DR. BRIAN C. VETTER
PATIENT HISTORY
PLEASE PRINT CLEARLY

TODAY'S DATE:___/___/___

NAME: Last _____ First_____ M.I. _____

ADDRESS_____CITY_____STATE_____ZIP_____

MARITAL STATUS: M S D W DATE OF BIRTH __/__/__ SS#___-___-___

HOME PHONE: (___) ___-_____ WORK PHONE: (___) ___-_____ CELL: (___) ___-_____

EMPLOYER:_____ADDRESS_____

OCCUPATION:_____

PLEASE ANSWER THE FOLLOWING YES OR NO & EXPLAIN "YES" ANSWERS:

1. Have you ever had any heart or lung trouble? NO YES_____
2. Have you ever had stomach, intestine, or liver trouble? NO YES_____
3. Have you ever been treated for a tumor or cancer? NO YES_____
4. Have you ever been diagnosed with arthritis? NO YES_____
5. Do you experience indigestion, nausea, or heartburn? NO YES_____
6. Do you often experience diarrhea or constipation? NO YES_____
7. Do you often get tired and run down? NO YES_____
8. Have you ever had high blood pressure? NO YES_____
9. Do you drink more than (2) cups of coffee per day? NO YES_____
10. Have you ever smoked? If YES - how long and how many packs per day NO YES_____
11. Have you ever had surgery? NO YES_____
12. Do you have more than (1) headache per week? NO YES_____
13. Are you taking any nutritional supplements? NO YES_____
14. Does cancer, diabetes, or heart disease run in your family NO YES_____
15. Have you ever had fainting spells or blackouts? NO YES_____
16. Have you ever had a stroke? NO YES_____
17. Have you ever been treated by another Chiropractor or Osteopath? NO YES_____
18. Have you ever been to a Physical Therapist? NO YES_____
19. Do you exercise regularly? NO YES_____
20. Have you had a physical in the past (2) years? NO YES_____
21. Do you drink alcohol? If Yes, how many drinks/week NO YES_____
22. Do you currently use recreational drugs? NO YES_____
23. **Men Only:** Do you have any trouble with your urine flow? NO YES_____
24. **Women Only:** Pregnant? Last menstrual period? NO YES_____

Who is your Primary Care Physician:_____ Phone _____

Your Height:_____ Your Weight: _____

Please be complete & specific:

Describe your symptoms that bring your here: _____

When did your problem start? _____ How did it start? _____

Have you had this or similar problem before? _____

Have you consulted another doctor for this problem? Yes No Doctor's Name _____

Have you had any tests, x-rays, etc performed? Yes No Where?_____

What is you goal in our office?_____

(PLEASE TURN PAGE OVER)

NAME:_____ **DATE:**_____ **PAGE 2**

How often do you have symptoms? (circle one) Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (0-25%)

On a pain scale of 1-10, how bad are your symptoms at their BEST and at their WORST? (circle one for each)
1 2 3 4 5 6 7 8 9 10
minimal unbearable

Describe your pain (check all that apply):__ sharp __dull ache __numbness __tingling __burning __stitch
__ shooting __ stabbing __nagging __tightness __pressure __weakness ___headache __dizziness

Does your pain affect your daily activities? YES NO How?_____

Are you having difficulty: __ sitting __standing __ walking __sleeping __ changing positions

Do you feel best when: __ sitting __standing __walking ___lying down

Do your **ARMS/HANDS** or your **LEGS/FEET** feel **NUMB, TINGLE, PINS/NEEDLES,** or **PAIN.** (circle any that apply)

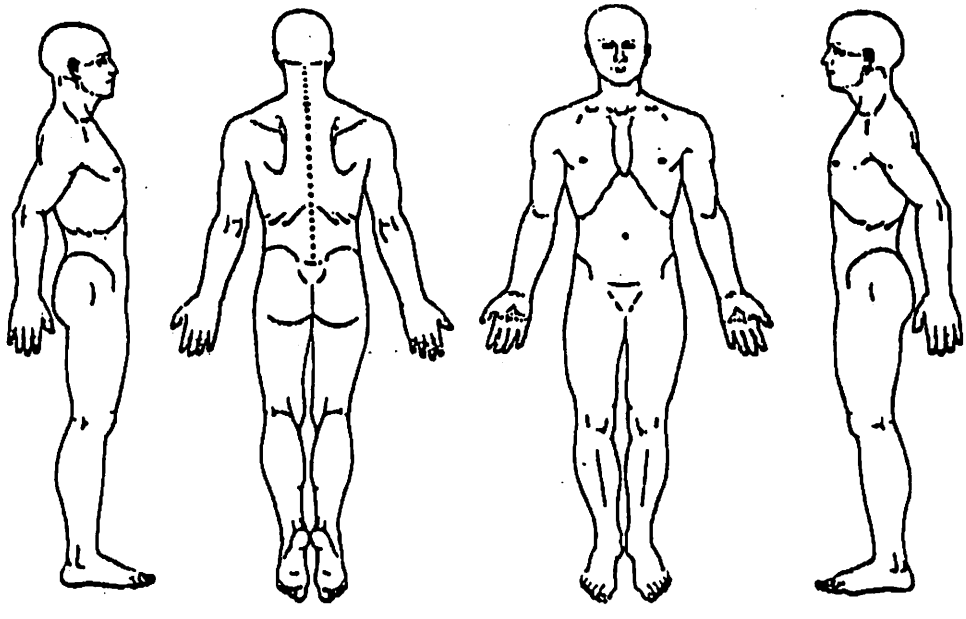
Is your injury work related? YES NO What is your occupation? _____ Are you working? YES NO

Have you had previous work related injuries or motor vehicle accident? YES NO Describe: _____

What position do you normally sleep in? _____ How old is your mattress _____

Do you sleep in a water bed? YES NO

Please mark the areas of discomfort or pain on the fugures below using the symbol that best describes the feeling:
+ + + Sharp or stabbing pain 0 0 0 Pins and needles V V V Dull or aching / / / Numbness



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Electronic Health Records Intake Form

In compliance with 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/ Text
Indicate carrier if you have selected text: _____

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

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

Last: _____ **First:** _____ **M.I.:** _____

PLEASE READ CAREFULLY AND SIGN THE AKNOWLEDGEMENT WHERE NOTED:

CONSENT TO THE RELEASE OF MEDICAL INFORMATION:

- I authorize the release and disclosure of any and all of my medical records to any other entity including, but not limited to, referring physicians, hospitals or other health care providers which may be of assistance in the opinion of this office in providing for the treatment of the patient.
- I authorize this office and it's employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be, liable for all or any part of the provider coverage.
- I authorize the release of medical records necessary to assist in the reimbursement of benefits to which I may be entitled. I authorize this office and it's employees to release via fax and/or electronic/internet transmission medical records, which are needed in order to provide the patient with the appropriate medical care.

CONSENT TO FINANCIAL RESPONSIBILITY:

- All fees are due and payable at the time when services are rendered unless one of the following applies to you:
  1. You were injured at work and are filing a Workers' Compensation claim.
  2. You were injured in a Motor Vehicle Accident and are filing a No Fault claim.
  3. You have health insurance that provides coverage for chiropractic care.
- We will accept direct assignment of your claim if it is allowable. However, please know that you will still be responsible for any non-covered services, such as deductibles, co-pays or co-insurance, etc. If your claim is denied, please know that you will be responsible for the services rendered.
- You are responsible for the office visit charge unless at least 24 hours of notice is given prior to cancellation.
- You are responsible for charges incurred from an overdrawn account. It is our policy to charge a fee of $20, in addition to the billing charges for incurred bank surcharges.

CONSENT FOR THE ASSIGNMENT OF BENEFITS:

- I authorize direct payment of medical benefits to this office from the listed insurance carrier. The signatures furnished below shall suffice for all insurance forms on a continuing basis.

AKNOWLEDGEMENT OF ACUTE VERSUS WELLNESS CARE:

- Please note that most insurance carriers do not cover "wellness" or "preventative" care. If you are not suffering from a health condition that necessitates care, and if your insurance carrier does not offer wellness or preventative coverage, your claim may be denied and you will be responsible for the charges.

I consent to the release of my medical information. I understand my financial responsibility, that my insurance may not cover wellness & preventative care, and I consent to the assignment of benefits: **X**_____ **DATE:** _____

CONSENT FOR EXAMINATION AND TREATMENT:

- I hereby authorize Dr. Brian C Vetter, an authorized covering doctor, and/or chiropractic assistants to perform upon me, the patient, the following course of treatments as deemed necessary by the doctor. These therapies include, but are not limited to, Chiropractic Manipulative Therapy, Myofascial Therapies, Exercise Therapies, Cryotherapy, Thermal Therapy, Electrical Stimulation Therapy, Ultrasound Therapy, Nutritional Therapy, and other therapies allowed under the scope of Chiropractic care.
- Doctors of Chiropractic (DC) utilize manual therapy treatments. The complications of these therapies may include soreness, bruising, swelling, sprains, strains, dislocations, burns from physiotherapies, fractures, disc injuries, stroke (although a small and remote possibility, we need to inform you that the risk is 1:3 million), and other possible soft tissue injuries. I understand that during the course of the procedure unforeseen conditions may arise which necessitate procedures different from those initially proposed.
- I acknowledge no guarantees or assurances have been made to me concerning results obtained from the procedure and treatment.

I consent to examination and treatment **X** _____ **DATE:** _____

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

- I acknowledge that I have received a copy of this office's Notice of Privacy Practice and/or it is posted and available for me to read.

I acknowledge this office's Notice of Privacy Practice is available to me **X** _____ **DATE:** _____