Patient Intake Form

Patient Full Name _____

Home Phone Number_____

Date of Birth_____

Cell Phone Number_____

Current Age_____

Employer_____

Street Address_____

Occupation_____

City_____

How were you referred?_____

State_____

Name of emergency contact/phone number_

Zip Code_____

_____

Have you previously had any chiropractic care?_____ Date of last visit_____

Have you previously had any massage therapy? _____ Date of lastmassage_____

Primary care physician_____

Primary care physician contact information_____

List any major surgeries with dates of treatment_____

_____

List any major trauma/injuries (ex- whiplash injuries, lifting injuries, falls, etc) with dates of incident

_____

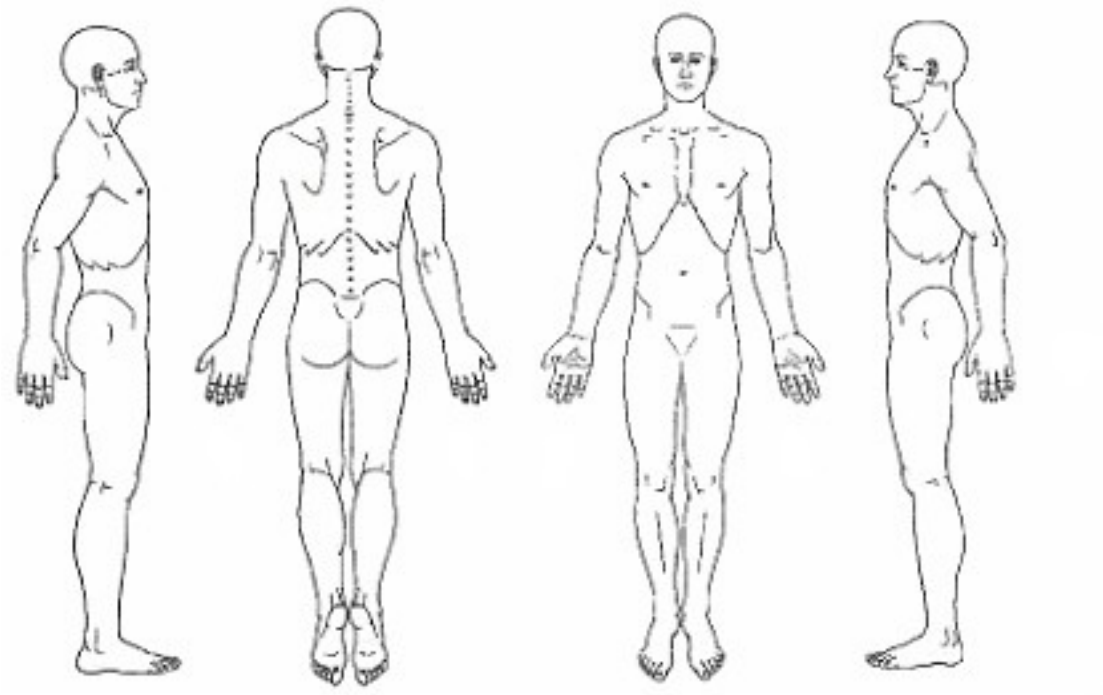
_____

How would you rate your current health? Great/good/fair/needs improvement/poor (circle one)

what portion of your day is spent sitting? 0-25% 25-50% 50-75% 75-100% (circle one

Patient Name:_____ Date:_____

Please mark any areas of complaint with an "X":



Describe your areas of complaint:

1)_____

2)_____

3)_____

4)_____

5)_____

How often do your symptoms bother you? (Please circle response)

0-25% of the time 25-50% of the time 50-75% of the time 75-100% of the time

Do any of the following help your symptoms? Circle all that apply

Ice/heat/stretching/pain reliever/rest/activity/massage/chiropractic/none/other:

_____

Patient Name:_____ Date:_____

Do any of the following make your symptoms worse? Circle all that apply

Coughing/sneezing/deep breaths/standing/sitting/lying/walking/exercise/none/other:

_____

Circle any activities that affect by your pain or symptoms:

Bending
Getting in and out of car
Climbing stairs
Sitting
Dressing
Standing
Walking
Exercising
Housework
Lifting
Lying in bed/sleeping
Changing positions
Turning or bending neck
driving a vehicle
Taking a deep breath
Dressing
Other _____

Circle any conditions you currently have, or have had in the past:

Headaches
Migraines
Numbness or tingling into arms/hands
Numbness or tingling into legs/feet
Numbness or tingling into face
Neck pain
back pain
Ankle pain
Stroke
Digestive issues
Blood clotting disorder
High blood pressure
Low blood pressure
Knee pain
Shoulder pain
Hip pain
Chest pain
Shortness of breath
Diabetes
Bowel or bladder incontinence
Heart attack
Seasonal allergies
Skin rash
Osteopenia/osteoporosis
Dizziness or vertigo
Cancer
Other _____

What are your goals for treatment? Circle all that apply

Wellness/preventative care Decrease pain

Increase range of motion Stress management

Return to normal activities

Recover more quickly fromtraining

Other _____

Please list anything else that may be of importance

Date

_____

Patient printed name

_____

Patient signature

_____

Printed Name of Parent or Guardian of above named minor

_____

Signature of Parent or Guardian of above named minor

_____

From Within Representative

INFORMED CONSENT

PATIENT NAME:_____ DATE:_____

From Within Healing Arts (hereinafter FWHA) requires all patients initial each informed consent as outlined below, as well as a completed signature at the end of this consent.
Please read this document in its entirety; questions or concerns should be addressed prior to initials and final signature.

The nature of the chiropractic adjustment:
A common treatment used by Doctors of Chiropractic's is spinal manipulative therapy: FWHA may use that procedure to treat you the patient in conjunction with manual muscle work/trigger point therapy. FWHA may use hands on adjustments or a mechanical instruments to move specific joints. You may hear audible "clicks" or "pops", much as you would when you "crack" your knuckles. You may also feel a sense of movement.

_____Patient Initials

Analysis/Exam/Treatment:
As part of the analysis, exam, and treatment, you the patient are consenting to the following procedures: spinal manipulative therapy, gentle traction, palpation, range of motion testing, orthopedic testing, basic neurological testing, vital signs, postural analysis testing, muscle strength testing, manual muscle work, instrument-assisted soft tissue mobilization, trigger point therapy, rehab/strengthening activities.

_____Patient Initials

The material risks inherent in chiropractic adjustments:
As with any healthcare procedure, there are certain complications that may arise during spinal manipulation and therapy. The most common complaints are of stiffness/soreness after adjustment which should not last longer than 24 hours. Other complications may include, but are not limited to fractures, disc injury, dislocations, muscle strain, cervical myelopathy, costovertebral strain or separation. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. From Within Healing arts will make every reasonable effort during the exam to screen for contraindications to care; however if you have a condition, which would otherwise not come to Dr. Nikki's attention, it is your responsibility to inform Dr. Nikki Daskal.

_____Patient Initials

The probability of those risks occurring:
Fractures are very rare occurrences and generally result from some underlying weakness of the bone, which Dr. Nikki Daskal will check for during the taking of your history and during exam. 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.

_____Patient Initials

The availability and nature of other treatment options:
Other treatment options 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 choose to use one of the above noted "other treatments", you should be aware that there are risks and benefits of such options; It is up to you the patient, to discuss these with your primary medical physician.

_____Patient Initials

The risk and dangers attendant to remaining untreated:
Remaining untreated may allow the formation of adhesions and reduced 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. It is up to you, the patient, to schedule any future treatments with FWHA.

_____Patient Initials

FINAL CONSENT AND AUTHORIZED SIGNATURES

CONSENT TO TREAMENT (MINOR)

I hereby request and authorize Dr. Sara Nikki Daskal, D.C. of From Within Healing Arts to perform diagnostic tests and to render chiropractic adjustments and other treatment to my minor son/daughter:____._____.

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.

_____
Printed Name of Parent or Guardian of above named minor

_____
Signature of Parent or Guardian of above named minor

_____
Date

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE CONSENT IN ITS ENTIRETY

I have read (or have had read to me) the above explanation of the chiropractic adjustment and related treatment. Any questions I have were discussed with Dr. Sara Nikki Daskal, D.C. of From Within Healing Arts and have had my questions answered to my satisfaction. By signing below I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____
Date

_____
Patient printed name

_____
Patient signature

_____
Printed Name of Parent or Guardian of above named minor

_____
Signature of Parent or Guardian of above named minor

FINANCIAL AGREEMENT

Review and sign the following Financial Agreement in its entirety prior to your first appointment. This financial agreement will remain in place, unless given notice by the office From Within Healing Arts of any payment changes.

Services provided by From Within Healing Arts (hereinafter FWHA) are not billable through your insurance provider; meaning FWHA will not accept your insurance information and bill any patient charges for you through them. By eliminating this third party, it allows From Within Healing Arts to administer the treatment that that is felt necessary for the patient's best interest. It is FWHA's policy that payment is collected same day of service or prior to service if a pre-payment option has been elected. FWHA accepts cash, personal checks, and credit cards for payment on your account.

I_____ (printed patient name) agree to pay for services at the time of service, or prior to service rendered. If responsible financial party is not the above named patient, they are signing this document stating that as of this date, they have the legal right to select and authorize health care services for the printed patient named above and that they are also accepting financial responsibility for the treatment of the above named patient for From Within Healing Arts services. It is the responsibility of the authorized signature below to inform the office of From within Healing Arts of any financial or legal changes.

_____ _____
Printed name of above named patient or responsible party Date

_____ _____
Signature of above named patient or responsible party Date

PATIENT CONSENT FORM (HIPAA COMPLIANCE)

I understand that some of my information may be used and/or disclosed by From Within Healing Arts to carry out treatment, payment, or healthcare operations. I understand that I may request restrictions on how my information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that I can revoke this consent, but only in writing.

From Within Healing Arts keeps a record of the healthcare services provide to you. You may ask to see and copy that record. You may also request to correct that record. We will not disclose your record to others, unless you direct us to do so, or unless the law compels us to do so. You may see your record by contacting FWHA.

_____
Patient signature and date

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures listed above, I hereby specifically authorize disclosure of my protected healthcare information to the person(s) indicated below.

_____
Name and Relation

_____
Designated Primary Care Physician name

_____
Patient signature and date

_____ _
FWHA Representative Date