Patient Name: _____

Adult New Patient Intake Form

Informed Consent | Financial Policy | Privacy Policy

Date_____

☐CWP_____ ☐PI ☐WC ☐VA ☐MEDICARE ☐INS

Full Name_____ **Date of Birth** _____ **Sex** □ Male □ Female

Address_____ **City**_____ **State**_____ **Zip** _____

Cell Phone _____ **Home Phone** _____ **E-mail**_____

Preferred method of communication. □ Cell Phone □ Home Phone □ E-mail □ Other _____

Marital Status □ M □ S □ W □ D **Name of Spouse/Significant Other**_____ **Phone** _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

How did you hear about us? _____

CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

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

Information about the Chiropractic Adjustment
The primary treatment used in the clinic is spinal manipulative therapy or the chiropractic adjustment. It is likely that spinal manipulative therapy will be used as part of your treatment. Spinal manipulative therapy includes placement of the doctor's hands or mechanical instruments upon your body in such a way as to mobilize your joints. This movement may cause an audible "pop" or "click," such as experienced when you "crack" your knuckles. You may also feel a sense of movement.

The Material Risks Inherent in the Chiropractic Adjustment
All patient care, including chiropractic treatment, has the potential for negative effects. The risks associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare but nevertheless exist. The Doctors at JayMac Chiropractic will develop a treatment plan recommending what they feel is in your best interest based on clinical examination, patient history, and professional experience.

The Probability of Those Risks Occurring
Fractures are rare occurrences and generally result from some underlying weakness of the bone which your doctor looks for during your initial consultation, examination, and while reviewing your x-rays if indicated or recommended. Stroke has been the subject of tremendous disagreement. The incidence of a stroke is exceedingly rare and is estimated to occur between one in one million and one in five million adjustments of the neck. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options
Other treatment options for your condition may include: Self-administered, over-the-counter analgesics, Rest, Medical care, Prescription medications such as anti-inflammatory, muscle relaxants and pain-killers, Hospitalization, and Surgery. If you choose 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 care physician.

Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's overall health, severity of discomfort, their pain tolerance, and their self-discipline in not abusing the medication. Professional literature describes highly undesirable effects from long term use of over-the-counter medications.

Prescription muscle relaxants and pain killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's overall health, severity of discomfort, their pain tolerance, their self-discipline in not abusing the medication, and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.

Hospitalization in conjunction with other care, bears the additional risk of exposure to communicable diseases, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse results from such exposure being dependent upon many variables.

The risks inherent with surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all risks associated with hospitalization, and an extended convalescent period. The probability of those risks occurring varies to many factors.

The Risks and Dangers Attendant to Remaining Untreated
Remaining untreated may allow the formation of adhesions and reduce mobility of your joints which may set up a pain reaction further reducing mobility and overall range of motion. Over time this process may compromise your recovery making treatment more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

The Chiropractic Examination
Prior to establishing a treatment plan, the doctor must perform a Chiropractic Examination in order to determine the probable cause of your complaint. During the examination the doctor will perform some procedures or maneuvers intended to reproduce your symptoms which will allow for a better understanding of the nature of your condition and for the development of an appropriate treatment regimen. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

Documented Patient Noncompliance
Every effort will be made to help you achieve maximum health. It is important to keep your appointments and follow through with the prescribed treatment plan. We understand busy schedules and anticipate these as a part of life, however, please be courteous and inform us of any conflicts in scheduling immediately so that we may accommodate you accordingly and schedule other patients in need. If the noncompliance reaches the point of jeopardizing "good quality care," we may formally discharge you as a patient with an appropriate letter of withdrawal. Your patient records will note such problems of noncompliance and you will be provided an alternative source of recovery.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanations regarding the chiropractic examination, adjustment, and related treatment and have discussed it with the Doctors at JayMac Chiropractic and have had my questions answered to my satisfaction.

By signing below I state that I understand the benefits, risks, and alternatives involved in undergoing treatment and have decided that it is in my best interest or my child's best interest to undergo the treatment recommended by the Doctors at JayMac Chiropractic. Having been informed of the benefits, risks, and alternatives, I hereby give my consent to the prescribed and recommended treatment. I intend this consent to cover any examinations and treatments for my present condition and for any future conditions for which I seek treatment from JayMac Chiropractic.

If the patient is a minor, I hereby authorize the doctors and staff at JayMac Chiropractic to examine my child and to treat his/her condition as deemed appropriate, which may or may not include diagnostic imaging.

Date _____ Date _____

_____ _____

Printed Name of Patient *or* Parent/Guardian (if a minor) Signature of Doctor

_____

Signature of Patient *or* Parent/Guardian (if a minor)

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I acknowledge and accept the following:

Health and accident insurance policies are an arrangement between an insurance carrier and me. JayMac Chiropractic will help prepare and submit claim forms and necessary medical records to assist me in making collection from the insurance company.

JayMac Chiropractic **CAN NOT** guarantee that my insurance company will pay. Prior to or immediately after my first visit, JayMac Chiropractic will make every attempt to receive and verify benefits and coverage. I understand that if I seek treatment outside of JayMac Chiropractic, my remaining benefits may not be accurate and claims may be denied due to exhausted benefits. I understand that insurance claims may be denied if I see multiple providers for the same injury or complaint.

I hereby assign all medical and chiropractic benefits to which I am entitled to JayMac Chiropractic. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other medical plan or representative to issue payment check(s) or direct deposits directly to JayMac Chiropractic for medical or chiropractic services rendered to myself and/or my dependents.

All services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that I am responsible for any amount not covered by insurance. I also understand that if I suspend or terminate my care and treatment or insurance policy, any fees for professional services rendered to me will be immediately due and payable.

*Effective October 1, 2022, all patients will be required to have a credit card on file (CCOF) regardless of insurance or visit type. Personal injury and worker's compensation patients will not be required to provide a CCOF until after discharge and continuation of care. See CCOF Policy online at *http://www.JayMacChiropractic.com/CCOF.html* for additional details.

Scan to view CCOF Policy

*A **Medical Lien** will be filed in Maricopa County, Arizona on behalf of JayMac Chiropractic for all ongoing medical expenses accrued in the office and with all involved 3rd party payers and legal representatives, regardless of fault, for all Personal Injury cases to ensure that all my treatments and visits are covered by the appropriate entity. A copy of the lien will be provided when filed. I acknowledge that any changes to this process must be discussed and agreed upon within 30 days. Please seek legal counsel relative to this financial policy.

Printed Name of Patient *or* Parent/Guardian (if a minor) _____ Signature of Patient *or* Parent/Guardian (if a minor) _____ Date _____

ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES

I have reviewed JayMac Chiropractic's Notice of Privacy Practices, located at *http://www.JayMacChiropractic.com/privacy.html*.

This policy explains how my Protected Health Information (PHI) will be used and disclosed. I have had my questions satisfactorily answered considering this policy. I understand that I may request a physical or digital copy of this document upon request at any time.

Scan to view Privacy Policy

Printed Name of Patient *or* Parent/Guardian (if a minor) _____ Signature of Patient *or* Parent/Guardian (if a minor) _____ Date _____

---------- **FOR OFFICE USE ONLY**----------

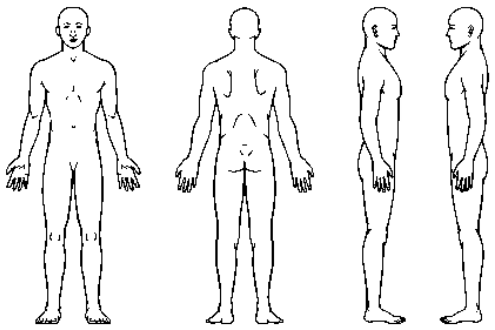
JayMac Chiropractic attempted to obtain written acknowledgment of receipt or review of our Notice of Privacy Practices, but acknowledgment could not be obtained because (please specify) _____

_____

Staff Signature _____ Date _____

Patient Name: _____

List your major complaints	How long?	Rate your pain
1.		0 1 2 3 4 5 6 7 8 9 10
2.		0 1 2 3 4 5 6 7 8 9 10
3.		0 1 2 3 4 5 6 7 8 9 10
4.		0 1 2 3 4 5 6 7 8 9 10
5.		0 1 2 3 4 5 6 7 8 9 10
6.		0 1 2 3 4 5 6 7 8 9 10



What Treatments have you had?

What makes your condition BETTER?

What makes your condition WORSE?

Does the pain/numbness RADIATE? □ Y □ N Explain:

When is your condition BETTER? **When is your condition WORSE?** □ **Same all day**

Does your condition interfere with any of the following: □ Work □ Sleep □ Recreation □ Social life □ Family life □ Sex life

Have you had this condition before? □ Y □ N Explain:

Date of last Chiropractic treatment? **Name of previous chiropractor?**

MEDICAL HISTORY: Describe any of the following. Provide approximate dates. □ PD

Infections: _____ Major Trauma: _____
Hospitalizations: _____ Spinal or neck injuries: _____
Automobile/Motorcycle accidents: _____ Falls or other injuries: _____
Other injuries: _____

Surgeries: _____

Allergies? □ Y □ N Explain _____

FAMILY MEDICAL HISTORY: Describe any medical issues in your family. Provide approximate dates. □ Adopted/Unknown □ PD

Mother: _____ Father: _____
Sister(s): _____ Brother(s): _____
Maternal Grandmother: _____ Paternal Grandmother: _____
Maternal Grandfather: _____ Paternal Grandfather: _____

SOCIAL HISTORY: □ PD

Tobacco Use: □ Y □ N □ Cigarettes/Cigars □ Chewing Tobacco Pack(s)/day_____ Start Date _____ End Date _____
Alcohol Use: □ Y □ N _____ Drinks/week
Recreational Drug Use: □ Y □ N Explain _____ Daily Water Intake: _____

LIST ALL MEDICATIONS and NUTRITIONAL SUPPLEMENTS **REASON FOR TAKING** □ PD

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Drug Allergies/Interactions? □ Y □ N Explain _____

Patient Name: _____

REVIEW OF SYSTEMS

Select the following conditions that apply to you.

Constitutional PD
- □ Balance issues
- □ Cancer
- □ Changes in appetite
- □ Changes in sleep
- □ Changes in weight
- □ Chills
- □ Dizziness
- □ Fatigue
- □ Fever
- □ Hyperactivity
- □ Tumor
- □ Vertigo

Cardiovascular PD
- □ Angina/Chest pain
- □ Atrial fibrillation (AFib)
- □ DVT or Blood Clot
- □ Embolism
- □ Fainting
- □ Hardening of arteries
- □ Heart attack
- □ Heart disease
- □ High blood pressure
- □ Low blood pressure
- □ Poor circulation
- □ Rapid heart beat
- □ Slow heart beat
- □ Stroke
- □ Swollen ankles
- □ Varicose veins

Respiratory PD
- □ Asthma
- □ Bronchitis
- □ Chronic cough
- □ COPD
- □ Difficulty breathing
- □ Emphysema
- □ Shortness of breath
- □ Sleep apnea □ CPAP

Gastrointestinal (GI) PD
- □ Acid reflux
- □ Belching or gas
- □ Celiac Disease
- □ Colon issues
- □ Constipation
- □ Crohn's Disease
- □ Diarrhea
- □ Gall bladder issues
- □ Heartburn
- □ Hemorrhoids
- □ Hiatal hernia
- □ Jaundice
- □ Liver issues
- □ Nausea
- □ Spitting up blood
- □ Stomach aches
- □ Stomach ulcers
- □ Vomiting

Genitourinary (GU) PD
- □ Bed-wetting
- □ Bladder infection
- □ Blood in urine
- □ Kidney infection
- □ Kidney stone
- □ Painful urination
- □ Poor urine control
- □ Urinary Tract Infection

Musculoskeletal PD
- □ Arm pain
- □ Arthritis
- □ Broken bones
- □ Bursitis
- □ Elbow pain
- □ Foot pain
- □ Hip pain
- □ Knee pain
- □ Leg pain
- □ Low backache
- □ Muscle atrophy
- □ Pain btwn shoulders
- □ Painful tailbone
- □ Plantar Fasciitis
- □ Rib Pain
- □ Scoliosis
- □ Shoulder pain
- □ Spinal curvature
- □ Sprained ankle
- □ Weakness in arms
- □ Weakness in legs
- □ Wrist pain

Integumentary/Skin PD
- □ Bruise easily
- □ Eczema/Hives
- □ Hair/Nail Changes
- □ Itching (Pruritis)
- □ Moles (Irregular)
- □ Psoriasis
- □ Rashes
- □ Scaling
- □ Skin cancer

Neurological PD
- □ Burning sensations
- □ Convulsions
- □ Numbness in arm/hand
- □ Numbness in leg/foot
- □ Pins/Needles/Tingling
- □ Restless Leg Synd. (RLS)
- □ Sciatica
- □ Seizures

Psychiatric PD
- □ ADHD/ADD
- □ Anxiety
- □ Dementia
- □ Depression
- □ Nervousness
- □ Paranoia
- □ PTSD
- □ Stress/Tension

Endocrine PD
- □ Diabetes Type: □ I □ II
- □ Enlarged Glands
- □ Frequent urination
- □ Gout
- □ Hypoglycemia
- □ Swollen joints
- □ Thyroid issues

Hematological/Lymphatic
- □ Anemia PD
- □ Blood disorder
- □ HIV/AIDS

Allergy/Immunologic PD
- □ Seasonal Allergies
- □ Food Allergy/Intolerance
- □ Rheumatic fever
- □ Tuberculosis

EEMNT PD
- □ Dental issues
- □ Difficulty swallowing
- □ Ear infection(s)
- □ Hearing issues
- □ Nasal congestion
- □ Nosebleeds
- □ Ringing in ears
- □ Sinus infection
- □ Sore throat
- □ TMJ pain
- □ Vision issues □ corrected

Head/Neck PD
- □ Headaches
- □ Migraines □ w/ Aura
- □ Painful neck
- □ Stiff neck

List any other conditions

_____
_____
_____
_____

For Women Only PD
- □ Breast lumps or pain
- □ Irregular cycle
- □ Menopausal symptoms
- □ Menstrual cramps
- □ Painful intercourse
- □ PCOS
- □ Premenstrual tension
- □ Unable to get pregnant

□ Hysterectomy Date: _____
□ Tubal ligation Date: _____
□ Breast Augmentation _____
□ Breast Reduction _____

Last Breast Exam: _____
Last Pap Smear: _____
Last Menstrual Period: _____

Regular Checkups? □ Yes □ No
Are you Pregnant? □ Yes □ No

For Men Only PD
- □ Breast lumps or pain
- □ Changes in bathroom habits
- □ Erectile dysfunction (ED)
- □ Low T, Testosterone
- □ Painful intercourse
- □ Prostate issues
- □ Testicular issues
- □ Vasectomy Date: _____

Last Prostate Exam: _____
Last Testicular Exam: _____

Regular Checkups? □ Yes □ No

PD = Patient Denied All Issues
CC = chief complaint
Circle current conditions

CONFIDENTIAL PROTECTED HEALTH INFORMATION (PHI)

I acknowledge that the health history and demographics above are complete and accurate, and that if any changes in my health or demographics occur, I will discuss these changes with the Doctors at JayMac Chiropractic.

_____ _____ _____ _____

Patient Signature *or* Parent/Guardian (if a minor) Date Signature of Doctor Date