***Orinda Chiropractic Center***

***Patient Intake Form***

**Patient Name:** _____ **Date:** _____

**Home Address:** _____ **City:**_____ **State:**_____ **Zip:**_____

**Date of Birth:** _____ **Spouse/ Partner Name:**_____

**Home Number:** _____ **Cell Phone Number:** _____

**Email Address:** _____ **for monthly updates/ newsletters**

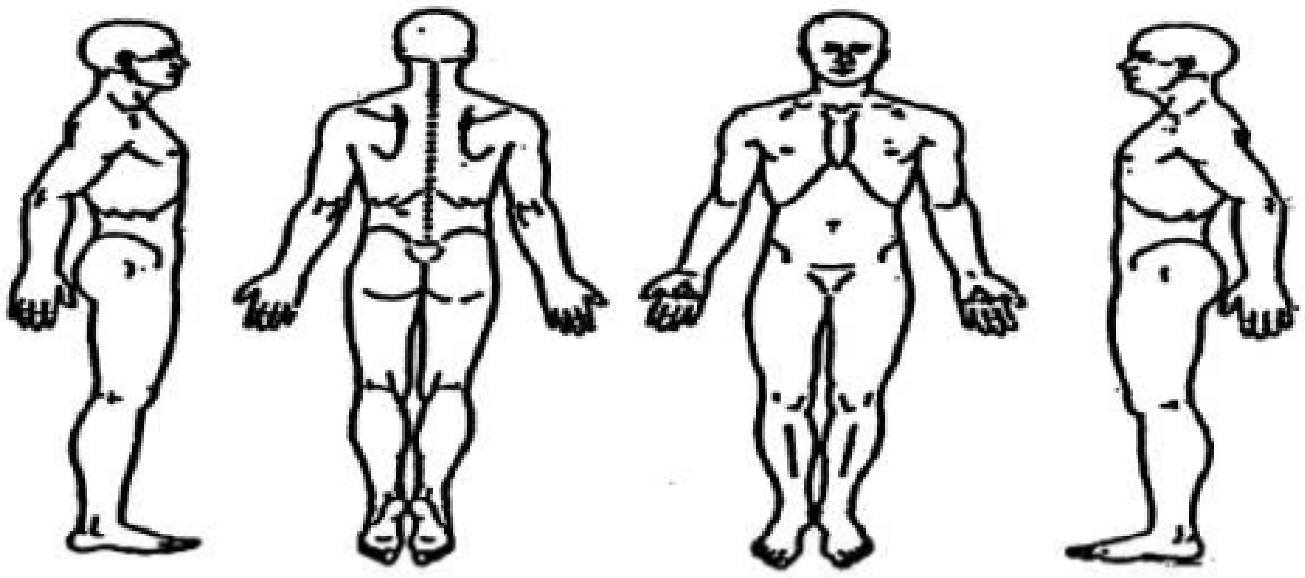
**What is your Preferred Method of Contact:** *Please Circle*

| Mail | Email | Text | Phone: _____ Home Work Cell |
|---|---|---|---|

**In case of an emergency please contact:** _____**Phone Number:** _____

**1. Is today's problem caused by:** □ Auto Accident □ Workman's Compensation □ Not caused by accident

**2. Indicate on the drawings below where you have pain/symptoms**



**3. How often do you experience your symptoms?**

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

**4. How would you describe the type of pain?**

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

**5. How are your symptoms changing with time?**

□ Getting Worse □ Staying the Same □ Getting Better

**6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?**

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

**7. How much has the problem interfered with your work?**

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

(over)

**8. How much has the problem interfered with your social activities?**
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

**9. Who else have you seen for your problem?**
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

**10. How long have you had this problem?** _____

**11. How do you think your problem began?** _____

**12. Do you consider this problem to be severe?**
□ Yes □ Yes, at times □ No

**13. What aggravates your problem?**_____

**What makes it better?** _____

**14. What concerns you the most about your problem; what does it prevent you from doing?**
_____

**15. What is your: Height**_____ **Weight** _____ **Occupation** _____**Blood Pressure** _____/_____

**16. How would you rate your overall Health?**
□ Excellent □ Very Good □ Good □ Fair □ Poor

**17. What type of exercise do you do?**
□ Strenuous □ Moderate □ Light □ None What kind? _____ How often? _____

**18. Indicate if you have any immediate family members with any of the following:**
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

**19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

| Past | Present | Past | Present | Past | Present |
|---|---|---|---|---|---|
| □ | □ Asthma | □ | □ High Blood Pressure/Hypertension | □ | □ Diabetes |
| □ | □ Headaches | □ | □ Heart Attack | □ | □ Excessive Thirst |
| □ | □ Neck Pain | □ | □ Chest Pains | □ | □ Frequent Urination |
| □ | □ Upper Back Pain | □ | □ Stroke | □ | □ Smoking/Tobacco Use |
| □ | □ Mid Back Pain | □ | □ Angina | □ | □ Drug/Alcohol Dependance |
| □ | □ Low Back Pain | □ | □ Kidney Stones | □ | □ Allergies |
| □ | □ Shoulder Pain | □ | □ Kidney Disorders | □ | □ Depression |
| □ | □ Elbow/Upper Arm Pain | □ | □ Bladder Infection | □ | □ Systemic Lupus |
| □ | □ Wrist Pain | □ | □ Painful Urination | □ | □ Epilepsy |
| □ | □ Hand Pain | □ | □ Loss of Bladder Control | □ | □ Dermatitis/Eczema/Rash |
| □ | □ Hip Pain | □ | □ Prostate Problems | □ | □ HIV/AIDS |
| □ | □ Upper Leg Pain | □ | □ Abnormal Weight Gain/Loss | □ | □ Asthma |
| □ | □ Knee Pain | □ | □ Loss of Appetite | □ | □ Other:_____ |
| □ | □ Ankle/Foot Pain | □ | □ Abdominal Pain | □ | □ Other:_____ |
| □ | □ Jaw Pain | □ | □ Ulcer | | |
| □ | □ Joint Pain/Stiffness | □ | □ Hepatitis | **For Females Only** | |
| □ | □ Arthritis | □ | □ Liver/Gall Bladder Disorder | □ | □ Birth Control Pills |
| □ | □ Rheumatoid Arthritis | □ | □ General Fatigue | □ | □ Hormonal Replacement |
| □ | □ Cancer | □ | □ Muscular Incoordination | □ | □ Pregnancy |
| □ | □ Tumor | □ | □ Visual Disturbances | | |
| □ | □ Chronic Sinusitis | □ | □ Dizziness | | |

| Smoking Status: | Every Day | Some Days | Former | Never |
|---|---|---|---|---|

If you smoke, how many cigarettes do you smoke per day? _____

**20. List all surgical procedures you have had:** _____

**21. List all of the over-the-counter medications you are currently taking:** _____

(over)

**22. List all prescription medications you are currently taking:**

| **Medication:** i.e. Lipitor | **# of MD refills issued** | **Quantity of Pills:** | **Strength:** i.e. 10 mg | **MD's instruction:** i.e. 1 per day |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**23. Are you allergic to any medicines? Please list each drug on a new line:**

**Check here if you do not have any medical allergies:** ☐

| **Name of Drug:** i.e. penicillin | **Symptom:** i.e. headache | **Severity**:i.e. Mild, Moderate, Severe, Fatal |
|---|---|---|
| | | |
| | | |
| | | |

**24. What activities do you do at work?**

| | | | |
|---|---|---|---|
| □ **Sit:** | □ Most of the day | □ Half the day | □ A little of the day |
| □ **Stand:** | □ Most of the day | □ Half the day | □ A little of the day |
| □ **Computer work:** | □ Most of the day | □ Half the day | □ A little of the day |
| □ **On the phone:** | □ Most of the day | □ Half the day | □ A little of the day |

**25. What activities do you do outside of work?** _____
**26. Have you had significant past trauma?** □ No □ Yes
**26. Have you ever been hospitalized?** □ No □ Yes If yes, why? _____
**27. Anything else pertinent to your visit today?**_____

EHR Certification Questions – *information required by US government:*

**Ethnicity: (Please circle)**

| | |
|---|---|
| Hispanic or Latino | Not Hispanic or Latino |

**Race (Please circle)**

| | | |
|---|---|---|
| White | American Indian/ Alaskan Native | Asian |
| Black/African American | Native Hawaiian/ Pacific Islander | Two or more |

**Preferred Language: (Please circle)**

| | | | | |
|---|---|---|---|---|
| English | Spanish | French | German | Italian |
| Mandarin | Cantonese | Tagalog | Japanese | Other: _____ |

***If there is an emergency, in which language would you like to receive the message?*** _____

***For confidential correspondence, please create a Secret Question, i.e., What was my first pet's name?***

***Secret Question:*** _____ ***Secret Answer:*** _____

# *Patient Signature*_____ **Date**:_____

I would like to electronically have access to my health information when available: (please initial box) ☐ (over)

**Financial Policy for Kevin M. Wong, D.C, Orinda Chiropractic Center PC**

☐ **INSURANCE**

If you have health insurance that you believe may cover chiropractic this office will verify your insurance coverage for you. Once your eligibility and coverage is determined we will file all insurance claims for you to the extent that your policy permits. If it is not verified within 5 days of the date of service, you may be required to pay the full amout.

_____ I am responsible for paying my deductible, co-payment and non-covered supplements, supplies and services at the time they are rendered. I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Not withstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

_____ I hearby instruct and direct my insurance company, _____ Initial to pay by check made out directly to: Kevin Wong, D.C., Orinda Chiropractic Center PC for any and all insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance or pre-paid health care plan. . I authorize the release of any medical or other information necessary to process my insurance claim.

☐ **NON-INSURED**

We request 100% of the first visit be paid at the time of the first visit. All future visits must be paid for at the time of service. If your financial situation requires special arrangements, please speak with the Financial Coordinator.

☐ **WORKERS' COMPENSATION**

Chiropractic services are covered by Workers' Compensation law, and you should be covered 100%, as long as your employer is aware you were injured on the job, you have completed the required papers with your employer, your employer has no objection to your receiving care here, and is covered by Workers' Compensation Insurance. You are responsible for non-covered items such as supplements and supports that are not a direct result of the accident. These items are to be paid for at the time they are received

☐ **MEDICARE**

Dr. Wong is not a Non-Participating Provider with Medicare and do not accept assignment from Medicare. Medicare does require that you pay for examinations, supplements, supplies, physical therapy and any other non-covered services. Therefore, ***you will be asked to pay for these services at the time you receive them***. If you have supplemental insurance policy that covers chiropractic, please provide us with a copy of your secondary coverage.

Medicare pays for manual manipulation of the spine only. Exams, physical therapy modalities, supports, braces, or nutritional supplements are not covered.

_____ I acknowledge that Orinda Chiropractic Center has informed me that some or all of my treatment in their office may not be covered by Medicare.

*Signature of Medicare patient*

**IT MUST BE UNDERSTOOD:**

1. This clinic DOES NOT promise that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged.

2. The clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. This is the patient's obligation.

3. I understand that I will be charged $40 missed appointment fee for appointments that are cancelled within 24 hours.

4. There is a $30.00 charge for any bank returned checks (NSF) Patient's

Signature_____ DATE_____

Representative's signature _____Print name _____