Brusveen
Chiropractic Clinic & Therapy

Thank you for choosing our clinic for your chiropractic care. Please complete this form **in ink.**

We are happy to help you---just ask! **Date:** _____

Last Name: _____ First Name: _____ M.I_____

Date of Birth (D.O.B.) _____/_____/_____ Age: _____ Gender: **M F**

Home Address: _____ Apt. #_____

City: _____ State: ____ Zip: _____ Height: ___ft. ___in. Weight: _____lbs.

Email: _____ ***Who may we thank for referring you**? _____

Home phone: _____ Cell phone: _____ Work phone: _____

Preferred places for messages? **Home Cell Work Email** (Circle all that apply)

Marital Status: □ Married □ Single □ Divorced □Widowed Spouse's name: _____

Women: Is there a chance you are pregnant? _____ Due date? _____

Children's names and ages: _____

_____

Your employer: _____ Job title: _____

Emergency contact: _____ Relationship to you: _____

Phone: _____ Address: _____

City_____ State_____ Zip_____

Primary Doctor (PCP)_____ Phone: _____

Have you had previous chiropractic care? No Yes Date of last care: _____

Is this an accident case? Yes No Date of accident: _____

Circumstances: Auto collision On the job Other_____

Details: _____

_____

Staff only: *BP* _____/_____ *Pulse:* _____ *Date:* _____ *Initials:* _____

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Staff only: *BP* _____/_____ *Pulse:* _____ *Date:* _____ *Initials:* _____

Patient Name_____Date of Birth_____

Insurance:

Insurance Company Name_____Subscriber's Employer_____

Subscriber's Name_____Date of Birth_____

Group #_____Contract #_____

Patient's Relationship to subscriber (Circle one): Self Spouse Child Dependent

_____I authorize BCC to copy my driver's license/personal I.D. --and insurance cards, if applicable--for my records.

Financial Responsibility With/Without Insurance: All services rendered to me are charged directly to me; I am personally and financially responsible for payment of all charges incurred at Brusveen Chiropractic Clinic & Therapy, PLC ("BCC" or, "BCC, PLC"), including insurance deductibles, copayments, and any & all services rejected/not covered by insurance. All charges are due at the time of service unless I have signed a payment plan agreement. I instruct and direct my insurance company to pay, by check made out to and mailed directly to BCC, PLC, the professional or medical expenses benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward charges for professional services rendered by BCC, PLC; a photocopy of this assignment shall be considered as valid as the original. I authorize BCC, PLC to release any pertinent Protected Health Information (PHI) to any insurance company, adjustor, and/or attorney involved in my case, and I hereby release BCC, PLC of any consequence thereof.

Health and accident insurance policies are an arrangement between the insurance carrier and me; I am responsible for knowing my carrier's rules, regulations, and payment policies. For specific questions regarding my insurance coverage, I must contact my carrier directly. **As a courtesy**, BCC will submit insurance bills within 4 weeks of date of service; BCC has no control over insurance carriers' response time(s). As BCC will collect approximated amounts from me, I may end up with a bill or credit on my account. For any automobile accident claim(s), I am responsible for any charges rejected, deemed unreasonable or unnecessary by my automobile insurance company and/or an independent medical examination, and BCC may require another form of payment guaranty. If workman's compensation is deemed unrelated to work, I will be responsible for all services.

Delinquent accounts (over 60 days of non-payment by patient and/or insurance) will be assessed a $25 billing charge. An additional $75.00 minimum amount will be charged if outside collection agency and/or small claims court are required to collect the balance on an account. I agree to resolve all financial matters with BCC on my own, without legal representation.

Chiropractic, like medicine, is an applied science as well as an art; absolute guarantees are not possible. I understand that regardless of individual results, I am responsible for payment for services received at BCC. If I suspend or terminate my recommended treatment of care, any fees for professional services will be immediately due and payable. ***There is a 0.0399% surcharge for using credit/debit cards.***

Health Insurance Portability and Accountability Act (HIPAA): BCC's current Notice of Privacy Practices (NOPP) has been made available to me. The NOPP explains my rights and BCC's duties regarding my PHI, including ways in which my PHI may be used or disclosed by BCC. BCC reserves the right to amend its NOPP. A printed copy of BCC's current NOPP is provided upon request at BCC's main administrative desk, or by calling BCC and asking that a copy be mailed to me.

These people are authorized to receive my health and financial information:

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

I understand and agree to all the above financial responsibility/HIPAA terms and conditions:

Patient/Guardian Signature: _____Date: _____Witness: _____

Patient/Guardian Signature: _____Date: _____Witness: _____

Patient/Guardian Signature: _____Date: _____Witness: _____

ELECTRONIC HEALTH RECORDS INTAKE FORM
for compliance with requirements for the U.S. government EHR incentive program

Full name: _____

D.O.B._____/_____/_____ **Gender**: _____

ETHNICITY ☐Hispanic ☐Non-Hispanic ☐I decline to answer/do not know

RACE (Choose one) ☐Native American ☐Asian ☐Caucasian
☐African American ☐Hawaiian / Pacific Islander ☐Other
☐I decline to answer/do not know

DO YOU SMOKE NOW? ☐Yes ☐No HAVE YOU EVER BEEN A SMOKER? Yes No

DO YOU USE ANY OTHER FORM OF TOBACCO? ☐Yes ☐No

If a current tobacco user, please complete the following:

What type? _____ How much? _____ Have you tried to quit? Yes No

What methods did you use? _____

List current medications: (Please include regularly used over the counter medications). ☐**NONE**

Medication	Reason	Dosage/Frequency	How long?	Rx: Brand (B) Generic (G) OTC (O)

Do you have any medication allergies? ☐**NONE**

Medication Allergy	Reaction	Onset Date	Additional Comments

What vitamins or supplements are you taking?	Location of purchase?

Signature _____ **Date**: _____

Patient Name: _____ **D.O.B.** _____

Medical History

Major Complaint: _____

_____

Came on: ☐Gradually ☐Suddenly Date of onset: _____/_____/_____

Has this happened before? ☐No ☐Yes When? _____

What makes the condition worse? ☐Cough ☐Laugh ☐Sneeze ☐Bend/Lift ☐Stand ☐Sit ☐Walk

What makes the pain better? ☐Sit ☐Stand ☐Lie down ☐Meds ☐Heat ☐Ice Other_____

When is the pain worse? ☐Morning ☐Afternoon ☐Evening ☐Night ☐All the time ☐Varies

When is the pain better? ☐Morning ☐Afternoon ☐Evening ☐Night ☐All the time ☐Varies

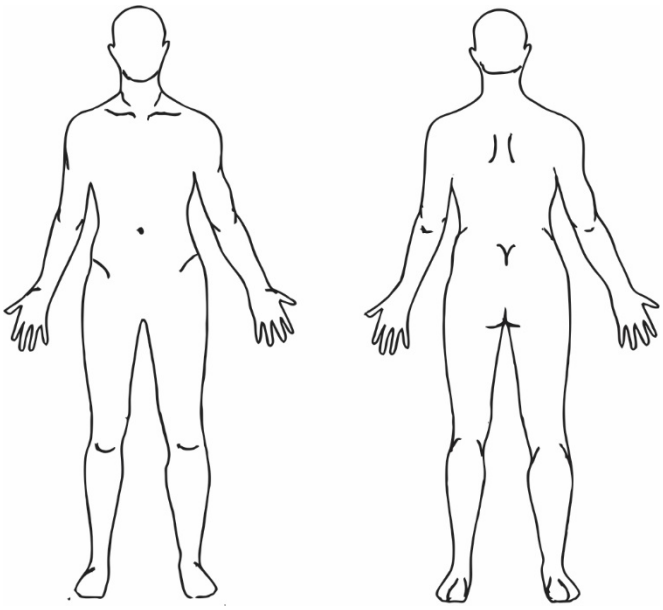
Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting
☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other_____

Pain is ☐Constant ☐Comes and goes

Rate severity of your pain:

(No symptoms) 0 1 2 3 4 5 6 7 8 9 10 (Extreme symptoms)

Please draw where you are experiencing symptoms:



Front **Back**

Which activities are hard to perform?

☐Sitting ☐Standing ☐Walking

☐Bending ☐Lying down

Is this condition interfering with your?:

☐Work ☐Sleep □ Daily routine

Other_____

What diagnostic tests have you had for this?

_____

What treatment have you received for this?

☐Medication ☐Surgery ☐Physical Therapy

Other_____

Name/address of other doctor(s) who have treated this condition(s):

_____

_____

_____

Brusveen Chiropractic Clinic & Therapy, PLC

Patient Name: _____ **D.O.B**. _____

How long has it been since you have felt really good? _____
What do you believe is wrong with you? _____

Have you been in an auto accident? ☐Past year ☐Past 5 years ☐Over 5 years ☐Never

Age of mattress: _____ ☐Comfortable ☐Uncomfortable

Are you wearing: ☐Heel lifts ☐Sole Lifts ☐Inner Soles ☐Arch supports

Exercise:	**Work activity:**	**Habits:**
☐ None	☐ Sitting	Chemical abuse:
☐ Moderate	☐ Standing	___ use per week ☐None
☐ Daily	☐ Light labor	Alcohol:
☐ Heavy	☐ Heavy labor	___drinks per week ☐None
☐ Weekend	☐ Computer work	Coffee/caffeine:
		_____ per day ☐None

EXAMS WITHIN THE LAST YEAR: Circle those that apply

Spinal exam	Spinal x-ray	Blood test	Urine test
Physical exam	MRI/CT	Chest x-ray	Other

INJURIES OR SURGERIES DESCRIPTION DATE

Falls: _____
Head Injuries: _____
Broken Bones: _____
Dislocations: _____
Surgeries: _____
_____
_____

HEALTH HISTORY (Check only those conditions that you have ever had)

O Change in bowel/bladder habits
O Thickening or lump in breast or elsewhere
O Unusual bleeding/discharge
O Obvious change in wart or mole
O Unintended weight loss over 10 lbs.
O Indigestion or trouble swallowing
O A sore that does not heal
O Nagging cough or hoarseness

O AIDS/HIV	O Chemical Dependent	O Heart Disease	O Osteoporosis	O Shingles
O Alcoholism	O Chicken pox	O Hepatitis	O Pacemaker	O Sinusitis
O Allergy shot	O Colon issues	O Hernia	O Parkinson's	O Stroke
O Anemia	O Depression	O Herniated disc	O Pinched nerve	O Scoliosis
O Anorexia	O Diabetes	O Herpes	O Pneumonia	O Suicide attempt
O Appendicitis	O Ear infection	O High cholesterol	O Polio	O Thyroid issues
O Arthritis-Osteo	O Emphysema	O Hypertension	O Prostate issues	O Tonsillitis
O Asthma	O Epilepsy	O Kidney disease	O Prosthesis	O Tuberculosis
O Bladder issues	O Fibromyalgia	O Liver disease	O Psychiatric care	O Tumors/growths
O Bleeding disorder	O Fractures	O Lung issues	O Rheumatoid arthritis	O Typhoid fever
O Breast lump	O GERD	O Measles	O Rheumatic fever	O Ulcers
O Bronchitis	O Glaucoma	O Migraines	O Scarlet fever	O Vaginal infection
O Bulimia	O Goiter	O Miscarriage	O Sexually transmitted disease	O Whooping cough
O Cancer	O Gonorrhea	O Mononucleosis		Other_____
O Carpal tunnel	O Gout	O Multiple Sclerosis		_____
O Cataracts		O Mumps		

Please complete back side of this form.

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Patient Name: _____

FAMILY HISTORY:

Please fill in spaces that apply. Since environment can be a factor, please circle if they live close to you.

CONDITION	FATHER age	MOTHER age	BROTHERS age(s)	SISTERS age(s)	SPOUSE	CHILDREN age(s)
Arthritis						
Asthma						
Back problems						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc problems						
Ear aches						
Emphysema						
Epilepsy						
Hay fever						
Headaches						
Heart trouble						
High blood pressure						
Insomnia						
Kidney problems						
Liver problems						
Nervousness						
Neuritis						
Pinched nerve						
Scoliosis						
Sinus problems						
Stomach problems						
Other						

Signature_____ (**D.O.B**) ____/_____/_____) **DATE**: _____