



## New Patient Intake Paperwork

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call 402-933-4447 if you have any questions or are unsure how to complete any section of this form.

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

### Patient Information

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Gender:  Male  Female  
Preferred Phone: \_\_\_\_\_  Home  Mobile  Work  
Secondary Phone: \_\_\_\_\_  Home  Mobile  Work  
Email: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Marital Status:  Married  Single  Divorced  Widowed  Other \_\_\_\_\_

### Referral

How were you referred to our clinic?  Another Physician  Internet  Phone book  Insurance Company  
 Family  Friend  Facebook  Other \_\_\_\_\_  
\_Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
\_\_\_\_\_ Phone: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_ City: \_\_\_\_\_

### Insurance Plan

**Please provide insurance information at your first appointment for all primary and secondary insurance coverage. We will request cards for photocopy and add them to your patient file.**

Payer (e.g. BC/BS): \_\_\_\_\_ Plan: \_\_\_\_\_  
Policy/I.D. Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
\_\_\_\_\_ If you are not the policy holder, please complete this section:  
Insurance policy holder:  Self  Spouse  Child  Other: \_\_\_\_\_  
Policy Holder Name: Policy Holder Gender:  Female  Male Date of Birth: \_\_\_\_\_

Initials \_\_\_\_\_

## Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim.

Workers Comp Company: \_\_\_\_\_ Adjuster Name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Date of initial injury: \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Fax number: \_\_\_\_\_

Approximately when did this pain begin? \_\_\_\_\_

Briefly describe what caused your current pain complaints? \_\_\_\_\_

What word best describes the frequency of your pain?  Constant  Intermittent

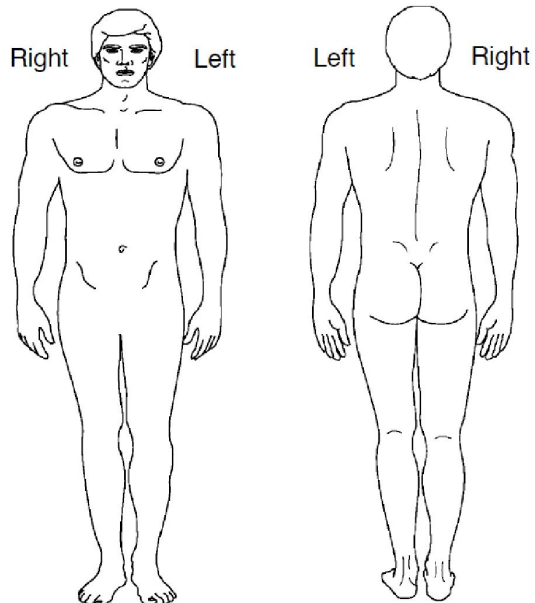
Since your pain began, how has it changed?  Decreased  Increased  Stayed the same

\_\_\_\_\_ What number on the pain scale (0-10) best describes your pain **right now**?

\_\_\_\_\_ What number on the pain scale (0-10) best describes your **worst pain**?

\_\_\_\_\_ What number on the pain scale (0-10) best describes your **least pain**?

**Please note the location of your pain and if it travels to other areas.**



Initials \_\_\_\_\_

## Pain Description

Please describe your pain: \_\_\_\_\_

What makes your pain worse?  Sitting  Standing  Walking  Lying down  Work   
other \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

## Pain Interference

Check all of the following activities that your pain interferes with:

- |  |  |                                       |   |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> Nothing           | <input type="checkbox"/> Driving       | <input type="checkbox"/> Intercourse  | <input type="checkbox"/> Leisure Activities |
| <input type="checkbox"/> Personal Grooming | <input type="checkbox"/> Relationships | <input type="checkbox"/> Sleep        |   |
| <input type="checkbox"/> Walking           | <input type="checkbox"/> Work duties   | <input type="checkbox"/> Other: _____ |   |

## Prior Pain Treatments

Mark all of the following treatments you have had prior to today's visit for your current pain complaints:

- Acupuncture  Chiropractic  Pain Medications  Physical Therapy  Psychological Therapy  
 Epidural Steroid Injection(s)  Trigger Point Injections  Joint Injection(s)  Nerve Blocks  
 Radiofrequency Ablation  Spinal Cord Stimulator – (circle one) Trial Only / Permanent Implant

Vertebroplasty / Kyphoplasty – Level(s) \_\_\_\_\_

Pain Pump – What Type? \_\_\_\_\_ Date Implanted? \_\_\_\_\_

Spine Surgery – What type? \_\_\_\_\_ When? \_\_\_\_\_

\_\_\_\_\_  
 Other: \_\_\_\_\_  I

HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.

## Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

MRI of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

X-ray of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

CT scan of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

EMG/NCV studies of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

\_\_\_\_\_  Other diagnostic testing: \_\_\_\_\_

I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Initials \_\_\_\_\_

## Past Medical History

Mark the following conditions/diseases that you are being or have been treated for:

- |                                       |                                     |   |                                       |
|---------------------------------------|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Anxiety    | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Asthma       |
| <input type="checkbox"/> Back Problem | <input type="checkbox"/> BPH        | <input type="checkbox"/> Breast CA        | <input type="checkbox"/> CAD          |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> CHF        | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> COPD         |
| <input type="checkbox"/> Dementia     | <input type="checkbox"/> Depression | <input type="checkbox"/> Dermatitis       | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> Epilepsy     | <input type="checkbox"/> GERD       | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Gout         |
| <input type="checkbox"/> Headache     | <input type="checkbox"/> Hepatitis  | <input type="checkbox"/> HIV              | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> MI           | <input type="checkbox"/> Migraine   | <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Kidney Stone |
| <input type="checkbox"/> Stroke       | <input type="checkbox"/> TB         | <input type="checkbox"/> Thyroid Disease  | <input type="checkbox"/> Ulcer (GI)   |

## Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

### Abdominal Surgery

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### Neurologic Surgeries

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### Heart Surgery

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### Joint Surgery

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### Spine / Back Surgery

Discectomy (levels) \_\_\_\_\_

Laminectomy (levels) \_\_\_\_\_

Spinal fusion (levels) \_\_\_\_\_

### Other Surgeries

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I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE

Initials \_\_\_\_\_

## Attestation, HIPPA, and Financial Policy

I certify that the information I have supplied is accurate, complete and true.

I authorize Elevate Chiropractic and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Elevate Chiropractic to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Elevate Chiropractic's Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize Elevate Chiropractic to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Elevate Chiropractic to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Elevate Chiropractic will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

Per our contract with Secure Care and those insurance carriers that we are In-Network with the providers of this office CAN NOT back bill insurance once a TIME OF SERVICE DISCOUNT (cash payment) has been chosen. You do not have to choose immediately.

If you choose to have us bill your insurance we can do that from the date that decision is made. We CAN NOT, however, bill any services prior to that decision.

Initial: \_\_\_\_\_

Testimonials and social media policy: Occasionally we ask patients to provide Elevate Chiropractic with video testimonials or have their photograph taken to be used on the website and other social media platforms. If you are asked and agree to this please initial here. Your full name will not be used and no personal information will be given to anyone. This is solely for promotional use by Elevate Chiropractic with your permission.

Initial \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date:

## **INFORMED CONSENT**

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I \_\_\_\_\_, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physiotherapy, exercises, nutritional supplementation, or acupuncture may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

## **TREATMENT RESULTS**

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty I will achieve these benefits.

I realize that the practice of medicine, along with chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

## **ALTERNATIVE TREATMENTS AVAILABLE**

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

**I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.**

To attest to my consent to these procedures, I hereby affix my signature to the authorization for treatment.

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent  
or Guardian (if a minor) \_\_\_\_\_

Date \_\_\_\_\_