Practice Member Intake Form

PRACTICE MEMBER

Last name: _____ First name: _____ M.I.: _____

Gender: M / F Date of Birth: _____/_____/_____ Age: _____ SSN: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Employer Name: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Number of Children and Ages: _____

SPOUSE OR GUARDIAN (if applicable)

Last name: _____ First name: _____ M.I.: _____

Employer Name: _____ Work Phone: (_____) _____-_____

Date of Birth: _____/_____/_____ SSN: _____

Relationship to Practice Member: _____

EMERGENCY CONTACT

Last name: _____ First name: _____ Middle: _____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Relationship to Practice Member: _____

Who may we thank for referring you to our office? _____

Have you received chiropractic care in the past? Yes No When? _____

If Yes, please give the name of the Chiropractor: _____

Reason for previous care: _____

Name of your Medical Doctor: _____

PAYMENT METHOD (check preferred payment)

Cash: _____ Check: _____ Debit: _____ Credit: _____ HSA/FSA: _____

Signature:_____ Date: _____

Breath of Life Chiropractic

Pregnancy Health Form

Welcome! I want to personally congratulate you on helping yourself and your developing baby take your first steps toward better health. This form is used to help me, your doctor, better understand my pregnant practice member. Please fill it out as completely as possible. We are proud to care for you and your baby, as well as the rest of your family.

Thank you for trusting us with your health,
Dr. Shae Doran
Breath of Life Chiropractic Wellness Center

Pregnancy History

How far along in the pregnancy are you? _____ weeks What is Baby's estimated delivery date: _____

How many pregnancies have you had? _____

During your current pregnancy, did you have any of the following:

Yes	No		Please describe:
□	□	Falls?	_____
□	□	Motor vehicle accidents?	_____
□	□	Near-miss car accidents?	_____
□	□	High blood pressure?	_____
□	□	Diabetes?	_____
□	□	Anemia?	_____
□	□	Morning sickness?	_____
□	□	Indigestion?	_____
□	□	Seizures?	_____
□	□	Swollen ankles?	_____
□	□	Thyroid problems?	_____
□	□	Heart problems?	_____
□	□	Back pain?	_____
□	□	Abnormal bleeding?	_____
□	□	Were you hospitalized?	_____
□	□	Did you have any other illnesses?	_____

During your pregnancy, did you use any of the following:

Yes	No		Please describe:
□	□	Tobacco?	_____
□	□	Alcohol?	_____
□	□	Non-prescribed drugs?	_____
□	□	Prescription medications?	Medication and Reason: _____

_____

Breath of Life Chiropractic

Practice Member Name:_____ **Date:**_____

Yes No

□ □ Has the baby ever been in the breech position? _____

□ □ If applicable, in previous pregnancy/ies, was the baby ever in the breech position?

How many ultrasounds have been performed this pregnancy? _____

With previous pregnancy/pregnancies, was the birth:

□ Normal Vaginal
□ Cesarean
□ Breech
□ Birthing Center _____
□ Forceps
□ Vacuum Extraction
□ Home Birth
□ Hospital _____

Labor or Delivery Problems _____

APGAR Scores: *(1st child)* _____ & _____ , *(2nd child)* _____ & _____ , *(3rd child)* _____ & _____

Congenital Defects/Anomalies _____

Pre-Pregnancy History

Research shows that many of our health challenges that occur in life originate during our developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Childhood Years (birth to age 17)	YES	NO	UNSURE	Comments
Did you have any childhood illnesses?	□	□	□	_____
Were you vaccinated?	□	□	□	_____
Have you had any falls from heights over 3 ft? *(i.e. crib, bunk bed, trees, ladder, stairs)*	□	□	□	_____
Did you play youth sports?	□	□	□	_____
Any prolonged/frequent use of medicine? *(i.e. Tylenol, antibiotics, inhalers)*	□	□	□	_____
Were you involved in any car accidents as a child?	□	□	□	_____
Nature of accident and when? Post Hospitalization?				_____
Did you have any surgery?	□	□	□	_____
Was your birth a traumatic birth process?	□	□	□	_____
Were you under regular chiropractic care?	□	□	□	_____
Were you on birth control?	□	□	*Duration*?	_____

Adult Years (18 years old to present)	YES	NO	Comments
Do you exercises regularly?	□	□	_____
Have you been in any accidents?	□	□	_____
Do/Did you play any adult sports?	□	□	_____
Have you been under regular chiropractic care?	□	□	_____
Have you been on birth control?	□	□	*Duration*? _____

Breath of Life Chiropractic

Practice Member Name:_____ **Date:**_____

Health History Questionnaire

Please put a (√) next to conditions you have currently and a "P" for conditions you have had in the past.

General
1 ___ Fever
2 ___ Chills
3 ___ Night Sweats
4 ___ Loss of Sleep
5 ___ Fatigue
6 ___ Nervousness
7 ___ Weight Loss/Gain
8 ___ Allergies
9 ___ Bleeding Problems
10 ___ Anemia
11 ___ Diabetes
12 ___ Cancer
13 ___ Thyroid Disease
14 ___ High Cholesterol
15 ___ Osteoporosis
16 ___ Alcoholism
17 ___ Drug Abuse

Eyes, Ears, Nose, & Throat
18 ___ Poor Vision
19 ___ Pain in Eye(s)
20 ___ Deafness/Difficulty Hearing
21 ___ Nosebleeds
22 ___ Nose Problems
23 ___ Sinus Trouble
24 ___ Dental Problems
25 ___ Hoarseness

Gastrointestinal
26 ___ Poor Appetite
27 ___ Poor Digestion
28 ___ Difficulty Swallowing
29 ___ Belching or Gas
30 ___ Frequent Nausea
31 ___ Vomiting Blood
32 ___ Pain over Abdomen
33 ___ Ulcer
34 ___ Black or Bloody Stool
35 ___ Liver Problems
36 ___ Gall Bladder Problems
37 ___ Jaundice
38 ___ Hernia
39 ___ Diarrhea
40 ___ Constipation
41 ___ Hemorrhoids
42 ___ Appendicitis

Respiratory
43 ___ Difficulty Breathing
44 ___ Chronic Cough
45 ___ Coughing-up Phlegm
46 ___ Coughing-up Blood
47 ___ Wheezing/Asthma
48 ___ Pneumonia
49 ___ Tuberculosis

Cardiovascular
50 ___ Irregular Heartbeat
51 ___ High Blood Pressure
52 ___ Pain in Chest
53 ___ Heart Trouble
54 ___ Ankle Swelling
55 ___ Varicose Veins
56 ___ Stroke

Genitourinary
57 ___ Frequent Urination
58 ___ Painful Urination
59 ___ Blood in Urine
60 ___ Urinary Infection
61 ___ Kidney Disease
62 ___ Inability to Control Urine
63 ___ Difficulty Starting Urine Flow
64 ___ Get up Frequently at Night to Urinate
65 ___ Breast Lumps or Pain
66 ___ Venereal Disease
67 ___ Sexual Dysfunction

Skin
68 ___ Itching/Dry Flaky
69 ___ Bruising Easily
70 ___ Change in Mole(s)
71 ___ Skin Cancer

Male Only
72 ___ Testicular Swelling/Pain
73 ___ Prostate Problems

Female Only
74 ___ Painful Periods
75 ___ Excessive Flow
76 ___ Irregular Cycles
77 ___ Vaginal Burning/Itching
78 ___ Hot Flashes
79 Date Last Period Began

_____
80 Date of Last PAP Test

_____

Neurological
81 ___ Weakness
82 ___ Twitching
83 ___ Tremors
84 ___ Headaches
85 ___ Fainting
86 ___ Dizziness
87 ___ Convulsions
88 ___ Epilepsy
89 ___ Numbness/Tingling
90 ___ Arm/Leg Pain
91 ___ Mental Disorder

Musculoskeletal
92 ___ Neck Stiffness/Pain
93 ___ Pain Between Shoulder Blades
94 ___ Low Back Pain
95 ___ Swollen Joints
96 ___ Stiff/Painful Joints
97 ___ Muscle Aches/Soreness
98 ___ Spinal Curvature
99 ___ Arthritis

Habits/Exercise
100 ___ Smoking _____ packs/day
101 ___ Alcohol _____ drinks/week
102 ___ Recreational Drug Use
103 Times per week you exercise _____

Family Medical History
Include information on brothers, sisters, parents and grandparents (not yourself)
104 ___ Diabetes
105 ___ Thyroid Disease/Goiter
106 ___ Kidney Disease
107 ___ High Blood Pressure
108 ___ Heart Disease
109 ___ Cancer
110 ___ Muscle, Bone or Nerve Disease
111 ___ Other _____
_____

Other
112 List any medical conditions you have (even if listed above):
_____
_____
_____
_____
_____

113 List all Surgeries/Hospitalizations you have had:
_____
_____
_____

114. list all Vitamins/Supplements/Herbs you are currently taking:
_____
_____
_____
_____

115. Please list all medications you are currently taking and why you are taking them: _____
_____
_____
_____

Breath of Life Chiropractic

Practice Member Name:_____ **Date:**_____

On a scale of 0-10, describe your level of stress (0 = none / 10 = extreme) _____ Occupational _____ Personal

On a scale of Poor, Good, Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Which answer best describes your own current ideas and values toward health?

□ CONDITION – I consult a doctor when I have a problem/symptom & discontinue when the symptom is gone.

□ PREVENTION – I try to eat healthy, exercise & seek care to avoid sickness & disease.

□ WELLNESS – I actively pursue a healthy lifestyle (diet, exercise, vitamins, meditation…) to be the best I can be.

□ FAMILY- I actively maintain my own health and am concerned with long-term health goals for my family as well.

To help us better explain chiropractic as it applies to your health and life, and how we may be able to help you, please check the best answer for each statement below:

1. I remember important things in my life by what I … □ see □ hear □ touch □ how I feel

2. The primary reason I brush my teeth is to … □ avoid tooth decay/gum disease □ to have healthy teeth/gums

3. When I make a decision I generally… □ make the right choice instantly □ gather facts & weigh the evidence
□ consult my friends & family □ depends on how I feel

4. What is your favorite sleeping position? □ side sleeper □ back sleeper □ tummy sleeper

Have you ever:

Belonged to a health club?	□ Yes	□ No
Bought bottled water?	□ Yes	□ No
Consumed vitamins or supplements?	□ Yes	□ No
If there is a need for dietary changes or nutrients would you like to be informed?	□ Yes	□ No
If there is a need for specific exercises would you like to be informed?	□ Yes	□ No
If there is a need for specific lab testing would you like to be informed?	□ Yes	□ No

The statements made on these forms are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Practice Member's Signature: _____ Date: _____

Breath of Life Chiropractic

Practice Member Name:_____ **Date:**_____

Please answer the following in relation to your current pregnancy:

Share how you feel about your care provider? _____

What classes/tools have you/do you plan to use to prepare for birth and postpartum? _____

_____

What techniques do you use to reduce stress? _____

Do you have any fear or concerns surrounding your birth? ☐ Yes ☐ No Explain: _____

_____

Is there anything else surrounding your pregnancy that you'd like to share? _____

_____

Edinburgh Postnatal Depression Scale[1] (EPDS)

As you are pregnant, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **in the past 7 days**, not just how you feel today.

1. I have been able to laugh and see the funny side of things
   - ❑ As much as I always could
   - ❑ Not quite so much now
   - ❑ Definitely not so much now
   - ❑ Not at all
2. I have looked forward with enjoyment to things
   - ❑ As much as I ever did
   - ❑ Rather less than I used to
   - ❑ Definitely less than I used to
   - ❑ Hardly at all
3. I have blamed myself unnecessarily when things went wrong
   - ❑ Yes, most of the time
   - ❑ Yes, some of the time
   - ❑ Not very often
   - ❑ No, never
4. I have been anxious or worried for no good reason
   - ❑ No, not at all
   - ❑ Hardly Ever
   - ❑ Yes, sometimes
   - ❑ Yes, very often
5. I have felt scared or panicky for no very good reason
   - ❑ Yes, quite a lot
   - ❑ Yes, sometimes
   - ❑ No, not much
   - ❑ No, not at all
6. Things have been getting on top of me
   - ❑ Yes, most of the time I haven't been able to cope at all
   - ❑ Yes, sometimes I haven't been coping as well as usual
   - ❑ No, most of the time I have coped quite well
   - ❑ No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping
   - ❑ Yes, most of the time
   - ❑ Yes, sometimes
   - ❑ Not very often
   - ❑ No, not at all
8. I have felt sad or miserable
   - ❑ Yes, most of the time
   - ❑ Yes, quite often
   - ❑ Not very often
   - ❑ No, not at all
9. I have been so unhappy that I have been crying
   - ❑ Yes, most of the time
   - ❑ Yes, quite often
   - ❑ Only occasionally
   - ❑ No, never
10. The thought of harming myself has occurred to me
    - ❑ Yes, quite often
    - ❑ Sometimes
    - ❑ Hardly ever
    - ❑ Never

Administered/Reviewed by: _____ Date: _____

Breath of Life Chiropractic

CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND/OR HEALTH CARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Breath of Life Chiropractic's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Breath of Life Chiropractic to provide treatment to me, and also necessary for Breath of Life Chiropractic to obtain payment for treatment and to carry out health care operations. Breath of Life Chiropractic explained to me that the Privacy Notice will be available to me in the future at my request. Breath of Life Chiropractic has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. Breath of Life Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders, communications from this office, welcome material, birthday greetings, recall notice, billing statements and newsletters that will be used by Breath of Life Chiropractic: a.) a postcard or letter mailed to me at the address provided by me; b.) telephoning and/or texting my home/work/mobile device and leaving a message on my answering machine or with the individual answering the phone; and c.) emailing me at the email address provided by me.
4. Breath of Life Chiropractic may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Breath of Life Chiropractic to treat me and obtain payment for that treatment, and as necessary for Breath of Life Chiropractic to conduct its specific health care operations.
5. I understand that I have a right to request that Breath of Life Chiropractic restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Breath of Life Chiropractic is not required to agree to any restrictions that I have requested. If Breath of Life Chiropractic agrees to a requested restriction, then the restriction is binding on Breath of Life Chiropractic.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that Breath of Life Chiropractic has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, Breath of Life Chiropractic has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosure described to me above and contained in the Privacy Notice, then Breath of Life Chiropractic will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ Name of Patient or Personal Representative (Printed)

_____ Signature of Personal Representative

_____ Signature of Patient

_____ Relationship to Patient

_____ Date Signed

_____ Witness

Office Policies

Welcome to Breath of Life Chiropractic – Breath of Life Chiropractic would like to provide you with the best care possible. Dr. Doran will conduct a thorough history and physical examination to decide if she can assist you. If Dr. Doran does not believe that your condition will respond to chiropractic care, she will refer you to another health care provider, if appropriate. Breath of Life Chiropractic welcomes all family members. Children are asked to be under parental observation at all times.

Fee and Payment Policy – For all visits, payment is due in full at time of service. Breath of Life Chiropractic is not contracted with your insurance company. The office accepts cash (please try to have exact change), personal check debit and credit (Visa, MasterCard & Discover). The office has a convenience fee for all debit and credit card transactions; however Health Savings Account (HSA) and Flexible Spending Account (FSA) transactions do not have a fee. The office charges $25 for any returned check. If fees for services are not paid in a timely manner, a late payment penalty (ies) will be assessed. If you (the practice member) do not pay your bill on a timely basis, and the office must pursue collection efforts, you will be responsible for all fees associated with said collections.

Cancellation Policy – Please notify the office as soon as possible if you will be unable to keep your appointment. Appointments not cancelled at least 24 hours in advance will be billed to the practice member at the value of the visit missed and cannot be billed to, nor reimbursed by, insurance.

Payment Agreement – I (the practice member/responsible party) understand that there is no guarantee that my insurance company (ies) or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges including service charges for services not covered by my insurance company. I also understand that Breath of Life Chiropractic is not billing my insurance and I am responsible for all charges at time of service. Should you discontinue care for any reason other than discharge by the doctor, any and all balances will immediately be due in full.

Insurance Policy – This office will provide you with the appropriate billing information to submit to your insurance carrier if you so desire. We will try to provide sufficient information to you to obtain payment for your treatment. All insurance reimbursement should be sent to you directly. If your insurance carrier mistakenly sends our office the reimbursement check, we will credit the amount to your account for future office visits and contact your insurance company to ask for them to prevent future errors. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full. Our office will not enter into any dispute with an insurance company over the amount of reimbursement. Your health insurance policy is a contract between you and your health insurance company. You are responsible for contacting your insurance company about unpaid claims.

The following signature demonstrates an understanding and acceptance of the office policies of Breath of Life Chiropractic.

_____

Signature of Practice Member/Guardian (if applicable)

_____ _____

Printed Name Date

Breath of Life Chiropractic reserves the right to change office policies as needed without notice.

Breath of Life Chiropractic

TERMS OF ACCEPTANCE

Please Read Carefully

When a person seeks health care it is essential for both the Practice Member and the Practice to be working toward the same objective.

Breath of Life Chiropractic has only one goal. It is important that each Practice Member understand the objective and the method(s) that will be used to attain the goal.

Subluxation-Based Wellness Care enables each individual to maximize his or her health. Health can only be maximized when the major cause of interference is removed.

The key to health is function. If you keep the parts you have today functioning at their highest potential, for the rest of your lifetime, you will have your best chance for optimum health. While you must have proper nutrition, rest and exercise, the primary factor of body function is the nervous system.

Health: A state of optimal physical, mental, social, and spiritual well-being, not merely the absence of disease or infirmity. Health will be maximized if all obstructions to it are removed.

Subluxation: A condition in which the spine malfunctions and causes an imbalance or damage to the nervous system, affecting overall health. The result is a lessening of the body's inborn "innate" ability to express life at maximum potential.

Adjustment: An adjustment is the special application of forces to facilitate the body's correction of subluxation. Our method of correction is by specific adjustments of the spine.

Regardless of what a disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. We believe any named condition is merely a physical manifestation and not necessarily indicative of the underlying cause. Our only objective is to remove interference to the nervous system, allowing the body's innate intelligence to heal the body, thus returning your body to balance.

We do not offer to diagnose or treat any disease or condition. However, if during the course of examination, we encounter unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we give you the option to seek the service of a health care provider who specializes in symptom-based care.

I _____have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept care on this basis. _____ _____
(Signature) (Date)

Since the patient is a minor and is being represented by another party, please sign below:

_____ _____ _____
Personal Representative Name Personal Representative Signature Date

_____
Relationship/Description of the authority to act on behalf of this patient

Breath of Life Chiropractic

Pre-Scan Checklist

Practice Member: _____ Date: _____

Your nervous system controls and regulates every cell of your body.
We use an instrument that reveals how well your nervous system is working.

Please let us know if we need to be mindful of the following:

DRINKING COFFEE OR TEA CAN EXCITE THE NERVOUS SYSTEM.
Have you had any of these caffeinated beverages today?
☐ No ☐ Yes
About _____ cups.

NICOTINE IS A NERVOUS SYSTEM STIMULANT.
Have you used any tobacco today?
☐ No ☐ Yes How much? _____

COLA DRINKS CONTAIN CAFFEINE AND CHEMICALS THAT CAN AFFECT THE NERVOUS SYSTEM.
How many sodas have you had today? _____

COMMON, OVER-THE-COUNTER DRUGS CAN IMPACT THE NERVOUS SYSTEM.
Have you taken any of these types of drugs today?
☐ No ☐ Yes Please list: _____

MANY PRESCRIPTION DRUGS AND MUSCLE RELAXERS AFFECT THE NERVOUS SYSTEM.
Have you taken any type of prescription medication today?
☐ No ☐ Yes Please list: _____

EXCESSIVE EXPOSURE TO THE SUN AFFECTS THE ACCURACY OF YOUR SCAN.
Have you had a sunburn in the last five days? ☐ No ☐ Yes

BATH SALTS, OILS OR SUNSCREEN ON YOUR SKIN CAN INFLUENCE INSTRUMENT SENSITIVITY.
Have you used any of these products today? ☐ No ☐ Yes

VIGOROUS PHYSICAL ACTIVITY CAN EXAGGERATE YOUR SCAN RESULTS.
Have you had a workout today? ☐ No ☐ Yes

STRESS, DEPRESSION, ANXIETY OR EMOTIONAL UPSETS CAN AFFECT NERVOUS SYSTEM TENSION.
Compared to a typical day, are you currently experiencing any type of emotional turmoil? ☐ No ☐ Yes