Simple Solutions Chiropractic
Patient Intake Form

Date_____

Name _____
(First) (Last)

Nickname/Preferred _____

Address_____

City_____

State_____ Zip_____

Date of Birth ____/____/_____ Age_____

Gender ☐ Male ☐ Female

Single/Married/Other

Who may we thank for referring you to our office?
_____

Home Phone (_____) _____-_____

Cell Phone (_____) _____-_____

Emergency Contact _____

(_____) _____-_____

Email _____
_____

Employed/Full Time/Part Time/
Full-Time Student /Part-Time Student/
Homemaker/Retired/Unemployed

Occupation _____

Employer _____

Have you seen a Chiropractor before? If so, when?_____
How many adjustments have you had? ☐ 0-20 ☐ 21-50 ☐ 51-100 ☐ 101-200

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in expressing greater overall health and maintaining a good quality of life (Wellness Care). Your doctor will weigh your needs and desires when recommending your treatment program.

RELIEF CARE
Relief Care is an intensive treatment plan intended to stop symptoms at their source. You can expect an honest assessment and explanation of your problem and the expected results of the treatment from your doctor of chiropractic.

WELLNESS CARE
Millions of people are choosing to make chiropractic care part of their healthy lifestyle. Much like regular dentist visits, regular chiropractic stops spinal decay so you can stay active and comfortable throughout your life.

I authorize Simple Solutions Chiropractic to render necessary services to me and I am responsible for all charges incurred.

Patient/Guardian Signature _____ Date _____

All charges are due when services are rendered.
Method of payment: ( ) Cash ( ) Check ( ) Credit Card

THANK YOU FOR ALLOWING US TO SERVE YOU!

Name: _____ Date: _____

Please check any of the symptoms that you have recently experienced.

□ Allergies/ Sinus
□ Asthma
□ Car Accident
□ Carpal Tunnel
□ Difficulty Sleeping
□ Dizziness
□ Elbow pain
□ Headaches
□ Hip pains
□ Leg pains
□ Low back pain
□ Menstrual cramps
□ Mid back pain
□ Migraine
□ Muscle tension
□ Neck pain
□ Numbness/ tingling
□ Poor posture
□ Ringing in ears
□ Shoulder/ arm pain
□ Slip or fall
□ Sports Injury
□ Stress/ irritability
□ Weight trouble
□ Other _____

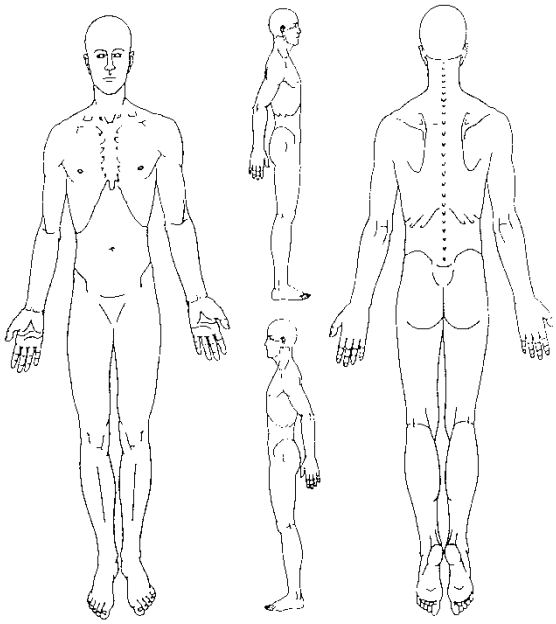
Which symptom would you like to get rid of the most? Why? _____

_____

Height:_____ Weight:_____ Blood Pressure:_____

Use the letters below to indicate the type and location of your sensations right now:

A=Ache B=Burning N=Numbness
P=Pins & needles S=Stabbing O=Other (please describe)



PATIENT QUESTIONAIRE

Please list any accidents or injuries you've had (head injuries, auto accidents, falls, etc.) and when:
1.) _____
2.) _____
3.) _____
4.) _____

Have you ever had any broken bones or fractures? (If so, state what & when.)
_____
_____

Please list any surgeries, hospitalizations, or medical procedures:
1.) _____ Date: _____
2.) _____ Date: _____
3.) _____ Date: _____
4.) _____ Date: _____

Are you currently taking any medications? (Please include 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

Please list any supplements and vitamins you are currently taking:
1.) _____
2.) _____
3.) _____
4.) _____

Do you have a family history of the following:
☐ Heart Disease ☐ High Blood Pressure ☐ Cancer ☐ Diabetes ☐ Stroke

Smoking Status: Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
Do you have a healthy diet? ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No

Simple Solutions Chiropractic
367 Dellwood Rd. Ste. E1
Waynesville, NC 28786
828-246-9699

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one primary goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to self-correct, heal and maintain balanced functioning.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment from those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR PRIMARY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate healing mechanisms. Our only method is specific adjusting to correct vertebral subluxation.

I _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Patient Signature) (Date)

Simple Solutions Chiropractic
Notice of Privacy Practices – H.I.P.A.A.

This notice describes how health information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

State and Federal Law requires us to maintain the privacy of your health information and to inform you about our privacy practices as described below. This notice took effect on September 25, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make significant changes this notice will be amended to reflect the changes and will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our privacy notice at any time by contacting our office. Information on contacting us can be found at the end of this notice.

Typical Uses And Disclosures of Health Information
We will keep your information confidential, using it only for the following purposes:

Treatment: We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care.

Health Care Operations: The environment in which care is provided is not completely enclosed. Thus, some incidental details about your care may be disclosed. In addition, your doctor may discuss your case and/or X-rays with another doctor in the office in order to provide the best care possible.

Disclosure: We may disclose and/or share your health with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy similar to this one. Health information may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree we may do so.

Payment: We may use your health information to seek payment for services we provide to you. This disclosure involves our business and may include other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care.

Required by Law: We may use or disclose your health information when we are required to do so by law. This includes court orders, subpoena or other lawful process.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.

Public Health Responsibilities: We will disclose your health information to report problems with products, disease/infection exposure and to prevent or control disease, injury and/or disability.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, included but not limited to, voicemail messages, postcards or letters.

Promotions and Marketing: We may use your information to send newsletters and/or notices of special promotions or events related to the office.

Your Privacy Rights as our Patient

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our office for a copy of the request form. You may also request access by sending us a letter to the address at the end of this notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $.25 for each page.

Amendment: You have the right to amend your health care information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these, but if we do, we will abide by our agreement (except in emergencies). Please contact our office if you want to further restrict access to your health care information. This request must be submitted in writing.

This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature requires that I have received a copy of this notice.

_____

Name (please print)

_____ _____

Signature Date

If you are a minor, or if another party is representing you, this notice must be acknowledged by a party authorized to act on your behalf.

_____

Name of Personal Representative (please print)

_____ _____

Signature Date

Description of authority to act on behalf of the patient.

Questions and Complaints:

You have the right to file a complaint if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our office. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health care information, you can complain to us (in writing). We support your right to privacy and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

How to contact us:

Practice Name:	**Simple Solutions Chiropractic**
	W. Todd McDougall, D.C.
	Hayley McDougall, D.C.
Telephone:	(828) 246-9699
Address:	367 Dellwood Rd. Ste. E1
	Waynesville, NC 28786