NPM INTAKE FORM

INFORMATION:

Name:		Date:
Chosen Name (What would you like to be called?):		Age:
Address:		City/State/Zip:
Home Phone No.:	Work Phone No.:	Cell Phone:
Email Address:		Date of Birth:
Occupation:	Employer Name and Address:	
Best Time to Contact:	Relationship Status:	
Number of Children:	Names and Ages:	
Emergency Contact Name / Relation / Phone No.:		
How did you hear about our services?:		

PERSONAL INFORMATION:

We take pride in helping people to reach their optimum health and wellness. Please place an “X” on the scale below to mark where you believe your level of health and wellness is at this time. Then place a star (*) on the diagram indicating where you would like your health and wellness to be.

Very challenged	Challenged	Transition	Good	Excellent
0 – 50	50 – 75	75 – 100	100 – 125	125+

YOUR HEALTH PROFILE:

Please briefly describe your chief concerns, including the impact it has had on your life. If you have no symptoms or concerns and are here for Wellness Services, please skip to the "General History" page.

____
____
____

Since the concern started, it is ____The Same ____ Getting Better ____ Getting Worse

What makes it worse? ____
____

What, if anything, makes it better? ____
____

Does this interfere with your: ____ Work ____ Leisure ____ Sleep ____ Sports
____ Other: ____

It's common for people to have multiple providers on their healthcare team. Have you consulted a physician, therapist, or other healthcare provider(s) for your concerns?
Please list: ____
____
____

During the above visits, was the cause of your health concern identified?
Circle one: Yes or No

If yes, what was the diagnosis: ____
____

Were there recommendations? ____
____

GENERAL HISTORY:

Prescription medications have many side effects – some of which may be contributing to your concerns. We are interested in knowing what, if any, medications you are taking and why: ____

____

____

____

____

Some people choose to use supplements to address their health concerns. Please list any supplements or vitamins you are taking and why: ____________________________

____

____

____

____

Have you had any surgeries or hospitalizations? (Please include all surgeries)

____

____

____

____

Have you ever had any work related injuries? _________________________________

____

Even minor falls and accidents can affect your overall health. If you have had any slips, falls or auto accidents, please list them here: __________________________________

____

____

____

____

Because the nervous system controls everything in your body and the fascial system affects everything, it is common that current health concerns can be related to the problems you are seeking care for in our office. Please check (✓) the following symptoms you have had, whether CURRENT (C) or PAST (P):

	Past	**Current**		**Past**	**Current**
Headaches	☐	☐	Neck Stiff / Pain	☐	☐
Loss of Smell	☐	☐	Loss of Balance	☐	☐
Loss of Taste	☐	☐	Tension	☐	☐
Ulcers	☐	☐	Dizziness	☐	☐
Fatigue	☐	☐	Irritability	☐	☐
Cold Hands / Feet	☐	☐	Constipation	☐	☐
Heart Irregularities	☐	☐	Hot Flashes	☐	☐
Diarrhea	☐	☐	Asthma	☐	☐
Cold Sweats	☐	☐	Arm Tingling	☐	☐
Fainting	☐	☐	Buzz/Ring in Ears	☐	☐
Back Pain	☐	☐	Numbness in Fingers	☐	☐
Nervousness	☐	☐	Numbness in Toes	☐	☐
Stomach Upset	☐	☐	Sleeping Problems	☐	☐
Depression	☐	☐	Light Bother Eyes	☐	☐
High Blood Pressure	☐	☐	Menstrual Irregularity	☐	☐
Fever	☐	☐	Tingling in Legs	☐	☐
Menstrual Pain	☐	☐	Allergies	☐	☐
Heartburn	☐	☐			

If we have no listed current health concerns on the list above, please list additional health concerns in the lines below:

____

____

____

____

YOUR GOALS:

It has been our experience that intention and goal setting are vital steps in the movement toward what you want to achieve with your health, and increase our ability to fully support you. Please list your goals / intentions below (physical, emotional, spiritual).

Physical Goals	Emotional Goals	Spiritual Goals

Now we just need your permission to continue through our process!

By signing this form I consent to a professional evaluation and examination by provider. I understand that any fee for service(s) rendered is due at the time of service. I affirm that I have stated all my known medical conditions and relevant health information, and have answered all questions honestly. I agree to keep my provider updated as to any changes in my medical history / life history, and understand that there shall be no liability on the provider's part if I fail to do so.

Signature ____ **Date** ____________

It has been shown that daily lifestyle stress significantly impacts your overall health and wellbeing. As a family wellness office, we specialize in not only removing the cause of your health challenges, but we also focus on teaching you how to manage the lifestyle stresses that are keeping you from reaching your optimum health and wellness.

Please rate the following and circle ALL answers that apply to your habits (1 being very poor and 10 being excellent):

Eating habits: _____

a. I eat 3 – 5x per day
b. I eat fruits and vegetables daily
c. I eat out 2 – 3 times weekly (min)
d. I drink 3 – 5 sodas weekly
e. I crave sweets
f. I don't watch what I eat

Sleep: _____

a. I sleep 7 – 9 hours per night
b. I wake up well rested
c. I wake up tired
d. I toss and turn
e. I stay up late

General Health: _____

a. I am not on medications
b. I take care of myself
c. I watch what I eat
d. I base my health on how everyone around me is doing
e. I think I am healthy but know I could make some changes

Exercise Habits: _____

a. I exercise 3 – 5 times per week
b. I walk daily
c. I don't exercise
d. I want to exercise
e. I sit at a computer 6 – 8 hours per day

Mindset: _____

a. I have a positive outlook
b. I have a negative outlook
c. I am always in a bad mood
d. I am always in a good mood
e. I trap things inside
f. I share easily

On a scale of 1 – 10, describe your psychological / emotional stress levels (1 = none; 10 = extreme):

Occupational:_____ Personal: ________

Thank you for providing us with information that could help us to better serve you and help you be the best you can be!

HEALTHCARE AUTHORIZATION FORM

A copy of our notice is attached. We encourage you to read it and to request your own copy if you would like one.

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of healthcare operations of this chiropractic office.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Dr. Jenn and Cournoyer Chiropractic PC to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Dr. Jenn and the Cournoyer Chiropractic PC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If Dr. Jenn and Cournoyer Chiropractic PC contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.
- I give permission to Dr. Jenn and Cournoyer Chiropractic PC to use my name on a welcome board, referral board, and birthday board.
- I give permission to Dr. Jenn and Cournoyer Chiropractic PC to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to Dr. Jenn and Cournoyer Chiropractic PC to use any testimonial written by me for marketing purposes, such as sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give Dr. Jen and Cournoyer Chiropractic PC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the

course of care. Should I need to speak with my provider at any time in private, the provider will provide a room for these conversations.

By signing this form you are giving Dr. Jenn and Cournoyer Chiropractic PC permission to use and disclose your protected health information in accordance with the directives listed above. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality healthcare and health information.

This authorization will remain in effect for the duration of my care with Dr. Jenn and Cournoyer Chiropractic PC plus 7 years or until revoked by me.

SPECIFIC AUTHORIZATIONS:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official for Dr. Jenn and Cournoyer Chiropractic PC. The written notice must contain the following information:

- Your name, Social Security number and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature

The revocation is not effective until it has been received by the Privacy Official.

This AUTHORIZATION is requested by ______________________ for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Dr. Jenn and Cournoyer Chiropractic PC will not refuse to provide treatment; however, it will not be possible for Dr. Jenn and Cournoyer Chiropractic PC to file third party billing on my behalf, and I will be responsible for:

1. Payment in full at the time services are provided to me
2. Scheduling my own appointments since Dr. Jenn and Cournoyer Chiropractic PC will be unable to contact me
3. All contact with Dr. Jenn and Cournoyer Chiropractic PC regarding my care

Additionally, any collection activity as permitted by law is not waived by refusal to sign the AUTHORIZATION.

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed AUTHORIZATION will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: ______________________________ DOB: ____________________

Patient's Name (please print): ___________________________

Patient's Signature: __________________________________

Today's Date: ________________________

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative Name (please print): _______________________

Signature: ___________________________

Description of Representative's Authority to Act on Patient's Behalf: _______________

____

____

____

____

Dr. Jenn
828-230-7253
3076 Sweeten Creek Road
Asheville, NC 28803
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Informed Consent

We encourage and support a shared decision-making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other

specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE____ TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATED THIS ____ DAY OF _____________, 20___

______________________ ______________________

Patient Signature Doctor's Signature

Parental Consent for Minor Patient:

Patient Name: ____________________________

Patient age: ___________ DOB: ____________

Printed name of person legally authorized to sign for

Patient: ________________________________

Signature: ______________________________

Relationship to Patient: ____________________

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Patient: ________________________________

Signature: ______________________________

Relationship to Patient: ____________________

Remarks:

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DATE OF VISIT ___/___/20___ Patient____Age_____________

Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms ___________________

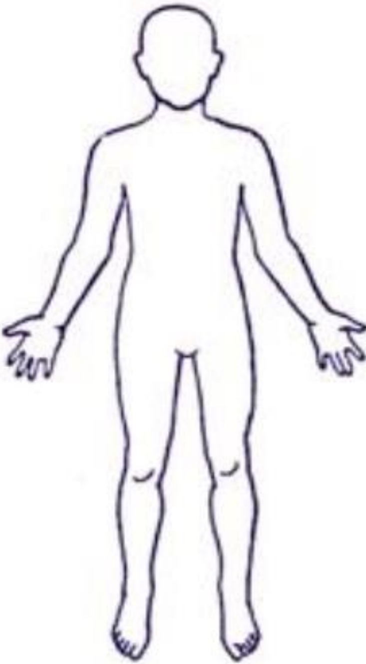
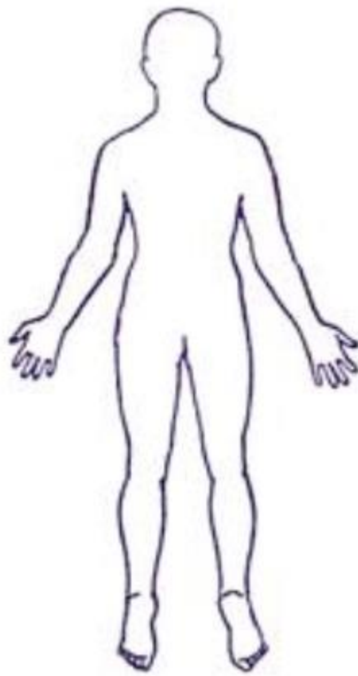
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint?______________________________
____
____
____

SUBJECTIVE PAIN ASSESSMENT

Right **Left**

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

Front **Back**

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing
E=Emotional

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
NONE		LITTLE			MEDIUM			SEVERE		EXCRUCIATING	

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

____ ________________

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