

BARKALOW CHIROPRACTIC & ASSOCIATES



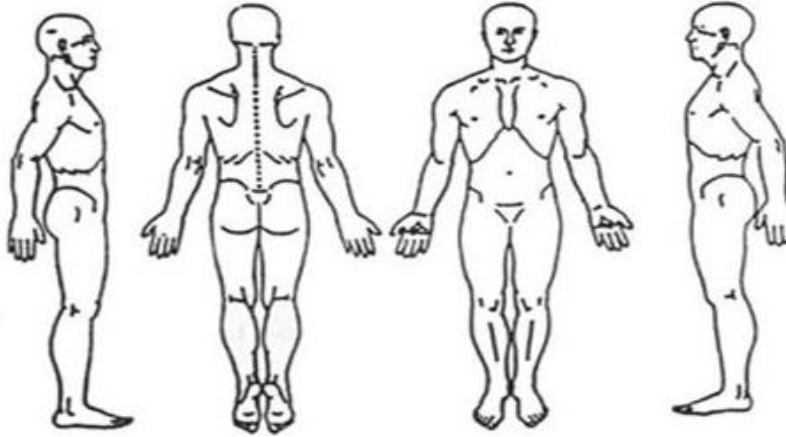
NEW PATIENT INTAKE

Patient Name: _____ Date: _____ Email: _____
 Address _____ City _____ State _____ Zip _____
 Telephone (Cell/home) _____ (work) _____ Birth Date _____ Last 4 SS# _____
 Occupation _____ Employer _____ Marital Status _____
 Spouse/Partner's name _____ Spouse/Partner's occupation _____
 Emergency Contact _____ Phone _____ Number of children _____
 Insurance Company _____ Primary insured name _____ Birth Date _____
 Who can we thank for referring you to our office? _____

Please describe your main problem _____
 When did it begin? _____ Is it getting better, worse, or staying the same (**circle one**)
 Did it start as a result of: (Circle) Auto Accident, Workers Comp, Other _____
 Describe activities that you cannot do because of the problem? _____
 What aggravates your problem? _____ What relieves your problem? _____
 Do your symptoms interfere with normal daily activities? Y / N Does it wake you at night? Y / N
 How do you feel today (Circle): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (**0 = No pain, 10 = Unbearable pain**)

Circle and Label where your symptoms are located:

A = Ache, B = Burning, N = Numbness, P = Pins & Needles, S = Stabbing, O = Other



List all practitioners seen for this injury (MD, Chiropractor, Physical Therapy, etc.) _____

Have you ever experienced this condition before? Y / N When? _____

Have you been treated for any other condition in the past 3 years? Y / N If yes, describe _____

Have you seen: A Chiropractor for *any other* conditions? Y / N A Physical Therapist for *any other* conditions? Y / N If yes, please explain _____

Last physical exam _____ Last blood test _____ Last Xray or MRI _____

Have you ever had: (circle)

Broken bones	Ear Aches	Numbness	Been hospitalized	Cancer
Allergies	Pacemaker	Been in an Auto Accident	Chest pain	Constipation
Jaw pain	Auto Accidents	High blood pressure	Bladder/bowel control	Shoulder pain
Been struck unconscious	Stroke	Digestive problems	Rib Pain	
Diabetes	Loss of balance/Dizziness	Loss of taste	Pelvic / Groin pain	
Surgeries _____	Swelling of _____	Headaches	Incontinence (leakage)	
Other _____	Fever	Hernia	Diastasis Recti	



For Women:

Is there a chance that you are pregnant? Y / N If yes, do you have an OB or Midwife _____

Are you seeking care for a Pelvic Floor Dysfunction? Y / N If yes, please describe _____

Please Read the DETAILED Laminated Forms attached with this packet. Sign and Date each line after reading.

Appointment and Cancellation Policy

I, _____, have read and agree to the "No Show and Late Cancellation" policy at this office. I agree and understand this office policy that I will be charged **\$35.00** if I do not give **24 hours notice to cancel or reschedule** after the 2nd occurrence. I may request a copy of this agreement to take home with me.

Patient Signature / Guardian Signature

Date

Financial Policy

I, _____, have read and agree to the "Financial Policy" at this office. I agree and understand this office policy for Non-Insured, Medical Insurance, Medicare or Auto Insurance. I agree that I will be responsible for paying my bill if my insurance does not cover my treatments. I may request a copy of this agreement to take home with me.

Patient Signature / Guardian Signature

Date

Notice of Privacy Practices

I, _____, have read and agree to the Privacy Notice and understand my rights contained in this notice. By my way of signature, I provide my Doctor with my authorization and consent to disclose my protected health care information for purposes of treatment, payment and healthcare operation as described in the Privacy Notice. I may request a copy of this agreement to take home with me.

Patient Signature / Guardian Signature

Date

Barkalow Chiropractic & Associates
550 Camino El Estero, Suite 103
Monterey, CA, 93940
(Ph) 831.655.6255 (F) 831.655.3443



INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by Dr. Stephen Barkalow, Dr. Derek Barkalow and/or Dr. Dustin Nagai including various modes of physical therapy modalities some of which may be performed by other office or clinic personnel. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to the following:

- While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments
- There have been reported cases of injury to a vertebral artery following cervical spine adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment and may, on rare occasion, result in serious injury. **The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.**
- There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment

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, and is in my best interest. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatments is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge that I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of the Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

PATIENT SIGNATURE

PATIENT PRINTED NAME

DATE

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Electronic Health Records Intake Form

In compliance with Medicare 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 / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I 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

Check here if you wish to have form emailed to you after each visit. (It will otherwise not be offered to you to update)

For office use only: Height: _____ Weight: _____ Blood Pressure: _____ / _____

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