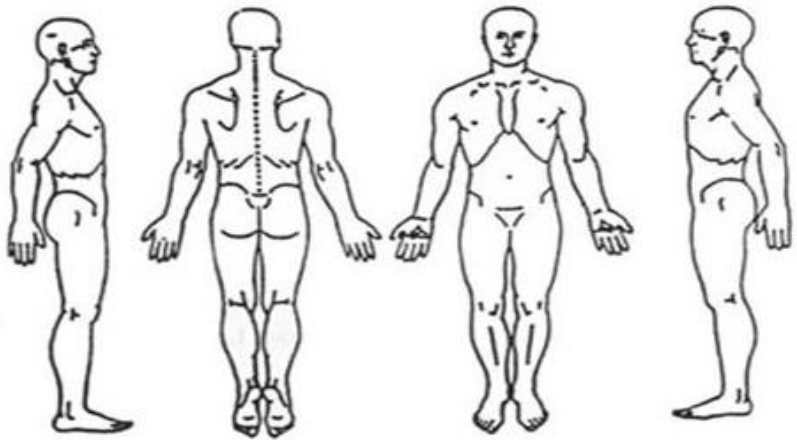
BARKALOW
CHIROPRACTIC & PHYSICAL MEDICINE

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

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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.**

_____ _____
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 & Physical Medicine
550 Camino El Estero, Suite 103
Monterey, CA, 93940
(Ph) 831.655.3255 (F) 831.655.3443

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AUTOMOBILE INJURY HISTORY

Name_____ Date of Accident_____ Time_____

Where did the accident happen?_____

Describe the accident in your own words:_____

_____

_____

What was your position in the car? : Driver / Passenger If passanger, were you sitting in: Front / Right Rear / Left Rear

Did your vehicle strike the other vehicle? Yes / No Was your car struck by the other vehicle? Yes / No

Was the impact from: the front / the right side / the left side / the rear

At the time of impact were you looking: straight ahead? / right? / left? Were both hands on the wheel? Yes / No

Was your foot on the brake? Yes / No Were you braced for impact? Yes / No Were you wearing seatbelts? Yes / No

Where in the car were you after the accident if there was no seatbelt? _____

Did you strike anything in the vehicle or did anything strike you at the time of impact? Yes / No

If yes, specify: Steering wheel / Dashboard / Windshield / Side door / Arm rest / Other _____

Please state part of body where you were impacted _____

Immediately following the accident, how did you feel? Anything that you can remember _____

_____

Were you unconscious at any point? Yes / No In a daze? Yes / No Did you go to the hospital? Yes / No

If you went to the hospital, when did you go? At the time of the accident / the next day / other _____

Name of Hospital_____

How did you get to the hospital? Ambulance / Private transportation At hospital, attended by Dr. _____

Did the ambulance place you in a neck collar? Yes / No A splint? Yes / No Brace? Yes / No

Were you x-rayed at the hospital? Yes / No Did you receive and MRI? Yes / No

If so, what was the diagnosis _____

Were you admitted to the hospital? Yes / No How long did you stay? _____

What treatment(s) did you receive? _____

Describe your symptoms from the day following the accident to today's date: _____

_____

What recommendations were made? See own family doctor / See and orthopedic doctor / Physical Therapy

Before the injury, were you capable of working on a equal basis to what is expected for your age group? Yes / No

Are your work activities restricted as a result of this accident? Yes / No Percentage of Restriction given _____

Are your home activities restricted as a result of this accident? Yes / No

Do you have a copy of the police report of the accident? Yes / No (If yes, please bring a copy to our office)

Signature _____ Date _____

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MOTOR VEHICLE ACCIDENT CLAIM & PAYMENT INFORMATION

Patient name: _____

Auto Insurance Company: _____

Account #: _____ Date of Injury: _____

Medical Coverage (MedPay) included in your policy? Yes / No / Unsure

If yes, what is the maximum coverage amount? $_____

Accident Claim #: _____ Date claim created:_____

Claim adjuster's name: _____

Adjuster's Phone #: _____ Adjusters's Fax #:_____

Claims Mailing Address: _____

_____

_____

ATTORNEY INFORMATION

Attorney's Name: _____

Attorney's Phone:_____ Attorney's Fax:_____

Attorney's Address: _____

_____

_____

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PERSONAL INJURY POLICY
State of California

AUTOMOBILE ACCIDENT
Services rendered are normally covered 100% as long as there is Medpay (Medical payment coverage) on the automobile that you were in at the time of the accident. Said coverage usually has a limit of responsibility from one to three years from the date of the accident, or until the available benefits are exhausted.

If there was another vehicle involved in the accident was found to be at fault, this may be considered a "liability claim" since the other party caused the accident. In this case, we may be able to assist you in obtaining the necessary information to help you file your claim. If the other vehicle was found to be liable, please be aware that their insurance WILL NOT pay us for your visits. Usually, they will pay you directly, and most likely will not pay you until the case is settled: therefore, the following is out policy regarding payment for services:

- We will bill the insurance carrier of the vehicle that you were in a the time of the accident, utilizing the "MedPay" coverage (if it's available)
- If you have no medical benefits available via "MedPay" but you have an attorney representing you, we will wait for payment until the case is settled. However, we must have complete information as to how to contact your attorney (name, address, phone number) and be able to verify that they are representing you. Your attorney must also sign and return a lien form to this clinic within 5 days of receipt.
- If you do not have " MedPay" coverage, or an attorney and you are working with the "third party" insurance (Other vehicle's insurance company) **you will be required to pay a co-pay of $100 per visit**. You will be responsible for all service costs after your treatment is finished. Please note, the insurance company will send the final check to you to pay our office for services. The does not guarantee that they will pay for all services, making you responsible for anything they do not cover.
    - If you require assistance finding an attorney, please ask us. We will provide you with the name(s) of attorney(s) who support chiropractic care. We must have confirmation that an attorney is representing you within 5 business days of your initial visit. If we do not have confirmation by the 5th business day, you will be required to pay for all services you received. Services must be paid in full.

It must be understood that; 1) This clinic does not promise that insurance companies will pay nor does out office promise that an insurance company should pay the fees as charged. 2) The clinic will no enter into a dispute with any insurance company over reimbursement or the amount of reimbursement. This is the patient's obligation. 3) If you have more than one insurance policy and would like to bill it, we will supply you with a billing statement to use for you to be able to file your own claim.

_____	_____	_____
PATIENT NAME	SIGNATURE	DATE

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DATE: _____

PATIENTS NAME: _____ DOB: _____

PHONE #: _____ DATE OF ACCIDENT: _____

INSURANCE COMPANY: _____ ID # _____

INSURANCE PHONE # _____ NAME OF INSURED: _____

LEGAL SSIGNMENT OF BENEFITS & RELEASE OF MEIDCAL AND PLAN DOCUMENTS

In considering the amount of medical expense to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Barkalow Chiropractic & Associates, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance for benefit payments. I hereby authorize the doctor to release all medical information necessary to process my claims. I hereby authorize any plan administrator or fiduciary, insurer any my attorney to release to such doctor and clinic any and all plan documents, insurance reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to the medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Furthermore, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts to pursue such claims chose in action or right against my insurers and/or employee health care plain including, if necessary, bring suit with such doctor and clinic against insurers and/or employee health care plain in my name at such doctor and clinic's expense. I understand that there will be no fees charged if I give 24-hours notice to cancel or reschedule and appointment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____ _____

PATIENT NAME SIGNATURE DATE

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PAIN SCALE

PLEASE RATE YOUR CURRENT PAIN LEVEL USING THE BELOW 'PAIN SCALE' ("0" DESCRIBES NO PAIN, "10" DESCRIBES SEVERE AND UNBEARABLE PAIN WHERE YOU CANNOT FUNCTION)

NORMAL	LOW PAIN	MODERATE PAIN	INTENSE PAIN	EMERGENCY
○ 0	○ 1 ○ 2 ○ 3	○ 4 ○ 5 ○ 6	○ 7 ○ 8 ○ 9`	○ 10

PLEASE CHECK THE STATEMENT THAT BEST DECRIBES YOUR CURRENT LEVEL OF PAIN

○	The pain is almost unbearable and I require help to manage the pain
○	The pain is very bad and almost intolerable most of the time
○	The pain is quite bad and often on my mind
○	The pain is moderate and I am able to function
○	I feel a little pain and it is an irritation
○	I feel no pain at all

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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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