RESILIENT HEALTH AND WELLNESS

New Patient Intake Form

Full Name: _____ DOB: _____ Gender: _____

Address:_____City/State:_____Zip:_____

Cell: _____ Home: _____ Email: _____

Marital Status: _Single_/_Married_/_Widowed_/_Divorced_ Occupation:_____

Emergency Contact Name: _____ Phone: _____

How did you hear about us? Please circle one

Website/_Internet_/_Radio_/_TV_/_Social Media_/_Friend or Family_/_Physician Referral_

*if referred by whom? _____

Please circle one: _Insurance_/_Self Pay_/_Personal Injury_/_Workers Comp_

Who is financially responsible for this account? _____ Relationship to patient: _____

Insurance Information

Primary Insurance:

Insurance Provider: _____ Member ID#: _____

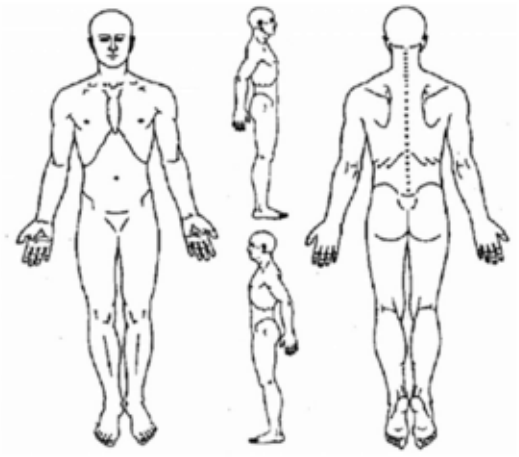
Subscriber's Name: _____ Subscriber's DOB: _____

Secondary Insurance:

Insurance Provider: _____ Member ID#: _____

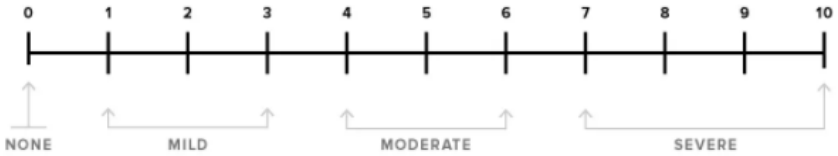
Subscriber's Name: _____ Subscriber's DOB: _____

Reason for Visit



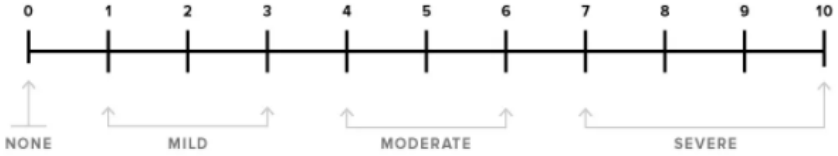
Problem 1:

Rate the severity of pain on a scale of 0 (no pain) to 10 (severe pain).



Problem 2:

Rate the severity of pain on a scale of 0 (no pain) to 10 (severe pain).



Problem 1: *main concern

_____

This was a result of: _____

When did your symptoms first appear: _____ Is this condition worsening? _Yes / No / Unknown_

How often do you have this pain? _Constant / AM / PM / Comes and Goes_

What makes the symptoms worse? _____What makes the symptoms better? _____

Symptoms interfere with: _Work / Sleep / Daily Routine / Recreational Activity_

Have you experienced this before? _Yes / No_ Number of previous episodes? _____

Have you been seen for this condition before? _Yes / No_ If so by whom: _____

Medications for this condition: _____ Previous imaging: _Yes / No / Unknown_

Problem 2:

_____

This was a result of: _____

When did your symptoms first appear: _____ Is this condition worsening? _Yes / No / Unknown_

How often do you have this pain? _Constant / AM / PM / Comes and Goes_

What makes the symptoms worse? _____What makes the symptoms better? _____

Symptoms interfere with: _Work / Sleep / Daily Routine / Recreational Activity_

Have you experienced this before? _Yes / No_ Number of previous episodes? _____

Have you been seen for this condition before? _Yes / No_ If so by whom: _____

Medications for this condition: _____ Previous imaging: _Yes / No / Unknown_

Physician Notes:

Personal Health History

Medications: *please include supplements

_____

_____

_____

Allergies: *please include type of reaction

_____

_____

_____

Recent Illness:_____

Hospitalization including surgeries: _____

Smoking/Vaping: _Never_/_Previous_/_Current_ If **Current**: number of years _____. If **Previous**: End Year _____
Recreational Drug Use: _Yes_/_No_/_Occasional_
Alcohol: _Never_/_Social_/_Daily_ Estimated Drinks Per Week: _____
Caffeine: _Yes_/_No_/_Occasional_ Estimated Daily Amount: _____

Health History

Constitutional
__Weight Loss
__Weight Gain
__Loss of Appetite
__Recent Fever/Chills
__Fatigue
__Cancer: _____
__Change in Bowel or Bladder Function
__Fainting / Loss of Consciousness
__Recent Falls

Skin
__Frequent Rashes
__Open Wounds
__Skin Lesion
__Itchy/Red Skin
__Skin Cancer

Eye
__Blurred Vision
__Vision Loss
__Double Vision

ENT
__TMJ/Jaw Pain
__Nose Bleeds
__Hearing Loss
__Ringing in Ears
__Hoarseness/Sore Throat
__Difficulty Swallowing
__Sinus Infections

Lungs/Respiratory
__Shortness of Breath
__Wheezing
__Chronic Cough
__Exercise Intolerance
__Asthma

Cardiovascular
__Chest Pain
__Irregular Heartbeat
__Calf Pain
__High Cholesterol
__High Blood
__Pressure

Digestive
__Heartburn
__Nausea/Vomiting
__Blood in Stool
__Liver/Gallbladder

Kidney/Bladder
__Painful Urination
__Problems Urinating
__Incontinence
__Kidney Stones
__Kidney Problems
__UTI
__Dialysis

Glands
__Excessive Thirst
__Frequent Urination
__Diabetes
__Always Hot/Cold
__Thyroid Problems
__Swelling

Blood
__Anemia
__Easy Bruising or Bleeding
__Clotting Disorder
__Blood Transfusion

Neurological
__Headaches
__Migraines
__Dizziness
__Vertigo
__Weakness
__Change in sensation
__Epilepsy
__Stroke
__Concussion

Skeletal
__Arthritis
__Osteoporosis
__Broken Bones
__Painful Joints
__Sports Injury

Psychiatric
__Drug/Alcohol
__Abuse
__Depression
__Anxiety
__Phobias

Male Reproductive
__Erectile Dysfunction
__Prostate Problems
__Dribbling Urine
__Low Testosterone
__Infections/STD's
__Discharge
__Pain in genitals

Female Reproductive
Last Cycle: _____
__Pregnancies # ____
__Pain/Discharge
__Yeast Infections
__Birth Control or Hormone Replacement
__Irregular Cycles
__Post-Menopause

Family History

Check and circle all of the following that apply to your FAMILY MEMBERS (Mother/Father/Brother/Sister):

Cancer: M / F / B / S List Type(s):_____
Blood Pressure: M/ F / B / S
Diabetes: M / F / B / S
Arthritis/Rheumatoid Arthritis: M / F / B / S
Neurological Disorder: M / F / B / S
Autoimmune Disorder: M / F / B / S
Stroke: M / F / B / S
Thyroid Disease: M / F / B / S
Heart Disease: M / F / B / S

AUTHORIZATION FOR TREATMENT

I HEREBY REQUEST AND CONSENT to the performance of Chiropractic procedures which may include but are not limited to various modes of physical medicine, therapies, joint manipulation, needling, and diagnostic tests on me by a licensed physician, residencies, chiropractic interns and/or other healthcare providers who are now or in the future employed by RESILIENT SPINE AND SPORTS HEALTH, LLC as deemed necessary. I understand I may refuse treatment(s) at any time.

I CERTIFY that all information provided to this office is true and correct, to the best of my knowledge, and will have the opportunity to discuss the nature of my case, including treatment, procedures, and other options. I understand that results are not guaranteed. I understand and am informed that in the applicable methods of treatment (chiropractic, dry needling, therapeutic exercise, etc.) there are some risks, including fracture, disc injuries, stroke, dislocation, sprains, pneumothorax, and infection. I do not expect the physician(s) or other provider(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the physician(s) or other providers judgement during the course of the treatment or procedure, given the facts known then to him/her, acting in my best interest.

I HAVE READ, or have had read to me, the above consent, and have been offered the amendment document "Informed Consent." I have had the opportunity to ask questions about its content. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition, and for any future condition(s) for which I seek treatment.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO THE FACILITY

I do hereby authorize RESILIENT HEALTH AND WELLNESS to furnish the insurance company, my attorney, or other interested party with full report of examination, diagnosis, treatment, prognosis, etc. regarding this injury or accident.
I hereby authorize and direct the insurance company, attorney, or other interested party to pay directly to RESILIENT HEALTH AND WELLNESS such as sums as may be due and owing for services rendered me and to withhold such sums for any settlement, judgement, or verdict as may be necessary to adequately protect RESILIENT HEALTH AND WELLNESS
I fully understand that I am directly and fully responsible to RESILIENT HEALTH AND WELLNESS for all bills submitted for services rendered, and that agreement is made solely for said facility's settlement, judgement, or verdict by which I may eventually recover said fee. I further understand that I am fully responsible for all fees, court costs and all other fees associated with collection of this debt.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of the RESILIENT HEALTH AND WELLNESS "Notice of Privacy Policies." This notice describes how RSSH may use and disclose my protected health information, certain restrictions on the use and disclosure of that information and rights I may have regarding my protected health information.

_____
Printed Name

_____
Signature

_____
Date