NEW CHIROPRACTIC PATIENT INTAKE FORM

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Email address: _____ Social Security #: _____

Check if you are: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other _____

Employer: _____ Work Phone: _____

Spouses Name: _____ Spouse's Employer: _____

Your days off: _____ Referred here by: _____

Who is responsible for your care?

☐ Self-Pay ☐ Medicare ☐ Worker's Comp. ☐ Health Ins. ☐ Auto Ins. ☐ Other: _____

Insurance Company Name: _____

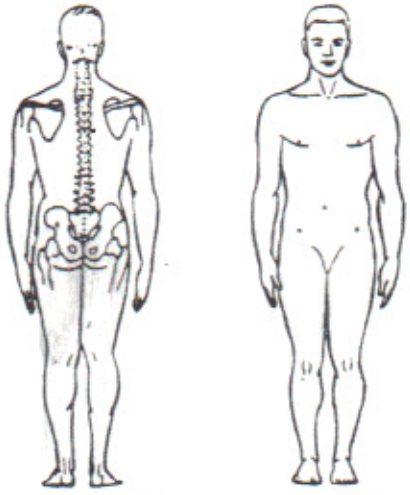
YOUR MAJOR COMPLAINT:

IMPORTANT: Please answer the following eleven questions as they pertain ONLY to your major problem. Any additional complaints that you want Dr. Charnstrom to be aware of can be listed under question #12, and he will address them in your consultation.

1. What is your **MAJOR COMPLAINT** that brought you to our office? _____
   _____

2. a. Please describe exactly **WHERE** the pain is located? _____
   _____

   b. Mark the **LOCATION** of your pain on the diagram(s) to the right:



3. Describe what the pain **FEELS LIKE** in your own words? *(ie. sharp, dull, burning, shooting, tingling, achy?)*
   _____
   _____
   _____

4. What term best describes **HOW OFTEN** you're in pain during the course of the day while awake? *(check only one)*

   ☐ A. Constant (76-100% of the day)
   ☐ B. Frequent (51-75% of the day)
   ☐ C. Intermittent (26-50% of the day)
   ☐ D. Occasional (0-25% of the day)

5. For **HOW LONG** have you suffered with this problem at its current intensity?_____

_____

6. Can you *estimate* the exact **DATE OF ONSET** of this condition? _____

7. What do you think has **CAUSED** this problem? _____

_____

8. On a scale of 1-10 where 10 is the worst (severe) and 1 is very mild, please rate the **INTENSITY** of your pain:

   a. Today? _____ b. On an average day? _____ c. At its worst since it started? _____

9. What activity, body position, or time of day makes the pain **WORSE**? _____

_____

10. What have you found on your own that makes the pain **BETTER**? _____

_____

11. Have you seen any **OTHER DOCTORS** for this complaint since it began? Y/N _____

    Who?_____ When? _____

    What did they do for you? _____

_____

_____

12. Please list any **ADDITIONAL COMPLAINTS** you have at this time from greatest concern to least concern:

_____

_____

13. Have you had any **BROKEN BONES** before? Y/N _____ Please list and give approximate dates:

_____

14. Have you had any **SURGERIES** either recently or in the past that Dr. Charnstrom should be aware of?

    Y/N _____ Please list and give approximate dates: _____

_____

15. Are you currently taking any **MEDICATIONS**? Y/N _____ Please list them ALONG WITH what the medication is for: *(Note: If you take several and have a list already prepared please give this to the front desk to be copied.)* _____

_____

16. Any **CHIROPRACTOR** consulted in the past? Y/N _____ Doctor's Name:_____

    Dates Consulted: _____ For what problem? _____

Note: Fees are payable at the time examinations are performed and/or treatments are received, unless other arrangements are made in advance.

Patient's Signature: _____ Date: _____

Parent's Signature *(if applicable)*: _____ Date: _____

Dr. Dan Charnstrom
3040 E. Cactus Rd Ste. 5
Phoenix, AZ 85032

INFORMED CONSENT AGREEMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and/or diagnostic x-rays if necessary, on me (or on the patient named below, for whom I am legally responsible) by Dr. Dan Charnstrom.

I have had an opportunity to discuss with Dr. Charnstrom and/or his office staff the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise his judgment during the course of the procedures which he feels at the time, based upon the facts then known, and are in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures referenced above. I intend for this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

_____ _____
Patient Signature Date

_____ _____
Parent Signature (if minor) Date

_____ _____
Office Signature Date

Dr. Dan Charnstrom
3040 E. Cactus Road Ste. 5
Phoenix, AZ 85032

Consent For Use or Disclosure of Your Health Care Information and Appointment Reminders

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are circumstances in which we may have to use or disclose your health care information, for example:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place restrictions on the use or disclosure of your health information, please let us know in writing.

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Dr. Charnstrom and his staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about your treatment, or other health-related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

This notice is effective immediately. This authorization will expire five years after the date on which you last received services from us. From time to time our practice does some direct mail to make you aware of products or services that you may have an interest in. We are requesting authorization to send you the following: Thank you cards, reactivation postcards, referral incentives, and/or special discounts.

_____ _____

Patient's Printed Name Today's Date

_____ _____

Patient's Signature Authorized Provider Representative

CANCELLATION POLICY

DR. DAN CHARNSTROM
3040 E. Cactus Rd. Ste. 5
Phoenix, AZ 85032
(602)788-7777

IF YOU WILL NOT BE ABLE TO MAKE YOUR SCHEDULED APPOINTMENT, YOU WILL BE REQUIRED TO GIVE OUR OFFICE AT LEAST A 24-HR NOTICE. THERE WILL BE A **$50.00** CHARGE FOR NO SHOW APPOINTMENTS AND SAME DAY CANCELLATIONS.

I, _____ HAVE READ AND UNDERSTAND DR. CHARNSTROM'S CANCELLATION POLICY.

_____ _____
PATIENT SIGNATURE DATE