ARIZONA CHIROPRACTIC

PREVENTION, WELLNESS, AND INJURY CARE

Name_____ Today's date_____

Address_____ City_____ State_____

Zip Code_____ Home Phone_____ Cell Phone_____

Date of birth_____ Age_____ Social Security Number_____

Name of Employer_____ Occupation_____

Work Phone_____ Email_____

How were you referred to this office?_____

Current Health Condition

What is the main purpose of today's appointment?_____

_____

_____

When and How did this condition begin?_____

_____

_____

Major Complaints?_____

Are you currently seeing another doctor for this same condition? Yes / No
What is the doctor's name?_____

Are you currently taking **ANY** Over the Counter or Prescription medications? Yes / No
What are you taking?_____

_____

_____

Are you having difficulty doing any of the following activities?
(1= no restrictions, 2= partially restricted, 3 = fully restricted)

___Lifting	___Standing	___Personal Grooming
___Sitting	___Bending	___Kneeling
___Climbing	___Sleeping	___Walking

If you had to rate the pain or discomfort you are experiencing when it is at it's worst, what would you rate it?

(0 being no pain) **0 1 2 3 4 5 6 7 8 9 10** (10 being severe)

If you had to rate the pain or discomfort you are experiencing when it is at it's best, what would you rate it?

(0 being no pain) **0 1 2 3 4 5 6 7 8 9 10** (10 being severe)

What makes the pain or discomfort worse?_____

What makes the pain or discomfort better?_____

Arizona Chiropractic Group

Past Health History

Please list any hospitalizations, accidents, surgeries, broken bones/fractures, or illness:_____
_____
_____

Any previous chiropractic care?_____

CHECK ANY DISEASES YOU HAVE HAD:

___Pneumonia	___Mumps	___Influenza	___Rheumatic Fever
___Small Pox	___Pleurisy	___Polio	___Chicken Pox
___Arthritis	___Tuberculosis	___Diabetes	___Epilepsy
___Whooping Cough	___Cancer	___Mental Disorder	___Anemia
___Heart Disease	___Lumbago	___Measles	___Thyroid Disorder

CHECK ANY YOU HAVE HAD IN THE PAST 3 MONTHS:

Musculo-Skeletal

___Neck Pain	___Pain between shoulders	___Arm/Shoulder Pain
___Mid Back Pain	___Joint Pain / Stiffness	___Walking Problems
___Low Back Pain	___General Aches / Pain	___General Stiffness

Nervous System

___Nervous	___Numbness	___Paralysis
___Dizziness	___Forgetfulness	___Confusion
___Depression	___Fainting	___Convulsions
___Cold Extremities	___Tingling Extremities	___Stress

General

___Fatigue	___Allergies	___Loss of Sleep
___Fever	___Headaches	___Migraine
___Vision Problems	___Ear Aches / Infections	___Hearing Problems
___Muscle Spasms		

Gastro-Intestinal

___Poor / Excessive Appetite	___Frequent Nausea	___Vomiting
___Diarrhea	___Constipation	___Hemorrhoids
___Liver Problems	___Gall Bladder Problems	___Weight Trouble
___Abdominal Cramps	___Gas / Bloating after meals	___Heartburn
___Black / Bloody Stool	___Colitis	

Family History:_____ Relation:_____

Genito- Urinary

___Bladder Trouble	___Painful / Excessive Urination	___Discolored Urine

C-V-R

___Chest Pain	___Short Breath	___Blood Pressure
___Irregular Heartbeat	___Heart Problems	___Lung Problems
___Varicose Veins	___Ankle Swelling	___Stroke

Family History:_____ Relation:_____

Male / Female

___Menstrual Irregularity	___Menstrual Cramping	___Vaginal Pain
___Breast Pain / Lumps	___Prostate / Sexual Dysfunction	

Family History:_____ Relation:_____

Social History:_____

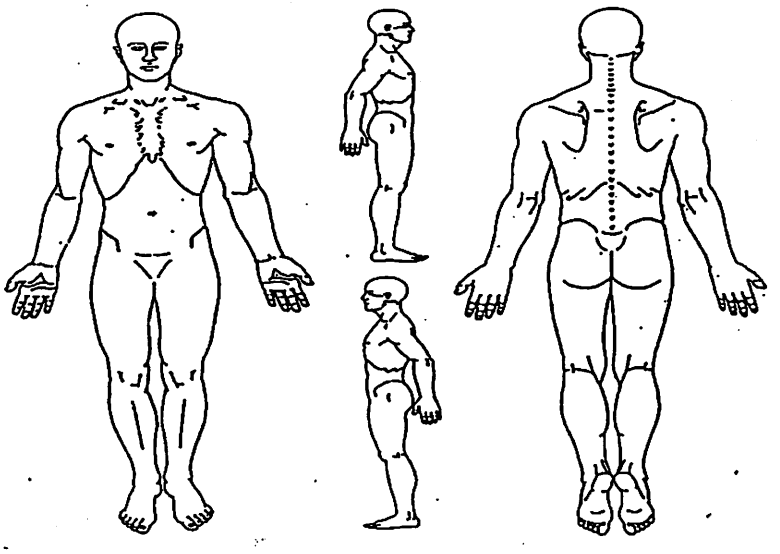
Patient Signature:_____ Date:_____ Dr. I.N._____

ARIZONA CHIROPRACTIC

PREVENTION, WELLNESS, AND INJURY CARE

PAIN DIAGRAM
Mark Area (s) of Concern

Circle Those That Apply



Ache
Spasm
Tenderness
Burning
Stabbing
Pain
Sharp
Dull
Stiffness
Constant
Comes & Goes
Tingling
Numbness

FINANCIAL POLICY AND PATIENT SERVICE AGREEMENT

Who is responsible for your bill?
You and:

_____Health Insurance
_____Auto Insurance
_____Worker's Comp.
_____Medicare
_____Liability (Auto)
_____OTHER:_____

Payment is due at the time of service in the form of a deductible, co-payment, co-insurance, or cash care payment.

Your insurance policy is a contract between you and the insurance company. You are responsible to Arizona Chiropractic Group to insure that your insurance company processes the claims pertaining to your treatment in our office. If your insurance company sends you a check for services rendered in our office, it is your responsibility to deliver them to our office within 5 (five) days of receipt.

Affordable payment / hardship plans are available for those who do not have third party insurance coverage.

Upon seeing the doctor, I have read and signed the NOTICE OF PRIVACY PRACTICES for Protected Health Information and the PRIVACY PRACTICE ACKNOWLEDGMENT FORM and have accepted these policies.

I certify that this information is true and correct. I assign my benefit payments to be paid directly to Arizona Chiropractic Group, Mioni DC; however I understand that I am ultimately responsible for payment of services. I also authorize the release of any information which is required. Furthermore, I understand that Arizona Chiropractic Group, Mioni DC is not claiming to be a cure all for my symptoms.

PATIENT SIGNATURE_____ **DATE**_____

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ Last Name: _____

Email address: _____ @ _____

Preferred method of communication for patient reminders (Circle one): Email/Phone/Mail

DOB: __/__/__ Gender (Circle one): Male/ Female Preferred Language:_____

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / former Smoker / Never Smoked

Smoking start date (Optional): _____

CMS requires providers to report race and ethnicity

Race (Circle one): American Indian or Alaska Native/ Asian /Black or African American /White (Caucasian)

Native Hawaiian or Pacific Islander / I decline to answer

Ethnicity (Circle one): Hispanic or Latino /Not Hispanic or Latino / I decline to answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name:	Dosage and Frequency (I.e.: 5mg once a day, ect)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ I chose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature:_____ date:_____

For office use only

Height: _____ Weight: _____ Blood Pressure:_____/_____