Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Dr. Gary Sash DC
117 E Carroll St
Macomb, IL 61455
PH: (309)837-2567 F:(309)837-2592

Name: _____ **Date:** _____ (dd/mm/yr)

Insurance: _____

Date of Birth: _____ ☐ **male** ☐ **female**

Address: _____ Race _____

_____ **Marital status**

_____

S	M	W	D	SEP

Phone #: home: _____ **work:** _____

E-mail address: _____

Occupation: _____ **Employer:** _____

Check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow: ____ Length of cycle: _____
Date - 1st day last period: _____
Are you pregnant? ☐ yes, ☐ no
If yes, how many months? _____
How many children do you have? _____
Birth control method: _____
Date of last PAP test: _____
☐ normal, ☐ abnormal
Date of last mammogram: _____
☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

_____

_____

_____

_____

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

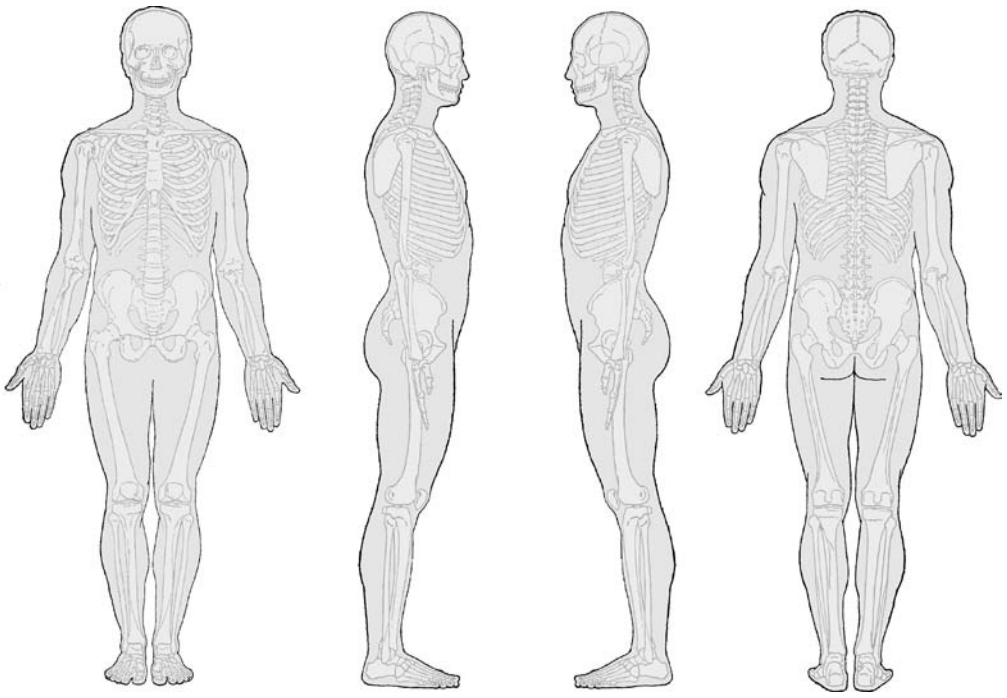
What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:

Worst Possible Pain

No Pain



Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____
Do you take minerals, herbs or vitamins?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Continued …

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

		Start Date			Start Date
1)			**5)**		
2)			**6)**		
3)			**7)**		
4)			**8)**		

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

Smoking History

* Denotes required information

*Do you currently smoke: __ Yes __ No
Years smoked: _____
Packs a day: _____
Interest in quitting on a scale of 0-10: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest
How long since you stopped: _____

Social History

* Denotes required information

Consumption

How much alcohol do you drink daily: _____
How many cups of coffee do you drink daily: _____
How much soda pop do you drink daily: _____
How much water do you drink daily: _____
How much do you depend on pain relievers: _____
Do you use recreational drugs: __ Yes __ No

Stress Information

*How much physical stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot
*How much emotional stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot
What are the major stressors in your life: _____

Sleeping Information

How many hours do you sleep per night: _____
What is your preferred sleeping position: _____
What type of mattress & pillow do you have: _____
How old are your mattress & pillow: _____

Healthy Eating & Exercise Information

How much regular exercise do you perform: _____
*Rate your healthy eating habits: Not healthy - 0 1 2 3 4 5 6 7 8 9 10 - Healthy
Typical eating habits: __ Skip Breakfast __ 2 meals per day __ 3 meals per day
__ Snacking between meals

What would be the most significant thing that would improve your health:

_____

_____

What additional health goals do you have:

_____

_____

Daily Activities

* Denotes required information

Rate the difficulty of the following daily activities on a scale of 0-10 (0 being easiest, 10 most difficult):

Activity	*Current Difficulty	*Prior Difficulty
Bending:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Carrying:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Driving:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Housework:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Lying:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Opening jars:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Personal care:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Picking up objects:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Pulling:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Pushing:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Reaching:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Reaching behind:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Reading:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Recreation:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Running:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Shopping:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Sit to stand:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Sitting:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Sleeping:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Standing:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Throwing:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Walking:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Writing:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Comments: _____

Acknowledgements

Chiropractic care:	☐	I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.
Privacy Verification:	☐	I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Permission to contact:	☐	I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Payment Verification:	☐	I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
X-ray Verification: *(females only)*	☐	I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks. Date of last menstrual period:
General Verification:	☐	To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature: _____ Date: _____

Family Chiropractic & Occupational Health Svc.
Dr. Gary L. Sash, D.C.
117 E Carroll Macomb, IL 61455 Phone 309-837-2567

1 **Forms of Payment:** Patients are responsible for payment at the time service is rendered unless insurance arrangements verified. We accept cash, credit, or check. Insurance verification is completed upon the initial office visit, and co-pays, deductible portion, or non-covered fees are due upon the date of service. All verifications with insurance are not guaranteed until processed with benefits.

2 **Insurance services:** *Insurance patients need to* ***view claims history regularly to record the number of visits, if insurance has limitations****. We can provide print-outs of service upon each visit, or when requested. CO-PAYS are due upon the visit and deductible amounts are due upon the claim process remainder bill, otherwise, 85%payable each visit, until deductible accumulated.* Patients who have reached their deductibles, need to pay co-ins upon insurance processing complete, otherwise the co-ins is collected, 10% less to allow insurance discounts, per visit. We will bill fees to your insurance and if your company is a **PPO or government contract provider**, we will accept the **allowed** fee and adjust off any above balance. **All non-covered fees or services exceeding your insurance allowed contract procedures, will be due and payable by the patient at the time service is rendered, when knowledge of non- covered services. All fees exceeding the contract allowed when insurance completes will be due and payable by the patient.**

3 **Workers comp and personal injury:** We will accept physician assignment for personal injury claims with the **patient listed as the insured of the policy**. In other words, our provider can only be paid in a timely fashion, for medical payments of an auto accident claim by your MED-PAY on your auto carrier policy. Auto accident claims can be submitted to your health insurance with a consent from the patient that all auto claim payment will be reimbursed at the time of a settlement, or directly billing your medical benefits on your insurance policy with the same consent. An at-fault auto claim will be billed, but not collected until a release date of treatment. Some medical treatment for some auto cases can take and allowed a 2-year window. Therefore, our provider cannot wait for medical payments of current services rendered for this time

frame. If you have no medical payments or health insurance coverage to file an at-fault auto claim, we ask you to sign a release of medical benefits to this provider, at the time your treatment has completed. We will submit this release with our final billing. This will release any other liability to the at-fault carrier for the said auto accident. According to the IL Dept. of Insurance, Dr. Sash cannot accept assignment of benefits with the at fault carrier. We will bill all parties involved. Your Med-Pay carrier will seek reimbursement for all monies paid by your policy for an at-fault carrier.

4 **Credit Policy:** To assist you in fulfilling your financial obligation, our office will extend a credit limit of $300.00 account balance maximum, ONLY during treatment. ***We will need specified payment arrangements to pay the account balance in full, in a reasonable time frame***.

5 **Special Arrangements:** We have never denied anyone the benefits of chiropractic care because of their inability to pay our standard fees. Our office participates in a many insurance provider organizations, providing a discounted fee. A fee schedule will be provided to indicate fees for recommended services to give accurate fees for your anticipated expense.

6 **Billing:** All fees are billed to insurance weekly, or bimonthly. Most claims are processed within 30-45 days and considered past due 60 days after billing date. Accounts 90 days old will have an additional *1.5% late fee added to balance monthly*. Accounts 90 days old ***without payment arrangements will be forwarded to our collector*** with all Legal and Collection fees due and payable by patient or guarantor.

7 **Questions:** Please ask if you have any questions about this agreement. We are here to help.

*Patient/Responsible Party Signature:*_____

*Date:*_____*Office staff* _____