BAREFOOT REHABILITATION CLINIC
WE FIX YOUR FRUSTRATING PAIN

NEW PATIENT INTAKE FORM

Please fill out all information. We cannot begin the consultation until this form is fully completed.

Date: _____

Patient's Legal Name _____ How would you like to be addressed by our staff? _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Gender _____ Age: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

□Single □Married □Widowed □Separated □Divorced Number of Children: _____ Ages: _____

Occupation: _____ Employer:_____ Business Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Address:_____ City: _____ State: _____ Zip: _____

Family Physician: _____ Phone: _____

Address: _____City: _____ State: _____ Zip: _____

Whom may we thank for referring to you? _____

IF YOU HAD A MAGIC WAND, WHICH PAIN AREA WOULD YOU GET RID OF?

(Please don't circle your neck and lower back; we won't be able to help you with both AT THIS TIME)

***What is the ONE PRIMARY AREA that hurts the most, for which you will be seen for today? (answer on line below)**

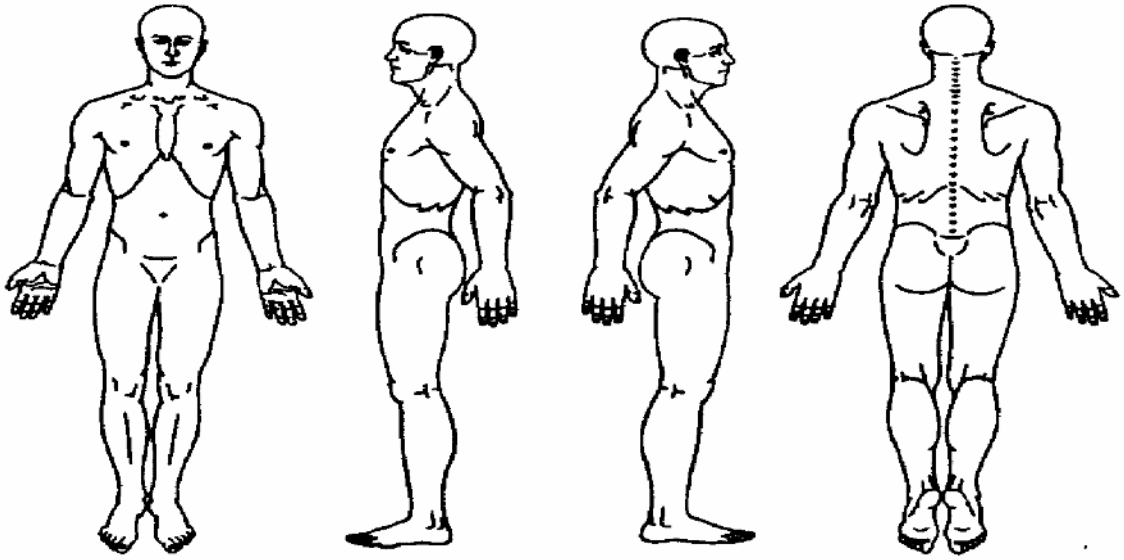
_____

Use the following letters to indicate the TYPE and LOCATION of discomfort:

A - Aching
B - Burning
N - Numb/Tingling
P - Pins & Needles
S - Stabbing/Sharp
T - Throbbing
O - Other

How bad is the pain on a scale from 0-10 (0 = no pain | 10 = worst pain ever)

_____



Do you feel pain sitting here, RIGHT NOW, **at REST,** WITHOUT MOVING,?

□Yes □No

If yes, how intense is it from 0-10? _____

What makes the pain **WORSE**? _____

How long (in mins or hours) do you have to do the above activity before it gets **WORSE**? _____

The symptoms are:

□ better as the day goes on
□ worse as the day goes
□ more prevalent at night
□ more prevalent in the morning

If you feel it more in the morning, **how many minutes/hours** does it take until it gets better?_____

Does it interfere with your daily activities:

□ minimal (annoyance, no impairment)
□ slight (tolerated, some impairment)
□ moderate (marked impairment)
□ marked (preclude any activity)

What activities help the pain in the AM?

_____

What makes the pain **feel BETTER**? _____

What is your long-term goal from treatment (e.g. play a round of golf without pain)? _____

What is your BIGGEST concern about your pain? _____

Do you want this pain gone? □Just now □Forever

Is there anything else we should know? _____

When did this pain episode **BEGIN** ? _____ Was the **Onset**: □Gradual □Sudden

What **caused** the pain: □no apparent cause □one incident _____

Since the onset, has it gotten: □Worse □Stayed the same □Better

Has this pain occurred before: □Yes □No How long ago since the first occurrence? _____ months / years ago

What type of physical activity do you do? □Weights □CrossFit □Walking □Running □Spinning □Yoga □Other _____

How many days per week do you exercise? _____

What is your **athletic history** (middle, high school, college, post-college)? _____

Secondary or related complaint(s) if any: _____

PAST INJURY/DISEASE HISTORY

Have you been treated for your **CURRENT** problem in the past? □Yes □No

If yes, when: _____ If yes, by whom: _____

Outcome: □No effect □Somewhat better □Resolved

Have you been treated for **OTHER** problems in the past? □Yes □No

If yes, when: _____ If yes, by whom: _____

Outcome: □No effect □Somewhat better □Resolved

Please list any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries:

Date	Injury / Fracture / Illness / Surgeries / Falls	Treatment	Results

Please indicate any of the following illnesses you have had, or currently have, with approximate dates.

Hypertension		Prostate Disease		M.S	
Heart Disease		Ulcer		Headaches	
Stroke		Allergies		Cancer	
Diabetes		Scoliosis		Seizures	
Kidney Disease		Mental/Emotional		Auto Accident	
Fevers		Upset Stomach		Other	

What **medications** are you currently taking? _____

What **vitamins/supplements** are you currently taking? _____

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PATIENT LIFESTYLE

How many nights per week do you drink **alcohol**? _____ On those nights, how many drinks do you have? _____

Do you smoke **cigarettes**? □Yes □No How many per day? _____ How much **mental stress** do you experience? □Mild □Moderate □Severe

How many hours of **sleep** do you get/night? _____ What time do you go to bed? _____

Do you eat the following with every meal? **Vegetables**: □Always □Sometimes □Never
Animal Protein: □Always □Sometimes □Never

What did you have for **breakfast**? _____

Females only: Are you currently pregnant? □Yes □No

In general, would you say your health is (check one): □Excellent □Very good □Good □Fair □Poor

Signature of Patient or Parent/Guardian: _____ ***Date***: _____

HIPAA NOTICE OF PRIVACY PRACTICES

YOUR HEALTH INFORMATION RIGHTS:
Unless otherwise required by law, your record is the physical property of the healthcare practitioner or facility that compiled it, but the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information, and request amendments to your health records. You may also request a copy of your medical records at any time. This organization is required by law to maintain the privacy of your health information.

By signing this document, I (**PRINT NAME**) _____, acknowledge receipt of Barefoot Rehabilitation Clinic's HIPAA policy (cited above), and acknowledge my right to privacy, or the sharing of my records with the below individuals.

In order to give you the best care possible, we've found it helpful to connect with, and send reports to other individuals close to you or healthcare providers who are serving you. This authorization may be rescinded at any time by the patient or parent/guardian with written notice given to our office.

I authorize my care/condition to be discussed/shared with the following people/providers:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Physician's Name	Specialty	Phone Number
Physician's Name	Specialty	Phone Number

****Please sign below, regardless of whether or not you will be sharing information with your physician in order to acknowledge our privacy practices.**

_____	_____	_____
****Patient/Guardian Name Printed**	**Patient/Guardian Signature**	**Date**
_____	_____	_____
Office Staff Witness Name Printed	**Office Staff Witness** Signature	Date

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INFORMED CONSENT

Health care professionals are required to obtain your informed consent prior to treatment. Informed consent is the patient's legal right to know all the risks and benefits inherent to a medical procedure prior to agreeing to treatment.

I (**PRINT NAME**) _____, do hereby give my consent to have chiropractic care procedures performed. I understand that the procedures will consist of a precise form of manual therapy to soft tissues. I acknowledge that all health care procedures have some risks and complications, and that treatment has some limited, inherent risks that seldom occur. I have considered the following risks and complications regarding Barefoot rehabilitation Clinic's chiropractic care:

- **Soreness/Bruising**: It is common to experience localized muscle soreness and occasionally minor bruising in treatment areas.

I also understand the beneficial effects associated with these procedures including decreased pain, improved mobility and function, and increased quality of life. Reasonable alternatives have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises, and surgery.

By signing below, I now voluntarily and freely agree to have chiropractic care procedures that are recommended to me by Barefoot Rehabilitation Clinic to be performed. I have had the opportunity to ask questions regarding the above information and possible consequences and risks. I have no further questions and I acknowledge that no guarantee or cure has been made to me concerning results and treatment.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent or Guardian (if patient is a minor) Date

_____ _____

Signature of Office Staff Witness Date

REFUND POLICIES

It is important to us at Barefoot Rehabilitation Clinic that you feel you are getting the value of the permanent pain relief services we provide. A refund can be given for our services if you relocate, aren't satisfied, or cannot comply with a treatment plan as discussed with the doctor.

Refunds for Consultation and Examination:

Consultations ($100 or $150) and Examination and Report of Findings ($200), are refundable up until 24 hrs before the appointment. **Any missed, rescheduled, or canceled Consultations or Examinations with less than 24 hrs notice will not be refunded and you will be subject to paying the full price of the appointment to reschedule.**

Care Packages: ____**Initials**

A patient has **up to 1 month** from their **last treatment/scheduled visit** in the office to receive a refund for treatment.
Refund will only be given for visits that are not used

____**Initials**

Case Fee:

Refunds may be allowed to be issued up to visit 16 in the treatment plan. The refund will be prorated from the Case Fee divided by the average number of visits (16) seen for each case.

____**Initials**