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.________

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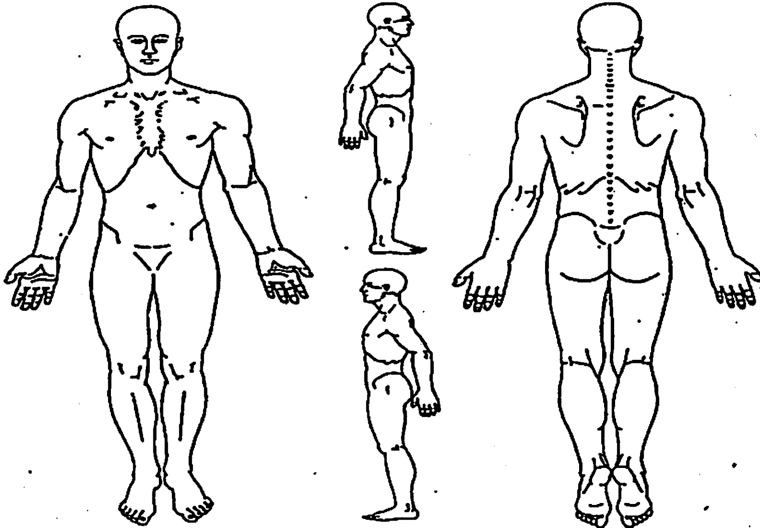
PAIN DIAGRAM
Mark Area (s) of Concern

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 _____Medicare
_____Auto Insurance _____Liability (Auto)
_____Worker's Comp. _____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:________/ ________

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Informed Consent

The nature of the chiropractic manipulation: I will use my hands or an instrument to move the joints of your body; this may result in an audible "pop" or "click".

The material risks inherent in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fractures are rare and can result from underlying weakness in the bones. The other complications are considered rare. One source states that a stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Ancillary treatments recommended: ______________________________

Risks involved with the recommended ancillary treatments:

____

Other treatment options for your condition include: Medical care with prescription drugs, self management with over-the-counter medication, rest and/or surgery. There are material risks inherent in each of those options including but not limited to: addiction to medication, improper self dosages and surgical risks including complications from the procedure and the anesthesia.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it was in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient Printed Name ______________________________ Date ________________

Patient Signature ______________________________ Dr. ________________

The patient had the following questions and was supplied the following answers:

____

____

PRIVACY PRATICES ACKNOWLEDGEMENT

ARIZONA CHIROPRACTIC GROUP

422 E. Southern Avenue, AZ 85282
Tempe, Arizona 85282

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_______________________________________ Birthdate___________

Signature____

Date____

Cash Practice® EZ-Pay Authorization

I, ______________________________, hereby authorize Arizona Chiropractic Group to initiate debits/credit card charges and/or corrections to previous debits/charges to my account with the financial institution identified by me on this form for payment and/or co-payment of services/products rendered to me. The authorization is to remain in effect indefinitely and may be withdrawn by me at any time by written request.

☐ **CREDIT CARD** on file ending in (last 4 digits) ___ ___ ___ ___ Visa® MasterCard® Discover® AMEX®

Card Holder Name: ____

E-mail For Electronic Receipts: ____

By signing below, I acknowledge that if choose to cancel my EZ-pay Authorization, or changes need to be made to the account being charged, I need to contact Arizona Chiropractic Group at (480) 497-9399. This authorization will remain in effect until I provide written notice revoking the authorization. Notice can be mailed to Arizona Chiropractic Group at 422 East Southern Ave. Tempe, AZ 85282.

Card Holder Signature: ________________________________ Date: ____________________

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