



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: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Employer Name: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Email: _____ (monthly newsletter will be sent electronically)

Number of Children and Ages: _____

SPOUSE OR GUARDIAN (if a minor)

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: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Relationship to Practice Member: _____

Who can 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

Cash: _____ Check: _____ MasterCard: _____ Visa: _____ Discover: _____

PRACTICE MEMBER SIGNATURE

Name: _____ Date: _____



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 the Baby's due date: _____

How many pregnancies have you had? _____

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

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

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

Yes	No		Please describe:
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Non-prescribed drugs?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Prescription medications?	Medication and Reason: _____



Practice Member's Name: _____ **Date:** _____

Yes No

Has the baby ever been in the breech position? _____

How many ultrasounds have been performed? _____

With previous pregnancy/pregnancies, was the birth:

- | | |
|--|--|
| <input type="checkbox"/> Normal Vaginal | <input type="checkbox"/> Forceps |
| <input type="checkbox"/> Cesarean | <input type="checkbox"/> Vacuum Extraction |
| <input type="checkbox"/> Breech | <input type="checkbox"/> Home Birth |
| <input type="checkbox"/> Birthing Center _____ | <input type="checkbox"/> Hospital _____ |

Labor or Delivery Problems _____ APGAR Scores _____ & _____

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.

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

<u>Adult Years (18 years old to present)</u>	YES	NO	<u>Comments</u>
Do you exercises regularly?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/Did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been under regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 _____



Practice Member's 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.

<p>General</p> <p>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</p> <p>Eyes, Ears, Nose, & Throat</p> <p>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</p> <p>Gastrointestinal</p> <p>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</p> <p>Respiratory</p> <p>43 ___ Difficulty Breathing 44 ___ Chronic Cough 45 ___ Coughing-up Phlegm 46 ___ Coughing-up Blood 47 ___ Wheezing/Asthma 48 ___ Pneumonia 49 ___ Tuberculosis</p>	<p>Cardiovascular</p> <p>50 ___ Irregular Heartbeat 51 ___ High Blood Pressure 52 ___ Pain in Chest 53 ___ Heart Trouble 54 ___ Ankle Swelling 55 ___ Varicose Veins 56 ___ Stroke</p> <p>Genitourinary</p> <p>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</p> <p>Skin</p> <p>68 ___ Itching/Dry Flaky 69 ___ Bruising Easily 70 ___ Change in Mole(s) 71 ___ Skin Cancer</p> <p>Male Only</p> <p>72 ___ Testicular Swelling/Pain 73 ___ Prostate Problems</p> <p>Female Only</p> <p>74 ___ Painful Periods 75 ___ Excessive Flow 76 ___ Irregular Cycles 77 ___ Vaginal Burning/Itching 78 ___ Hot Flashes 79 ___ Date Last Period Began</p> <p>80 ___ Date of Last PAP Test</p> <p>Neurological</p> <p>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</p>	<p>Musculoskeletal</p> <p>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</p> <p>Habits/Exercise</p> <p>100 ___ Smoking _____ packs/day 101 ___ Alcohol _____ drinks/week 102 ___ Recreational Drug Use 103 ___ Times per week you exercise _____</p> <p>Family Medical History Include information on brothers, sisters, parents and grandparents (not yourself)</p> <p>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 _____</p> <p>Other</p> <p>112 List any medical conditions you have (even if listed above): _____ _____ _____ _____</p> <p>113 List all Surgeries/Hospitalizations you have had: _____ _____ _____ _____</p> <p>114. list all Vitamins/Supplements/Herbs you are currently taking: _____ _____ _____ _____</p>
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115. Please list all medications you are currently taking and why you are taking them: _____



Practice Member's Name: _____ Date: _____

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 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

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

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: _____



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 my home 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 Individual

Signature of Personal Representative

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.

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 and charge (Visa, MasterCard & Discover). 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. There is a \$20 minimum for credit card charges.

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. We will 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



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