Bountiful
SPINAL CARE

535 W 500 S #1, Bountiful UT 84010

NEW PATIENT INTAKE - HEALTH HISTORY

Please complete the following information:

Patient's Name: Age: Todays Date:

Sex: □ Male □ Female Birth date: SS#:

Address: City, State, Zip:

(Temp. Address if in college):

Cell Phone: Home Phone:

Email Address: Occupation/work duties:

Height: Weight: Shoe Size: Orthotic? Y N Heel Lift? Y N

Status: □ Married □ Single □ Widowed □ Divorced □ Seperated Ethnicity:

Spouse's Name: # of Children: Ages:

In case of emergency, contact: Relationship: Phone Number:

Whom may we thank for referring you to our office?

How did you hear about us? □ Sign/Location □ Yellow Pages □ Online □ Facebook □ Ins. □ Other:

Health Insurance Carrier: □ check if none Policy #:

Family Medical Doctor: Location/clinic:

Previous Chiropractor:

What is the reason for this visit?

Worst Area (#1) How bad? □ Mild □ Moderate □ Severe

How did this come about?

Does it interfere with: □ Work □ Sleep □ Self Care □ Daily Routine □ Exersice □ Other:

If headache/migrane, how many per day/week/month? How long before it goes away?

□ Mild □ Moderate □ Severe Any sensitivity: □ Light □ Sound □ Dizziness

Have you seen any other healthcare providers/explain?

Additional Symptom Areas:

#2 □ Mild □ Moderate □ Severe

#3 □ Mild □ Moderate □ Severe

#4 □ Mild □ Moderate □ Severe

#5 □ Mild □ Moderate □ Severe

#6 □ Mild □ Moderate □ Severe

Family Health History

Any family members with history of cancer, diabetes, heart disease, or neurological disorders?

Parents	□ Cancer	□ Diabetes	□ Heart disease	□ Stroke	□ Neurologic	Who:
Siblings	□ Cancer	□ Diabetes	□ Heart disease	□ Stroke	□ Neurologic	Who:
Grandparents	□ Cancer	□ Diabetes	□ Heart disease	□ Stroke	□ Neurologic	Who:

Personal Health History

Past surgeries:

Past traumas/auto accidents:

Broken bones:

Hospitalized:

Struck unconscious:

Eating disorder:

Past Illnesses:

Other health problems:

Currently taking medications: □ None If yes, list:

Currently taking supplements: □ None If yes, list:

Allergies, including to medications: □ No Known medication allergies. If yes, list:

Vaccination history: □ Current □ Some delayed/reduced □ None

Female Obstetric History

Are you pregnant? Y N Are you taking birth control? Y N Do you have irregular cycles? Y N

Are you nursing? Y N Do you have breast implants? Y N Do you experience painful periods? Y N

Date of Last Menstrual Period? Date of last PAP/Pelvic exam?

Social Health History

Exercise: □ Daily □ Weekly □ Occasionally □ Never

Water: □ 1 liter daily □ 2 liters daily □ 3+ liters daily (100oz)

Alcohol: □ Daily □ Weekly □ Occasionally □ Never

Tobacco: □ Daily □ Weekly □ Occasionally □ Never

Marijuana: □ Daily □ Weekly □ Occasionally □ Never

Caffeine: □ Daily □ Weekly □ Occasionally □ Never

Soda: □ Daily □ Weekly □ Occasionally □ Never

Review of Systems - Mark your Current Issues

□ headaches	□ eye/ear/throat	□ thyroid/endocrine	□ sinus pain/allergies	□ sleeping problems
□ stressed shoulders	□ leg and hip pain	□ scoliosis	□ depression	□ wrist or joint pain
□ neck pain	□ stiffness	□ numbness	□ chest/heart pain	□ stomach/digestive trouble
□ lower back pain	□ mid-back pain	□ loss of energy	□ breathing/asthma	□ frequent colds/flus
□ high blood pressure	□ Fibromylagia	□ vertigo/dizziness	□ other:	

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 goal. It is important that each patient understand 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, symptoms, 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 a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than a vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual 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 only practice objective is to eliminate a major interference of the expression of the body's innate wisdom. Our only method is specifically adjusting to correct vertebral subluxation.

INSURANCE & FINANCIAL NOTICE

I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. By signing below, I understand and agree that all services rendered to me will be charged to me with payment due at the time of service unless other arrangements are made, and any lapse in time for the office to send billing does not negate my responsibility.
In-Network health insurance plans will be billed according to their regulations. Out-of-Network health insurance plans are subject to self-billing, services must be paid for at the time of service. The doctor must bill Original Medicare plans if Medicare-covered services are provided. Medicare replacements have an alternate regulatory policy. Reimbursement checks from Medicare and Out-of-netowrk insurance will then come directly to the patient. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. Patients may request a copy of an itemized SUPERBILL RECEIPT, along with statements, reports, or other documents to help receive reimbursement from a third party, but the doctor will not become legally involved with my insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information.
I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. Fees are subject to change. Outstanding balances will be billed monthly and considered past due 10 days after the invoice date. Returned check fees will be passed on to the patient. Balances beyond 30 days will be *assessed interest at an 18% APR plus any legal or collection fees*. I understand that a canceled/missed appointment fee, may be applied if an appointment is missed or sufficient notice not given within 24 hours.

PRE-PAID SERVICES POLICY

Pre-paid packages or account credits must be used in a timely manner and will expire after 12 months from purchase on accounts that are inactive with no future appointment scheduled. They do not expire for patients on an active care schedule. Refunds can be requested in writing and will be processed within 1 week of receiving written request.

HIPAA NOTICE

The Practice's Privacy Notice has been made available to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law. The Practice's "Notice of Privacy Practices" is also provided in the reception area of the office. I may also request a copy from this office at any time via US Mail. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information. By signing below I have read and understand this notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

CONSENT TO TREAT & X-RAY AUTHORIZATION

I certify that I am the patient listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Bountiful Spinal Care. I authorize this office and its staff to examine and give my CONSENT TO TREAT my condition as the doctors see fit, including x-ray examination. If female, I certify that to the best of my knowledge I am not pregnant and the doctor and associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. **If pregnant**, I will notify the doctor and/or staff before proceeding with an x-ray exam.

By signing below, I acknowledge that I have read, understand, and agree to the above listed terms and policies.

Print Name _____ Signature _____ Date _____

Bountiful
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