ST. JOHNS CHIROPRACTIC CLINIC

1004 N. US 27
St. Johns, MI 48879
(989)224-8228

Entrance Record or History Update

Today's Date: _____

Last Name: _____ **First Name**: _____ **Middle Initial**: _____

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

Home Phone:_____ **Cell Phone**:_____ **Work Phone**:_____

E-Mail Address: _____ **Social Security #**: _____

Date of Birth:_____ **Age:**_____ **Sex**: Male / Female **Marital Status**: Married / Single / DIV / WID

Employer: _____ **Employer Address:** _____

Employed: Full Time / Part Time / Retired **Student**: Full Time / Part Time / Not Applicable

SPOUSE INFORMATION

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

Spouse SS#: _____ **Spouses Employer**:_____

Employer Address: _____

INSURANCE INFORMATION

Primary Insurance Information	**Secondary Insurance Information**
Company: _____	**Company**: _____
Group #: _____	**Group #**: _____
Contract #: _____	**Contract #**: _____
Policy Holder: _____	**Policy Holder**: _____
Policy Holder Date of Birth: _____	**Policy Holder Date of Birth**: _____

PRIOR CARE INFORMATION

Previous Chiropractic Care by: _____ **Referred here by:** _____

Who is your Primary Care Provider (PCP)? _____

PCP Phone Number:_____ **PCP Address:**_____

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Past Medical History:

-Aneurysm? ☐Yes ☐No
-Lupus, Rheumatoid, Psoriatic, or other inflammatory arthritis? ☐Yes ☐No
-Blood clots? ☐Yes ☐No
-Heart disease, vascular disease, or stroke? ☐Yes ☐No
-Any pacemaker, defibrillator, or other electrical devices? ☐Yes ☐No
-Cancers? ☐Yes ☐No
-Ehlers Danlos, Marfans, or other connective tissue disorders? ☐Yes ☐No
-Diabetes? ☐Yes ☐No
-Kidney stones or other kidney pathology? ☐Yes ☐No
-Osteopenia? ☐Yes ☐No
-Osteoporosis? ☐Yes ☐No
-Corticosteroid or Prednisone use? ☐Yes ☐No
-COPD (emphysema or chronic bronchitis)? ☐Yes ☐No
    -Albuterol use? ☐Yes ☐No

-For females over 50, have you had bone density tested? ☐N/A ☐Yes ☐No
    -If yes**, results**? _____
    -If no, any broken bones or family history of osteoporosis ☐Yes ☐No

-Any past major **trauma** (car accidents, broken bones, etc.) ☐Yes ☐No
    -If so, **what and when:** _____
_____
_____
_____
_____
_____

-Have you had any **surgeries**? ☐Yes ☐No
    -If so, please specify **type** and **date**: _____
_____
_____
_____
_____
_____

-Any other **major illnesses/diseases or hospitalizations**? ☐Yes ☐No
_____
_____
_____

-Date of **last hospitalization**:_____ For what:_____

-Date of your last medical check-up:_____

-If you are female, are you pregnant? ☐ N/A ☐Yes ☐Possibly ☐No

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Family History (if present, **please specify relation**):

-Lupus, Rheumatoid, Psoriatic, or other inflammatory arthritis? ☐Yes ☐No
-Relation: _____

-Blood clots or other blood disorders? ☐Yes ☐No
-Relation _____

-Heart disease, vascular disease, aneurysms, or stroke? ☐Yes ☐No
-Relation: _____

-Cancers? ☐Yes ☐No
-Relation: _____

-Ehlers Danlos, Marfans, or other connective tissue disorders? ☐Yes ☐No
-Relation: _____

-Diabetes? ☐Yes ☐No
-Relation: _____

-Osteoporosis (weak bones)? ☐Yes ☐No
-Relation: _____

-Other Major Diseases (and relation)? ☐Yes ☐No

_____

_____

_____

I understand that the information covered on this intake paperwork is important to my care and I have completed this paperwork to the best of my ability.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

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Therapeutic Modalities Preference:

St. Johns Chiropractic Clinic utilizes several different therapeutic modalities to support patient recovery. These modalities are an additional cost that your insurance may not cover (Medicare does not cover any of these modalities). If your insurance does not cover the service, you would be responsible to pay for these services. If you do not wish to receive these services it is your responsibility to inform the doctor prior to receiving the therapy.

- Ultrasound ($10)
  A six to eight minute treatment that facilitates recovery through vasodilation, muscle relaxation, and/or increased fibroblast activity to increase tissue repair.

- Electric Motor Stimulation ($10)
  A 10 to 15 minute treatment to help relax muscles and/or decrease inflammation.

- Cold Laser ($5)
  A two to seven minute treatment that facilitates recovery through stimulating increased cellular energy and decreased inflammation.

- Kinesiotaping ($5)
  A two to five minute taping application that can be used to support structure, improve proprioception, decrease pain, and/or improve lymphatic drainage.

- Flexion Distraction (FD) Traction ($5)
  A treatment that utilizes the flexion distraction tables in which the head piece or lower extremity piece falls away to decompress the spinal structures which can relieve nerve pain radiating down the arms or legs. Also great for stretching the paraspinal muscles and decreasing irritation to the facet joints.

- Mechanical Traction ($30)
  A 15-20 minute treatment used to decompress the spinal structures which can relieve nerve pain radiating down the arms or legs.

_____ _____

Patient Signature Date

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Billing Service

Our office is set up to accept direct payment from most insurance companies. This is done as a service for our patients. However, it is important that you understand that health and accident insurance policies are an arrangement between you and your insurance company. You are personally responsible for all charges incurred in our office.

Assignment

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Patient Signature Date

Release of Information

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequences thereof.

_____ _____

Patient Signature Date

Financial Responsibility

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company.

_____ _____

Patient Signature Date

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that **St. Johns Chiropractic Clinic's** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review **St. Johns Chiropractic Clinic's** Notice of Privacy Practices prior to signing this document. **St. Johns Chiropractic Clinic's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care information that will occur in my treatment, payment of my bills or in the performance of health care operations of **St. Johns Chiropractic Clinic**. The notice of Privacy Practices for **St. Johns Chiropractic Clinic** is also provided on request at the main administration desk of this practice. Notice of Privacy Practices also describes my rights and **St. Johns Chiropractic Clinic's** duties with respect to my protected health information.

St. Johns Chiropractic Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling **St. Johns Chiropractic Clinic** and requesting a revised copy be sent in the mail or asking for one at the time of the next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ___/___/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American
White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit**

(These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____