Whom may we thank for referring you to this office → ___________________________________?

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.

□ Migraines
□ Headaches
□ Slurring of speech
□ Ringing in Ear
□ Jaw Pain
□ Neck Pain
□ Mid-Back Pain
□ Chest pain
□ Low Back Pain
□ Sciatica
□ Restless Leg Syndrome
□ Numbness/Tingling
□ Fatigue
□ Asthma
□ Chest Congestion

□ Wheezing
□ Stomach pains/cramping
□ Constipation
□ Reflux or Heartburn
□ Bloating
□ Nausea or Vomiting
□ Joint Pain
□ Arthritis
□ Chronic Pain
□ Muscle Aches
□ Eczema
□ Dermatitis
□ Palpitations
□ Rashes
□ Brittle Nails

□ Hair Loss
□ Easy Bruising
□ Menstrual Problems
□ Uterine Fibroids
□ Ovarian Cysts
□ Cancer (breast, ovarian, prostate, uterine)
□ Prostate problems
□ Depression
□ Anxiety
□ Mood Swings
□ Irritability
□ Memory Loss
□ Confusion
□ Respiratory Infections

□ Hyperactivity
□ Restlessness
□ Insomnia
□ Decreased Libido
□ Anemia
□ Decreased Appetite
□ Weight Gain
□ Inability to Lose Weight
□ Altered taste/smell
□ Sore throat
□ Water Retention

Please Identify the condition that brought you to this office: ____

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

____

____

____

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 Wellness Center for any and all services I receive at this office. Should you receive payment from your insurance company, you are responsible to forward those payments in full to Thrive Wellness Center: ____________.

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___________________________

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment Objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Thrive Wellness Center have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____ _____/_____/_____ ● *Witness Initials*

Patient or Authorized Persons Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully, and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

□ The first day of my last menstrual cycle was on ____-____-____ Date

□ I have been provided a full explanation of when I am mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____ _____/_____/_____ ● *Witness Initials*

Patient or Authorized Persons 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:

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

LIST RESTRICTED ACTIVITY (from above):	CURRENT ACTIVITY LEVEL	IDEAL ACTIVITY LEVEL
Example: **Sitting** :	**30 minutes**	**2 hours**
___________________:	___________________	___________________
___________________:	___________________	___________________
___________________:	___________________	___________________
___________________:	___________________	___________________
___________________:	___________________	___________________

QUADRUPLE VISUAL ANALOGUE SCALE

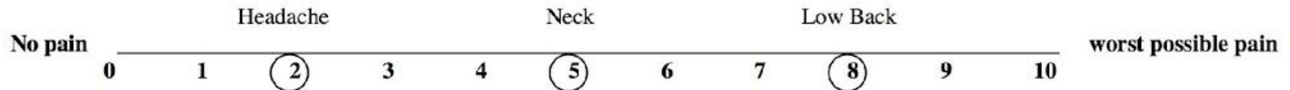
Patient Name ____________________ Date ____________

Please read carefully:

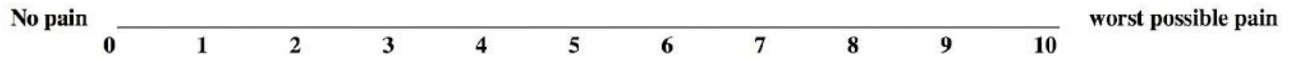
Instructions: Please circle the number that best describes the question being asked.

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.

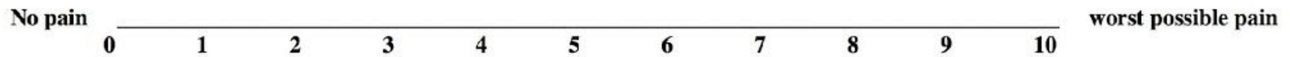
Example:



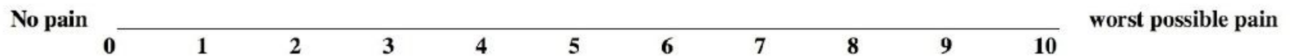
1 – What is your pain RIGHT NOW?



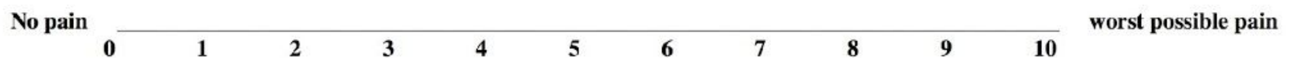
2 – What is your TYPICAL or AVERAGE pain?



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:

____

____

____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

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 **P**ersonal **H**ealth **I**nformation. 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 apprize 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 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