Surfside Chiropractic
Confidential Intake Form

Full Name		Age:	Birth Date:
Address:	City:	State:	Zip:
Gender: □Male □Female	Marital Status □Single □Married □Divorced □Widowed	SS#/:	
Email:	Cell Phone:	Home Phone:	
Occupation:		Employer:	
Emergency Contact (Name, Relationship & Phone No.):			
Family Medical Doctor:		Who referred you to us?	
Insurance Company Name:			

What is reason for your visit today? *(Location, description)* _____

How long has this complaint bothered you? *(Days, Weeks, Months, Years?)* _____

What caused your complaint and does anything aggravate it? _____

What gives you relief? _____

Do you have additional complaints? _____

Check below area(s) of complaint		**Location of complaint?**				**Type of Complaint?**							**Frequency of Complaint?**				**Pain Level?**		
Mark all that apply		Left	Right	Center	Both	Radiating	Sharp	Dull	Tingling	Numbness	Burning	Inflamed	Constant	Frequent	Intermittent	Constant	Mild pain	Moderate Pain	Severe Pain
□	Neck																		
□	Upper Back																		
□	Mid Back																		
□	Lower Back																		
□	Hips																		
□	Shoulders																		
□	Headache/ Migraine																		
□	Other:																		

Have you had X-Rays, MRIs or CAT Scans? □Yes □No *(list and date)* _____

Do you exercise? □Yes □No **If so what type and how often?** _____

Do you smoke? □Yes □No □I Quit

Do you drink alcohol? □Never □Daily □Weekly □Monthly □Special Occasions

Do you take pain medications? □Daily □Weekly □Monthly □Rarely □Never

Have you seen a chiropractor in the past? □Yes □No

Do you have any of the following? □No (If so, please mark):

☐ Arthritis	☐ Cancer	☐ Disc Herniation	☐ Liver Disease
☐ Anxiety	☐ Headaches	☐ Epilepsy/ Seizures	☐ Kidney Disease
☐ Anemia	☐ Migraines	☐ High Blood Pressure	☐ Prostate problems
☐ Diabetes	☐ Osteoporosis	☐ High Cholesterol	☐ Digestive disorders
☐ Depression	☐ Osteopenia	☐ Stroke	☐ Urinary problems

Do you have any other medical conditions? □No (**If so, please list)**? _____

Do any of the following conditions run in your family □No **(If so *please mark*):**

□Anemia □Cancer □Diabetes □Heart Problems / Stroke □High Blood Pressure □Genetic Disorders □Rheumatoid Arthritis

Current Height: _____ Weight: _____

Past Fractures, Injuries, Accidents: □No (**If so, *list and date***): _____

Past Surgeries □No (**If so, *list and date***): _____

Allergies □No (**If so, *list***): _____

Medications □No **(If so, *list***): _____

What are your hobbies? _____

WOMEN:
Currently Pregnant? □Yes □No #Weeks? _____
Do you have children? □Yes □No How Many? _____ Circle: Vaginal Birth or C-Section

AUTHORIZATION AND RELEASE: I certify the above information is complete and accurate to the best of my knowledge. I give permission to Surfside Chiropractic to contact me. I give authorization to my chiropractor to contact my physician if necessary. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with payers to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

Signature: _____ Name: _____Date: _____

Doctors Notes:

Functional Rating Index

For each item, please **circle** the number which most closely describes your condition right now.

1. Pain Intensity
0) No pain
1) Mild pain
2) Moderate pain
3) Severe pain
4) Worst possible pain

2. Sleeping
0) Perfect sleep
1) Mildly disturbed sleep
2) Moderate disturbed sleep
3) Greatly disturbed sleep
4) Totally disturbed sleep

3. Personal Care (washing, dressing, ect.)
0) No pain; no restrictions
1) Mild pain; no restrictions
2) Moderate pain; need to go slowly
3) Moderate pain; need some assistance
4) Severe pain; need 100% assistance

4. Travel (driving, etc.)
0) No pain on long trips
1) Mild pain on long trips
2) Moderate pain on long trips
3) Moderate pain on short trips
4) Severe pain on short trips

5. Work
0) Can do usual work plus unlimited extra work
1) Can do usual work no extra work
2) Can do 50% of usual work
3) Can do 25% of usual work
4) Cannot work

6. Recreation
0) Can do all activities
1) Can do most activities
2) Can do some activities
3) Can do a few activities
4) Cannot do any activities

7. Frequency of pain
0) No pain
1) Occasional pain; 25% of the day
2) Intermittent pain; 50 % of the day
3) Frequent pain; 75% of the day
4) Constant pain; 100% of the day

8. Lifting
0) No pain with heavy weight
1) Increased pain with heavy weight
2) Increased pain with moderate weight
3) Increased pain with light weight
4) Increased pain with any weight

9. Walking
0) No pain; any distance
1) Increased pain after 1 mile
2) Increased pain after 1/2 mile
3) Increaed pain after 1/4 mile
4) Increased pain with all walking

10. Standing
0) No pain after several hours
1) Increased pain after several hours
2) Increased pain after 1 hour
3) Increased pain after 1/2 hour
4) Increased pain with any standing

Name: _____

Date: _____

Total Score:

Signature: _____

_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____
Patient Name (please print) Date

_____
Parent, Guardian or Patient's legal representative

_____
Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize Surfside Chiropractic to release PHI.

_____ _____

_____ _____

_____ _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with Dr. R. Nick Baiata and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Parent/Guardian and Relationship to Patient: _____

Parent/ Guardian Signature: _____ Date: _____

Patient Name: _____Signature: _____ Date: _____