BARKALOW
CHIROPRACTIC & PHYSICAL MEDICINE

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 __________________________________

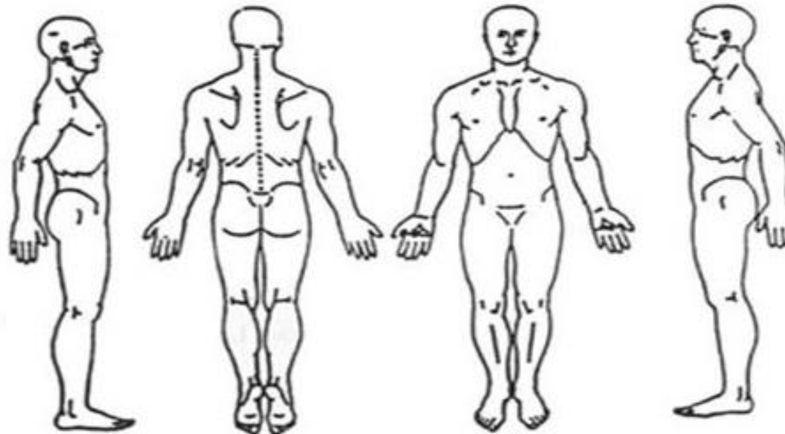
Describe activities that you cannot do because of the problem? ____

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______________________________

Appointment and Cancellation Policy

I, ____________________________, 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**.

____ __________________
Patient Signature / Guardian Signature Date

Financial Policy

I, ____________________________, 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 my insurance verification form.

____ __________________
Patient Signature / Guardian Signature Date

Notice of Privacy Practices

I, ____________________________, agree to the Privacy Notice that all my information is private and protected. 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 (please see laminated form in the office). I may request a copy of this agreement to take home with me.

____ __________________
Patient Signature / Guardian Signature Date

Barkalow Chiropractic & Physical Medicine
550 Camino El Estero, Suite 103
Monterey, CA, 93940
(Ph) 831.655.3255 (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

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 DO NOT wish to have a copy of this form emailed to you after each visit.**

For office use only: Height: _________ Weight:____________ Blood Pressure:______ /______

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