

Patient Intake Form

Name: _____ Date: _____
Email: _____ Referred by: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (H) _____ (W) _____ (C) _____
Age: _____ Birth date: _____ Social Security #: _____ Marital Status: M S D W
Occupation: _____ Employer: _____
Emergency contact: _____ Phone: _____

Are your present problems due to an injury? Yes No Enter the date of the injury: _____

Was the Injury? Job Related Auto Accident Personal Injury Other: _____

Has the accident been reported? Yes No If so, to whom? Employer Auto Carrier Other: _____

Briefly describe the accident, injury or illness: _____

List symptoms experienced immediately after the injury: Choose the severity level associated with each Symptom

_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

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_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

List any tests, studies or medications received for this condition:

Tests/Studies: _____

Medications: _____

Where you admitted to the hospital due to this condition: Yes No

If yes, what hospital? _____ Transported by? Ambulance Police Other: _____

Date Admitted: _____ Date released: _____ Length of Stay: _____

List the hospital procedure received: _____

List symptoms you are experiencing today: Choose the severity level associated with each Symptom

_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

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_____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

Do you have any current work restrictions due to this condition?

Off work: Yes No Previously From: _____ To: _____

Light duty: Yes No Previously (If yes, what are/were your restrictions?) _____

What type of work do you do? _____

Do you suffer from any condition other than that for which you are now consulting us? Yes No _____

List any past conditions you may have had: _____

HABITS

- Smoking Packs/day: _____
- Drinking Alcohol: (Cups/day): _____
- Coffee Cups/Day: _____
- Soft Drink Bottles or Cans/Day: _____
- Water Cups/Day: _____

EXERCISE

- None
- Moderate
- Daily
- Type: _____

FAMILY HISTORY

- | | | | | |
|------------|--------------------------|--------------------------|--------------------------|--------------------------------|
| | Diabetes | Cancer | Back Pain | Other |
| Mother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Father | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Brother(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |
| Sister(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> _____ |

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc? Y N

If yes, which ones?: _____

Have you taken any medications in the past? Y N If yes, which ones? _____

Do you have allergies? Y N If yes, please explain: _____

Have you ever had any surgeries? Y N (If yes, please enter the approximate date of surgery.

DATE	DATE	DATE
_____ Back Operation	_____ Hernia	_____ Gall Bladder
_____ Female Organs	_____ Thyroid	_____ Stomach

Other _____

Have you ever had X-Rays taken? Y N When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed. C= Current P=Past

GENERAL SYMPTOMS

- | | |
|---|--------------------------|
| P | C |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Allergy (What) _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Chills (Constant) | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Convulsions | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Fatigue | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Headache | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Numbness or Pain | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> In arms/legs/hands | |

GASTRO-INTESTINAL

- | | |
|---|--------------------------|
| P | C |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Belching or Gas | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Nausea | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Gall Bladder Trouble | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hemorrhoids (piles) | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Jaundice | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Liver Trouble | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Colon Trouble | |

EYE/EAR/NOSE/THROAT

- | | |
|--|--------------------------|
| P | C |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Deafness | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Earache | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ear Discharge | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ear Noises | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Frequent Colds | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hay Fever | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Nasal Obstruction | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Tonsillitis | |

RESPIRATOR

- | | |
|---|--------------------------|
| P | C |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Chronic Cough | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Difficulty Breathing | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Spitting Blood | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Spitting Phlegm | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Chest Pain | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Wheezing | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bronchitis | |

GENERAL SYMPTOMS

- P C**
 Loss of Sleep
 Loss of Weight
 Nervousness
 Night Sweats

GASTRO-INTESTINAL

- P C**
 Stomach Pain
 Vomiting
 Vomiting Blood
 Heart Burn
 Bloody Stools
 Acid Reflux
 Irritable Bowel

EYE/EAR/NOSE/THROAT

- P C**
 Nose Bleeds
 Pain in Eyes
 Poor Vision
 Blurred Vision
 Sinusitis
 Sore Throats

GENITO-URINARY

- P C**
 Frequent Urination
 Inability to Control
 Kidney Infection
 Kidney Stones
 Painful Urination
 Prostate Trouble
 Bed Wetting
 Blood in Urine

MUSCLES & JOINTS

- P C**
 Backache
 Foot Trouble
 Hernia
 Pain Between
Shoulders
 Painful Tail Bone
 Stiff Neck
 Spinal Curvature
 Swollen Joints
 Tremors

CARDIO-VASCULAR

- P C**
 High Blood
Pressure
 Low Blood
Pressure
 Chest Pain
 Heart Trouble
 Poor Circulation
 Rapid Heart
 Slow Heart
 Strokes
 Swelling Ankles

SKIN OR ALLERGIES

- P C**
 Bruising Easily
 Dryness
 Eczema
 Hives or Allergy
 Itching
 Sensitive Skin
 Skin Eruptions

FOR FEMALES ONLY

- P C**
 Cramps
 Hot Flashes
 Irregular Cycle
 Painful Periods
 Vaginal Discharge
 Pregnant Now
 _____ Last Pap Date
 _____ Last Menstrual
Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- P C**
 Appendicitis
 Goiter
 Polio
 Alcoholism
 Anemia
 Epilepsy
 Chicken Pox
 Eczema
 Heart Disease
 Rheumatic Fever
 Pleurisy
 Whooping Cough

- P C**
 Arthritis
 Mumps
 Lumbago
 Cancer
 Pneumonia
 Influenza
 Tuberculosis
 Venereal Disease
 Measles
 Mental Disorder
 Diabetes
 HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ **Date:** _____

Patient Name _____ 3

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other procedures, including examination tests, diagnostic x-rays and physiotherapy techniques necessary to treat or diagnose my condition. Furthermore, I consent to treatment by any other doctor or chiropractor that may be working for, associated with, or serving as a backup for my regular doctor or chiropractor names below.

I understand that, as with any health care procedure, there are certain risks involved. Some of the risks or complications which may occur during a chiropractic adjustment include, but are not limited to; fractures, disc injuries, muscle strains, and costovertebral strains and/or separations. In a small percentage of the population there have been injuries to the arteries in the neck resulting in or contributing to stroke. In some of these incidents the manipulative procedures were performed by untrained people such as massage therapists, beauticians, and even medical doctors not adequately trained in the science of chiropractic.

I understand that I will have the opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

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. I hereby give consent to the treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Montana Wellness Center
670 King Park Dr., Ste 1
Billings, MT 59102
(406) 655-4940

Treating Doctor: Mark J. Haynes, D.C.
Heidi C. Chapnick, D.C.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE

_____ Printed name of Patient	_____ Date
_____ Signature of Patient	_____ Date
_____ Signature of Patient's Representative	_____ Date
_____ Witness to Patient's Signature	_____ Date



OFFICE VISITS-BILLING AND PAYMENT POLICY

As validated by my signature on the bottom of this form, I understand that:

1. I am financially responsible for all charges, whether or not covered by my insurance carrier.
2. I realize that full payment is strongly preferred the day of service. We accept cash, check, or you may charge your balance on your Visa, Master Card, Discover, or American Express. If we are a provider with your insurance company and if your insurance company has made you responsible for a dollar amount per visit or a co-pay, we will collect that at the time of your visit. **It is your responsibility as the insured to verify whether or not we are a participating provider with your particular insurance company.** If we are not a participating provider the benefits may be less, or non-existent.
3. If I am unable to pay in full the day of service, the unpaid balance is due within 30 days unless I have made other arrangements in advance with the billing department.
4. My insurance will be billed by Montana Wellness Center's insurance department if I provide complete insurance information. Any balance left unpaid by my insurance company is due and payable upon receipt after I receive a statement from Montana Wellness Center.
5. Montana Wellness Center's Doctor's are committed to providing the best treatment possible for their patients, at rates that are usual and customary for this area. I am responsible for payment in full, regardless of the interpretation of what is "usual and customary" or "usual and reasonable" by a given insurance company.
6. Should my account become delinquent, I agree to pay collection costs, attorney fees, and court costs as permitted by law if such are incurred by my physician at Montana Wellness Center.
7. I also agree to be responsible for finance charges on balances greater than 30 days old. finance charges will be computed at the rate of 1.25% per month (15% annually).

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

Patient Name Printed

Date

Signature of patient or responsible party

For your convenience you may retain your credit card number on file with us.

Credit card #

Expiration Date

Name as appears on card: _____
(PRINTED)

MONTANA WELLNESS CENTER
670 KING PARK DRIVE, SUITE 1
BILLINGS, MONTANA 59102

HIPPA INDIVIDUAL
ACKNOWLEDGMENT OF PRIVACY
PRACTICES

By signing this form, I am indicating that I have been provided a copy of Montana Wellness' Privacy Practices related to health information. I understand that the Notice is subject to change, and I can obtain a current Notice by contacting Montana Wellness Center.

Patient name printed: _____

Patient/Authorized Signature: _____

Date of signature: _____

I am the: PATIENT
CIRCLE ONE

GUARDIAN

OTHER

NECK DISABILITY INDEX

Name: _____ Date: _____ File #: _____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4 – Reading

- I can read as much as I want with no pain in my neck.
- I can read as much as I want with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all due to pain.

SECTION 5 – Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

SECTION 6 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7 – Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can not do any work at all.

SECTION 8 – Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

SECTION 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

REVISED OSWESTRY INDEX

Name: _____ Date: _____ File #: _____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 – Pain Intensity

- The pain comes and goes and is very mild
- The pain is mild and does not vary much.
- The pain comes and goes and is moderately increasing
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 – Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 – Sitting

- I can sit in any chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain immediately.

SECTION 6 – Standing

- I can stand as long as I want without pain.
- I have some pain standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

SECTION 7 – Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than ¼.
- Because of pain, my normal night's sleep is reduced by less than ½.
- Because of pain, my normal night's sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing . . .
- Pain has restricted my social life and I do not go much.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

SECTION 9 – Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain prevents all forms of travel except done lying down.
- Pain restricts all forms of travel.

SECTION 10 – Changing Degrees of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but slowly improves.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.