0 - I have no pain at the moment ☐ 1 - The pain is very mild at the moment ☐ 2 - The pain is moderate at the moment

☐ 3 - The pain is fairly severe at the moment ☐ 4 - The pain is very severe at the moment

☐ 5 - The pain is the worst imagineable at the moment

Personal Care

☐ 0 - I can look after myself normally with out causing extra pain ☐ 1 - I can look after myself normally but it causes extra pain

☐ 2 - It is painful to look after myself and I am slow and careful ☐ 3 - I need some help, but manage most of my personal care

☐ 4 - I need help every day in most aspects of self-care ☐ 5 - I do not get dressed. I wash with difficulty and stay in bed

Lifting

☐ 0 - I can lift heavy weights with out extra pain ☐ 1 - I can lift heavy weights, but it causes extra pain

☐ 2 - Pain prevents me from heavy lifting, I can manage if convenient (eg on a table)

☐ 3 - Pain prevents me from heavy lifting, I can manage light lifting if convenient (eg on a table) ☐ 4 - I can lift very light weights

☐ 5 - I cannont lift or carry anything at all

Reading

☐ 0 - I can read as much as I want to with no pain in my neck ☐ 1 - I can read as much as I want to with slight pain in my neck

☐ 2 - I can read as much as I want to with moderate pain in my neck

☐ 3 - I cannot read as much as I want to because of moderate pain in my neck

☐ 4 - I cannot read as much as I want to because of severe pain in my neck ☐ 5 - I cannot read at all

Headaches

☐ 0 - I have no headaches at all ☐ 1 - I have slight headaches, which come infrequently

☐ 2 - I have moderate headaches, which come infrequently ☐ 3 - I have moderate headaches, which come frequently

☐ 4 - I have severe headaches, which come frequently ☐ 5 - I have headaches almost all of the time

Concentration

☐ 0 - I can concentrate fully when I want to with no difficulty. ☐ 1 - I can concentrate fully when I want to with slight difficulty

☐ 2 - I have a fair degree of difficulty in concentrating when I want to. ☐ 3 - I have a lot of difficulty concentrating when I want to.

☐ 4 - I have a great deal of difficulty in concentrating when I want to. ☐ 5 - I cannot concentrate at all

Work

☐ 0 - I can do as much work as I want to ☐ 1 - I can do only my usual work, but no more

☐ 2 - I can do most of my usual work, but no more ☐ 3 - I cannot do my usual work ☐ 4 - I can hardly do any work at all

☐ 5 - I cannot do any work at all

Driving

☐ 0 - I can drive my car with out any neck pain ☐ 1 - I can drive my car with slight neck pain

☐ 2 - I can drive my car with moderate neck pain ☐ 3 - I cannot drive my care as long as I want because of moderate neck pain

☐ 4 - I can hardly drive at all because of severe pain in my neck ☐ 5 - I cannot drive my car at all

Sleeping

☐ 0 - I have no trouble sleeping ☐ 1 - My sleep is slightly disturbed (less than 1 hour sleepless)

☐ 2 - My sleep is midly disturbed (1-2 hours sleepless) ☐ 3 - My sleep is moderately disturbed (3-5 hours sleepless)

☐ 4 - My sleep is greatly disturbed (3-5 hours sleepless) ☐ 5 - My sleep is completely disturbed (5-7 hours sleepless)

Recreation

☐ 0 - I am able to engage in all of my recreations with no neck pain

☐ 1 - I am able to engage in all of my recreations with some neck pain

☐ 2 - I am able to engage in most of my recreations with some neck pain

☐ 3 - I am able to engage in few of my recreations because of neck pain

☐ 4 - I can hardly do any recreations because of pain in my neck ☐ 5 - I cannot do any recreational activities at all

Lower Back Disability

Revised Oswestry Chronic Low Back Disability Questionnaire

Please read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by selecting the one choice that applies to you.

Pain Intensity

☐ 0 - The pain comes and goes and is very mild. ☐ 1 - The pain is midl and does not vary much.

☐ 2 - The pain comes and goes and is moderate. ☐ 3 - The pain is moderate and does not vary much.

☐ 4 - The pain comes and goes and is severe. ☐ 5 - The pain is severe and does not vary much.

Personal Care

☐ 0 - I do not have to change my way of washing or dressing to avoid pain

☐ 1 - I do not normally change my way of washing or dressing to avoid pain

☐ 2 - Washing and dressing increases the pain, but I manage not change my way of doing it

☐ 3 - Washing and dressing increases the pain, and I change my way of doing it

☐ 4 - Because of the pain, I am unable to do some washing and dressing with out help

☐ 5 - Because of the pain, I am unable to do any washing or dressing with out help

Lifting

☐ 0 - I can lift heavy weights without extra pain ☐ 1 - I can lift heavy weights, but it causes extra pain

☐ 2 - Pain prevents me from lifting heavy weights off of the floor

☐ 3 - Pain prevents me from lifting heavy, but I can manage if convient (eg on a table)

☐ 4 - Pain prevents me from lifting heavy, but I can manage light to medium weights if convient

☐ 5 - I can only lift very light weights, at the most

Walking

☐ 0 - Pain does not prevent me from walking any distance ☐ 1 - Pain prevents me from walking more than one mile

☐ 2 - Pain prevents me from waling more than 1/2 mile ☐ 3 - Pain prevents me from walking more than 1/4 mile

☐ 4 - I can only walk while using a cane or on crutches ☐ 5 - I am in bed most of the time and have to crawl to the toilet

Sitting

☐ 0 - I can sit in any chair as long as I like without pain ☐ 1 - I can only sit in my favorite chair as long as I like

☐ 2 - Pain prevents me from sitting more than one hour ☐ 3 - Pain prevents me from sitting more than 1/2 hour

☐ 4 - Pain prevents me from sitting more than ten minutes ☐ 5 - Pain prevents me from sitting at all

Standing

☐ 0 - I can stand as long as I want with out pain ☐ 1 - I have some pain while standing but it does not increase with time

☐ 2 - I can not stand for longer than one hour with out increasing pain ☐ 3 - I can not stand for longer than ten minutes

☐ 4 - I can not stand for longer than ten minutes with out increasing pain

☐ 5 - I avoid standing because it increase the pain straight away

Sleeping

☐ 0 - I get no pain in bed ☐ 1 - I get pain in bed, but it doesn't prevent me from sleeping well

☐ 2 - Because of my pain, my normal night's sleep is reduced by less than 1/4

☐ 3 - Because of my pain, my normal night's sleep is reduced by less than 1/2

☐ 4 - Because of my pain, my normal night's sleep is reduced by less than 3/4 ☐ 5 - Pain prevents me from sleeping at all

Social Life

☐ 0 - My social life is normal and gives me no pain ☐ 1 - My social life is normal but increases the degree of my pain

☐ 2 - Pain has no significant effect on my social life apart from limiting my energetic interests

☐ 3 - Pain has restricted my social life, I do not go out often ☐ 4 - Pain has restricted my social life to my home

☐ 5 - I have hardly any social life because of the pain

Traveling

☐ 0 - I get no pain while traveling ☐ 1 - I get some pain while traveling, but none of my usual forms of travel make it worse

☐ 2 - I get extra pain while traveling, but it does not compel me to travel differently

☐ 3 - I get extra pain while traveling which compels me to travel differently ☐ 4 - Pain restricts all forms of travel

☐ 5 - Pain prevents all forms of travel except that done lying down

Changing Degree of Pain

☐ 0 - My pain is rapidly getting better ☐ 1 - My pain fluctuates, but overall is definitely getting better

☐ 2 - My pain seems to be getting better, but improvement is slow ☐ 3 - My pain is neither getting better or worse

☐ 4 - My pain is gradually getting worse ☐ 5 - My pain is rapidly worsening

Comments

Signature

Date