PATIENT INTAKE

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit: _____

Is this purpose related to an auto accident / work injury? Yes No If so, when: _____

Describe: _____

Please describe the pain & its location: _____

Indicate your current level of pain from 0 (No Pain) to 10 (Excruciating): 0 1 2 3 4 5 6 7 8 9 10

When did this condition begin? _____/_____/_____ When did you first notice it? _____

Is this condition getting worse? Yes No Is this condition: Constant Comes & goes Activity related

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? Yes No Describe:_____

Have you experienced this condition before? Yes No If so, please explain: _____

Have you had treatment anywhere else for this condition? Yes No What type of treatment? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take x-rays before or after? Yes No

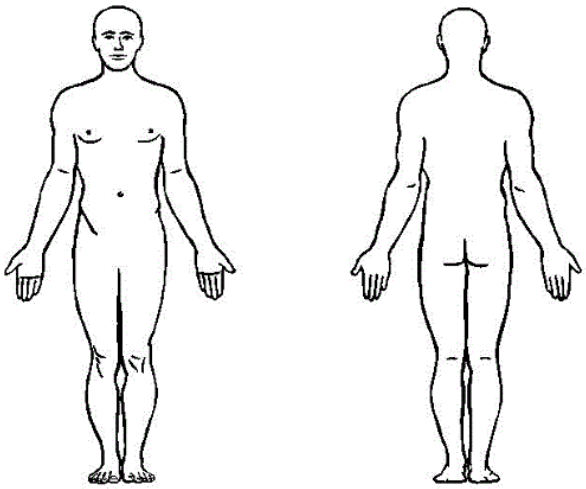
Did you know posture determines your health? Yes No

Are you aware of any of your poor posture habits? Yes No

Explain: _____

Please use the diagram to indicate where you experience pain and discomfort and the type of pain or discomfort following the key below:

A – Dull/ache
N – Numbness
T – Tingling
S – Sharp or Stabbing
B – Burning
St – Stiffness
Th- Throbbing
D – Deep
C- Cramping



HEALTH CONDITIONS

Please indicate if you currently have or have a history of any of the following injuries or illnesses.

○ Headaches	○ Neck Pain	○ Allergies/Sinusitis	○ Dizziness
○ Migraines	○ Pain into shoulders/Arms	○ Numbness/Tingling in Arms/Hands	○ Grip Weakness
○ TMJ Pain/clicking	○ Low Energy/Fatigue	○Visual or Hearing Trouble	○Mid Back Pain
○ Pain around ribs/chest	○ Indigestion/Heartburn	○ Nausea	○ Asthma/Wheezing
○ Shortness of Breath	○ Heart Conditions _____	○ Diabetes	○ Ulcers/Gastritis
○ Low Back Pain	○ Numbness/Tingling in Legs/Feet	○ Pain into Hips/legs/feet	○ Weakness in legs/feet
○ Constipation/Diarrhea	○ Cramping in legs/feet	○ Cold hands/feet	○ Frequent urination
○ Scoliosis	○ Thyroid Conditions	○ Dislocations/Fractures	○ Cancer
○ "Hump" at base of neck	○ Hives/Eczema	○ Arthritis	○ Varicose Veins

Women Only: ○ Menstrual Irregularities Currently Pregnant? Yes No

Please list any conditions not mentioned: _____

Please list any medications / surgeries: _____

Have you ever had any injuries to your spine? Yes No

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming Other: _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following?

○ Diabetes	○ Cancer	○ Stroke	○ Heart Disease/Heart Attack	○ Measles
○ Varicose Veins	○ Polio	○ Mumps	○ Neurological Conditions	○ Kidney Disease
○ Liver Disease	○ Eczema	○ Depression	○ Infectious Diseases	○ Tuberculosis
○ Bleeding Disorders	○ Osteoporosis	○ Arthritis	○ Dementia/Alzheimers	○ Lung Conditions

Other: _____

RADIOGRAPH CONSENT

I _____ do hereby give my consent to allow this office and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

Signature of Patient/or Guardian of said Minor _____ Date _____

IN CASE OF EMERGENCY

Name_____

Relationship_____

Work Phone_____

Home Phone_____

Cell Phone_____

AUTHORIZATION OF CARE and INFORMED CONSENT

I authorize and agree to allow the doctor and/or physical therapist to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I acknowledge and understand that even though negative results are rarely experienced, as with any form of treatment they are possible. Some of the potential risks may include but are not limited to: fractures, worsening of symptoms, muscle injury, joint irritation/dislocation. I recognize it is my responsibility to inform of the doctor of any and all conditions that may affect my care.

Although no significant data shows a correlation between chiropractic adjustments and the cause of stroke, I understand that there is concern in certain situations and if I have questions I agree to consult with my doctor. In the uncommon case that negative results from treatment occur at any time, I will notify the doctor immediately so that proper treatment can be administered and the result noted for future reference.

It is with full understanding and acknowledgment that I authorize and agree to the recommended course of treatment for conditions related to my spine and joints as prescribed by my doctor in this office.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or physical therapist specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I authorize the assignment of all insurance benefits be directed to the doctor and/or physical therapist for all services rendered.

_____	_____	_____	_____
Patient's Name Printed	Date	Patient's signature	Date

_____	_____	_____
Minors Name	Guardian/Spouse's Signature of Authorizing care for minor	Date

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services [ ] YES [ ] NO

Patients Signature_____ Date_____

Guardian or Spouse's Signature Authorizing Care_____ Date_____

*I hereby authorize Dr. Kevin Morford, Dr. Brenda Hooper, and/or Dr. Ryan Hooper to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Please only fill out the following information if we have not received a copy of your insurance card

Name of Insurance Co. _____ Policy#_____

Address_____ Phone # _____

Insured's Name_____ Insured's SS# _____

Relationship to Insured _____ Birthdate _____/_____/_____

Employer_____

Who should receive charges on your account?

○ Patient ○ Spouse ○ Parent/Guardian ○ Workers Comp ○ Auto Insurance ○ Personal Health Insurance

The Chiropractic Offices of
Dr. Brenda Hooper, Dr. Kevin Morford, & Dr. Ryan Hooper
520 W. 15th St. Edmond, OK 73013
(p) 405.844.4492 (f) 405.341.8291

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____

Staff signature **Date**