1410 E. 17th St.
Idaho Falls, ID 83404
208-552-9600 * 208-524-6402 Fax
www.evochiropractic.com

Patient Intake Form

Please present insurance card(s) so we can put a copy in your file.

Date: _____

PATIENT INFORMATION

Name:_____
(First) (M.I.) (Last) (Name called by)

Address: _____
(Number, Street, unit #) (City, State) (Zip)

Birthday: _____Age:_____ ☐ Male ☐ Female SSN _____/_____/_____

Occupation:_____Employer: _____

Single Married Divorced Widowed Separated Spouse's Name: _____

How did you hear about us? _____

Parent(s) Name (if a minor):_____

SMOKING STATUS
☐current every day smoker
☐current some day smoker
☐former smoker
☐never smoker

DEMOGRAPHICS
Race
☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or other Pacific Islander
☐White
☐Declined to state

Ethnicity
☐Hispanic or Latino
☐Not Hispanic or Latino
☐Declined to state

Preferred Language
☐Chinese
☐English
☐French
☐Italian
☐Japanese
☐Portuguese
☐Russian
☐Spanish
☐Declined to state

CONTACT INFORMATION

Home Phone_____Cell_____Work_____Ext._____

Email_____Best way to reach you: Home Cell Work Email

*If you do not want our newsletter/promotions please check here to opt out. ☐

IN CASE OF EMERGENCY, CONTACT

Name_____Relationship_____

Home Phone _____Cell_____Work_____

HEALTH HISTORY

Date of Last: Spinal X-Ray_____ MRI_____CT-Scan_____ Other_____

List any Medications you are taking:_____

List any Medications you are allergic to:_____

Vitamins / Herbs / Minerals: _____

Females: Are you Pregnant? ☐Yes ☐No Beginning of last menstrual cycle_____

PATIENT CONDITION

What is your major symptom/problem_____

When did your symptoms begin? _____ What triggered the onset of symptoms? _____

_____

Have you had this problem before? ☐Yes ☐No

Is your condition getting progressively worse, better, or staying the same? Is this problem: 100% 75% 50% 25% of the day

How does it feel? Burning Sharp Shooting Dull Aching Stiff Tingling Throbbing Swelling

Other_____

Circle below the severity of your pain on a scale of 0 to 10: **(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)**

What makes your condition better? _____Worse? _____

Does it interfere with your: Work Sleep Daily Routine Recreation Other_____

What other treatments have you had for this condition?

Chiropractic Orthopedic Neurologist Physical Therapy Medication Surgery Other:_____

Name of other doctors who have treated you for this condition_____

Describe the other doctor's treatment for your condition_____

Other Symptoms other than major condition:_____

Check any of the following conditions you have had: Place a star by anything current.

AIDS/HIV
Allergies
Anxiety/Depression
Arm/shoulder pain
Arthritis
Asthma
Bladder Problems
Cancer
Chronic Fatigue
Deafness
Diabetes
Digestion Problems
Earache
Ear Ringing
Epilepsy
Headaches
Migraines
Heart Disease
Hemorrhoids
Herniated Disk
High Blood Pressure
Insomnia
Irregular Cycle
Kidney Problems
Leg Pain
Low back pain
Neck pain
Numbness
Osteoporosis
Poor Circulation
Prostate Problems
Rheumatoid Arthritis
Sciatica
Shingles
Sinus Infection
Stroke
Thyroid Problems
TMJ
Venereal Disease
Vertigo/Dizziness
Ulcer/hernia

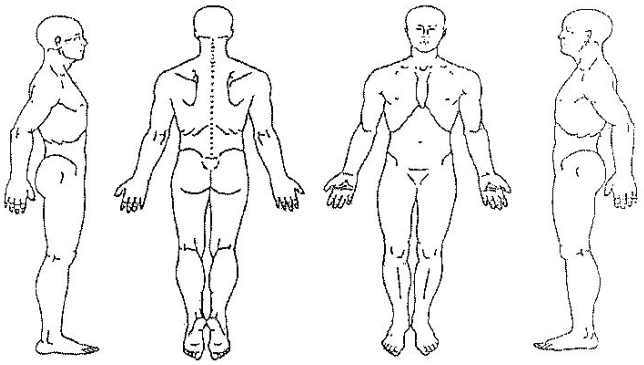
Please mark your current symptoms as described below on the figure to the right:

X - pain

O - ache

// - pins and needles

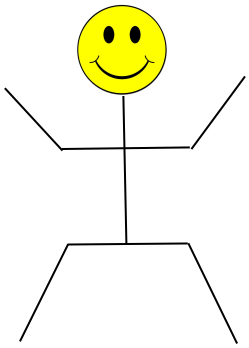
^^ - numbness

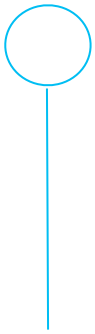


OFFICE USE ONLY

VITALS
Temp:
Pulse:
BP:
Resp:
Height:
Weight:

CROM:
TROM:
LROM:
MOTOR:
SENS:
ORTHO:





STRESSORS

Smoking	Packs/Day_____	None
Alcohol	Drinks/Week_____	Occasional
Coffee/Caffeine Drinks	Cups/Day_____	Daily
High Stress Level	Reason_____	Moderate
		Heavy

EXERCISE

Have you had any:	**Description**	**Date**
Automobile Accidents		
Surgeries		
Broken Bones		
Falls/Head Injuries		

Financial Agreement

Thank you for choosing us as your health care provider. We are committed to giving you the best care available. We hope the following will answer any questions you may have about our insurance and billing procedures and policies in relation to your appointment and procedures.

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Evolution Chiropractic / Thomas Bench, D.C. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

Insurance: Your insurance policy is a contract between you and your insurance company. We cannot guarantee to you that your insurance will pay all, or any part, of your claim. If your company denies, or only pays a portion of your claim, you are personally responsible for your total outstanding account balance(s).

Regarding insurance plans where we are a participating provider, all co-pays, deductibles and co-insurance are due at the time of treatment. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred. In summary, your financial responsibility pertains to:

- Denied and Non-covered services
- Services deemed not medically necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pending claims due to lack of patient and/or guarantor information
- Non-insurance and/or out of network benefit
- Self pay patients must pay in full at time of service.

X_____ Date: _____

Signature of Patient or Responsible Party

Witness: _____ Date: _____

Notice of Privacy Practices

Keeping your medical records confidential – What you need to know about Evolution Chiropractic: Evolution Chiropractic is committed to providing you with high quality care and forming a relationship with you that is built on trust. That means respecting your privacy and confidentiality of your medical information. We protect your privacy and confidentiality rights by creating and putting into practice Evolution Chiropractic policies and procedures that allow access to your personal medical information only for legitimate reasons.

Your medical record - As we provide your health care, we are required to maintain a complete copy of your medical history, current condition, treatment plan and all treatment given, including the results of all tests, procedures and therapies. Whether this information is stored in writing, on a computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality. Of course, the physicians and other health care professionals who are involved in your care need to access this information in order to provide appropriate treatment for you.

Your medical information is private and confidential – You, or anyone to whom you give written permission, or your legal representatives, have the right to read or get a copy of your medical information. Your medical record is the physical property of Evolution Chiropractic.

How do we assure your privacy? – Evolution Chiropractic has put in place detailed policies regarding access to medical records by our staff and employees and has carefully outlined the circumstances under which your medical information may be released to parties outside of this facility. The policies conform to state and federal law and are designed to safeguard your privacy. Our staff and employees are trained in the appropriate use of medical information and know that it is available to them only to continue to provide care to you or for other limited but legitimate reasons. A violation of confidentiality or failure of an employee to protect your information from accidental or unauthorized access will not be tolerated. This may include the employee being fired from his or her job.

We ask your permission – We do not allow others outside of Evolution Chiropractic access to any information unless we have the appropriate authorization to do so. We will respect your authorization to release information on your first visit. In addition, some laws prevent certain types of patient information from being released without specific patient permission. Examples include, but are not limited to:

*Confidential details of: Psychotherapy (treatment by a psychiatrist, licensed psychologist or psychiatric clinical nurse specialist.

*Other professional services of a licensed psychologist * Social Work Counseling/therapy * Domestic Violence Victims Counseling

* Sexual Assault Counseling * HIV Test Results * Records pertaining to Sexually transmitted diseases * Alcohol and drug abuse records - Please note, however, that the law requires some information to be disclosed in certain circumstances. This includes mandatory reports of the abuse of children or elderly or disabled persons. Also, subpoenas or court orders may compel the disclosure of confidential or privileged health information in the context of a lawsuit or administrative proceeding. Medical records are sometimes used for reasons other than patient care. For example, records are periodically reviewed to evaluate the quality of care, or to be sure that Evolution Chiropractic follows the rules of regulatory agencies for the efficient and effective utilization of care such as Medicare, Department of Public Health, or Department of Mental Health. Your insurance company may request information that we are required to submit in order to provide and bill for your care. Anyone reviewing records must follow the same confidentiality laws and rules required of all health care providers. Patient records are valuable tools used by researchers in finding the best possible treatments for diseases and medical conditions. All researchers must follow the same rules and laws that other health care workers are required to follow to insure the privacy of patient information. Information that may identify you will not be released to anyone outside Evolution Chiropractic without your written approval. In all research conducted within Evolution Chiropractic, concern for your privacy and well-being is our first priority.

If you have any questions about the privacy of your medical records, please speak with us. We will be happy to help you.

Patient Acknowledgment of Privacy Practices

Patient Name_____ DOB_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature_____Date_____

Relationship to patient (if signed by a personal representative of the patient).____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-rays, physical therapy techniques, on me (or on the patient named below for which I am legally responsible) by the licensed doctors of chiropractic at this office.

I understand that, as with any health procedure, there are certain conditions that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in three million chance). We screen our patients for indications that they are candidates for chiropractic adjustments to the best of our ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in the best interest.

I have had an opportunity to discuss with the doctor the nature, purpose, and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having being informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

_____ _____

Printed name of Patient Date of Birth

_____ _____

Signature of Patient Date

CONSENT TO TREAT A MINOR

I, _____(Parent or legal guardian) do hereby consent to have Dr. Tom Bench at Evolution Chiropractic, render care to my son/daughter/etc. _____ who is _____ years of age. Date of birth of child _____.

Signature of Parent or Legal Guardian _____Relationship_____

Witness: _____Date _____