

## INTAKE FORM FOR THRIVE WELLNESS CENTER

Today's Date: \_\_\_\_\_

### PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Preferred Method of Contact:  Text  Call

Social Security #: \_\_\_\_\_ Marital Status:  Married  Single  Widowed  Divorced

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Number and Ages of your children: \_\_\_\_\_

Health Insurance:  Yes: \_\_\_\_\_ or  No College Student:  Yes or  No

Name & Number Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Have you seen a Chiropractor before?  No  Yes If yes, when: \_\_\_\_\_

### YOUR HEALTH SUMMARY (REVIEW OF SYSTEMS)

Please **checkmark** (✓) all symptoms you are **currently** experiencing.

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Migraines             | <input type="checkbox"/> Wheezing               | <input type="checkbox"/> Hair Loss                                   | <input type="checkbox"/> Hyperactivity            |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Stomach pains/cramping | <input type="checkbox"/> Easy Bruising                               | <input type="checkbox"/> Restlessness             |
| <input type="checkbox"/> Slurring of speech    | <input type="checkbox"/> Constipation           | <input type="checkbox"/> Menstrual Problems                          | <input type="checkbox"/> Insomnia                 |
| <input type="checkbox"/> Ringing in Ear        | <input type="checkbox"/> Reflux or Heartburn    | <input type="checkbox"/> Uterine Fibroids                            | <input type="checkbox"/> Decreased Libido         |
| <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Bloating               | <input type="checkbox"/> Ovarian Cysts                               | <input type="checkbox"/> Anemia                   |
| <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Nausea or Vomiting     | <input type="checkbox"/> Cancer (breast, ovarian, prostate, uterine) | <input type="checkbox"/> Decreased Appetite       |
| <input type="checkbox"/> Mid-Back Pain         | <input type="checkbox"/> Joint Pain             | <input type="checkbox"/> Prostate problems                           | <input type="checkbox"/> Weight Gain              |
| <input type="checkbox"/> Chest pain            | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Depression                                  | <input type="checkbox"/> Inability to Lose Weight |
| <input type="checkbox"/> Low Back Pain         | <input type="checkbox"/> Chronic Pain           | <input type="checkbox"/> Anxiety                                     | <input type="checkbox"/> Altered taste/smell      |
| <input type="checkbox"/> Sciatica              | <input type="checkbox"/> Muscle Aches           | <input type="checkbox"/> Mood Swings                                 | <input type="checkbox"/> Sore throat              |
| <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Irritability                                | <input type="checkbox"/> Water Retention          |
| <input type="checkbox"/> Numbness/Tingling     | <input type="checkbox"/> Dermatitis             | <input type="checkbox"/> Memory Loss                                 |   |
| <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Palpitations           | <input type="checkbox"/> Confusion                                   |   |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Rashes                 | <input type="checkbox"/> Respiratory Infections                      |   |
| <input type="checkbox"/> Chest Congestion      | <input type="checkbox"/> Brittle Nails          |  |   |

Please Identify the condition that brought you to this office: \_\_\_\_\_

List Prescription & Non-Prescription drug(s) you take:

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This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: \_\_\_\_\_.

**SOCIAL HISTORY**

- 1. **Smoking:**  cigars  pipe  cigarettes → How often?  Daily  Weekends  Occasionally  Never
- 2. **Alcoholic Beverage:** consumption occurs →  Daily  Weekends  Occasionally  Never
- 3. **Recreational Drug use:**  Daily  Weekends  Occasionally  Never

**FAMILY HISTORY:**

- 1. Does anyone in your family suffer with the same condition(s)?  No  Yes  
**If yes whom:**  grandmother  grandfather  mother  father  sister's  brother's  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know
- 2. **Any** other hereditary conditions the doctor should be aware of:  No  Yes: \_\_\_\_\_

I hereby authorize payment to be made directly to [Thrive Wellness Center](#), for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Thrive Integrated Health for any and all services I receive at this office: \_\_\_\_\_.

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

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Providers Signature \_\_\_\_\_ Date \_\_\_\_\_

# Activities of Daily Living/Symptoms

**Patient Name:** \_\_\_\_\_

**File#** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

**LIST RESTRICTED ACTIVITY (from above):**

**CURRENT ACTIVITY LEVEL**

**IDEAL ACTIVITY LEVEL**

**Example:** Sitting \_\_\_\_\_ :

30 minutes

2 hours

\_\_\_\_\_ :

\_\_\_\_\_

\_\_\_\_\_ :

\_\_\_\_\_

\_\_\_\_\_ :

\_\_\_\_\_

\_\_\_\_\_ :

\_\_\_\_\_

\_\_\_\_\_ :

\_\_\_\_\_

# QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

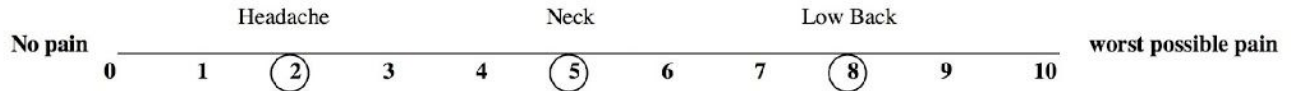
Date \_\_\_\_\_

**Please read carefully:**

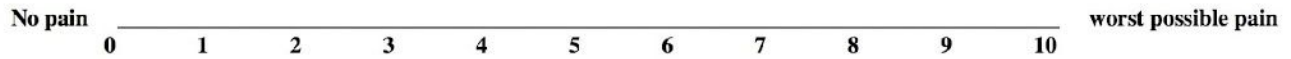
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

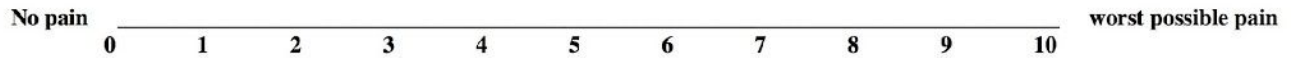
**Example:**



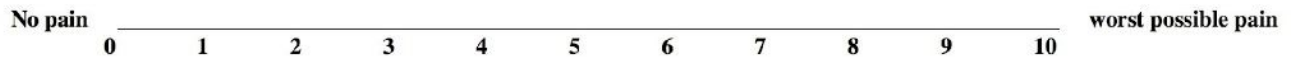
**1 – What is your pain RIGHT NOW?**



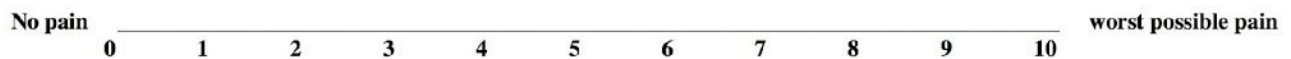
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

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Examiner \_\_\_\_\_

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Patient initials: \_\_\_\_\_-retaining page 1 of 2

**Thrive Wellness Center's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....**

I have received a copy of Thrive Wellness Center's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

In respect to our privacy policy, we need to know who you authorize us to speak to in your behalf in regards to appointments and your account. Please list below any persons we may receive and release information from:

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Patient's Name DOB HR#:

\_\_\_\_\_  
Patient signature Date

\_\_\_\_\_  
Witness Date

# Thrive Wellness Center NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

## PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent to or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patients death
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or up coming events.
11. Change of ownership- in the event this practice is sold the new owners would have access to your PHI

## YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to although we are not required to comply. If however we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however like restrictions we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource, them to an imaging center, to have copies made, we will be happy to accommodate you, however you will be responsible for this cost.

## COMPLAINTS:

If you wish to make a formal complaints about how we handle your health information please call [Lucy](tel:479-856-3416) at 479-856-3416. If [she](#) is unavailable, you may make an appointment with our receptionist to see [her](#) within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201