Owners: Sarah Ayers, D.C.
Landon Taylor, D.C.

Mount Sterling Family Chiropractic

Patient Intake/History Form

How did you hear about our office? (please check one)

Internet _____Another Patient Yes/No (if so) Patients Name:_____
Advertising/Event /Mailer_____ Was a Former Patient_____Walk-In_____ Sign out front_____

Demographic Information

First Name:_____Last Name:_____Middle Initial:____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ SS #_____ Full Time Student: Yes / No

Gender: (Circle one) Male Female Race: (Circle one) White Black/African American Hispanic Other

Marital Status: (Circle One) Single Married Divorced Other Preferred Language:_____

Contact Information

Primary Number:_____Email:_____

Best Contact Method:_____

Emergency Contact Name:_____ Emergency Contact Number: _____

Employment Information Occupation_____

Employer's Name_____ Employer's City:_____ State:__

Other Health Care Providers/Family Doctor Office use: Weight:_____ Ht:_____

Doctor/Provider's Name:_____ Temp:_____

Type of Doctor/Provider:_____ BP:_____/_____

May we contact your family physician to discuss your condition/case? Yes / No Pulse:_____

Medications

Name and Purpose (if known)_____

_____

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Personal Medical History

Surgeries: (Please list surgery and date to the best of your knowledge)_____

_____

_____

Allergies: _____

Family Medical History: (please circle if your immediate family suffers from any of these conditions)

Diabetes Heart Disease Stroke Cancer Genetic Condition: _____

If female, to the best of your knowledge are you currently or possibly pregnant?_____

Social History

Do you smoke: _____ If you quit, how long since quitting in years_____

How would you rate you physical fitness from 0-10, with 10 being very fit and 0 being extremely unfit: _____

How would you rate your diet from 0-10, with 10 being very healthy and being extremely unhealthy: _____

How many glasses/bottles of water do you consume daily on average: _____

How many caffeinated beverages do you consume daily on average: _____

Do you have a history of depression _____

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Review of Body Systems
Do you have or have you had any of the following conditions?

Musculoskeletal : (circle any that apply) **Now** **Past**

Osteoporosis Scoliosis Back Problems Neck Problems Shoulder problems Elbow/Wrist problems

Hip problems Knee problems Foot problems TMJ problems

Neurological: (circle any that apply) **Now** **Past**

Headaches Dizziness Numbness/Tingling Anxiety Depression

Cardiovascular: (circle any that apply) **Now** **Past**

Heart attack Stroke High Blood pressure High Cholesterol Angina/Chest Pain Poor Circulation

Respiratory: (circle any that apply)

Asthma Emphysema Shortness of Breath Sleep Apnea Pneumonia

Digestive: (circle any that apply) **Now** **Past**

Heartburn Ulcer Diarrhea Constipation Anorexia/Bulimia

Sensory: (circle any that apply) **Now** **Past**

Blurred Vision Hearing loss Loss of Smell Ringing in Ears Loss of Taste

Integumentary: (circle any that apply) **Now** **Past**

Skin Cancer Eczema Psoriasis Rash

Endocrine: (circle any that apply) **Now** **Past**

Diabetes Thyroid Conditions Chronic Low Energy Immune Disorders Frequent Infections

Genitourinary: (circle any that apply) **Now** **Past**

Kidney Stones Prostate Issues Reproductive Issues Pain during urination

Constitutional: (circle any that apply) **Now** **Past**

Poor appetite Sudden weight gain or loss Chronic Fatigue Weakness Fainting

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HISTORY OF PRESENT ILLNESS/CONDITION

Please describe what problem(s) you are having that brought you to this office today:

_____

_____

_____

_____

Please rate the intensity and area of your pain from 0-10, where **0 is NO PAIN** and **10 is WORST PAIN**

Area_____
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Area_____
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Area_____
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

What date did this problem begin: _____

How did this problem begin: (i.e. lifting, exercise, car accident) _____

Describe the symptoms you are having: (circle all that apply)

Dull Sharp Stabbing Throbbing Burning Deep Aching Tingling Cramping Numb Radiating

If the pain does radiate, to what area of you body does it travel: _____

What seems to aggravate your symptoms:

Sitting Standing Bending Lifting Twisting Walking Driving Exercise House Chores Sleeping

Looking Down Looking Up Typing Sneezing/Coughing Going up/down stairs

What have you tried that has helped your symptoms:

Ice Heat Rest Stretches/Exercises Ibuprofen/Tylenol Prescription Medication Brace

Topical (i.e. Icy Hot/Biofreeze) Laying flat on back

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FINANCIAL POLICY

Welcome to Georgetown Family Chiropractic! We are delighted that you chose our office to care for you. Our goal is to treat patients of all ages with different needs and we use our best efforts to make your experience as pleasant as possible. Please be aware that even if you have insurance, your account is your responsibility, NOT that of your insurance company. Before or during your initial visit, we contact your insurance company to get benefit information. The representative or online system immediately reads us a disclaimer that states they do not guarantee payment and that payment is based on the plan booklet that you received. We urge you to be fully aware of the provisions of your policy, as we are NOT responsible for any errors, omissions or misinformation given to us by your insurance company. Although we do our best to provide the most accurate information to you, it is possible you may owe money after your insurance has paid. We ask the balance be paid upon receipt of your billing statement.

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided and you may receive a copy of this fee schedule upon request.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- If you are a member of DMPO we may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.
- Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, our office will be unable to extend any type of discounts other than those listed above.

***Acknowledge below that: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be due and payable.

Acknowledged By: _____

Date: _____

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Mount Sterling Family Chiropractic

PRIVACY POLICY

Our office policy of privacy practices outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services:

1. The patient understands and agrees to all this office to use their PHI for the purpose of treatment, payment, health care operations, and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligation: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.
7. A copy of this policy will be available upon request and is also posted in the waiting room area of our office located at 100 Eastside Drive, Georgetown, KY 40324.

Please list anyone we may share you information with:

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

Patient Name (printed): _____

Patient Signature: _____ Date:_____

Updated 7/2022

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Informed Consent

Patient Name: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: Spinal manipulative therapy, palpation, taking of vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy, electric muscle stimulation, spinal rehabilitation exercises, and radiographic studies.
Note: You will only receive what the Doctor prescribes as necessary to treat your condition.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote.
Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest.
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Georgetown Family Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____.
This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.
As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment.
By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that itis in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name: _____ Date: _____

Patient's Signature: _____

Signature of Parent or Guardian (if a minor): _____

Signature of Provider:_____