Ultimate Health

Today's Date: _____

Patient Data

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss Sex: ☐ Female ☐ Male Birth Date: _____

First Name: _____ Middle Initial: _____ Last: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Social Security Number: _____ Marital Status: ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Other

Spouse Data

Is your spouse a patient in the clinic?: ☐ Yes ☐ No

First Name: _____ Middle Initial: _____ Last: _____

Home Phone: _____ Work Phone: _____

Employer Data

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Emergency Contact

Name: _____ Phone: _____

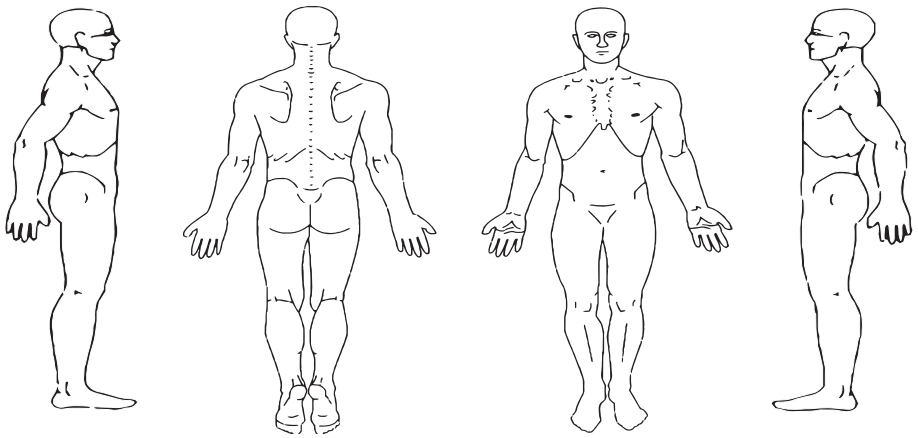
Ultimate Health

Patient Intake Form

Patient Name: _____ Date: _____

1. **Is today's problem caused by:** ☐ Auto Accident ☐ Workman's Compensation

2. **Indicate on the drawings below where you have pain/symptoms.**



3. **How often do you experience your symptoms?**
   - ☐ Constantly (76-100% of the time)
   - ☐ Occasionally (26-50% of the time)
   - ☐ Frequently (51-75% of the time)
   - ☐ Intermittently (1-25% of the time)

4. **How would you describe the type of pain?**
   - ☐ Sharp ☐ Dull ☐ Diffuse ☐ Achy ☐ Burning
   - ☐ Shooting ☐ Stiff ☐ Numb ☐ Tingly ☐ Sharp with motion
   - ☐ Shooting with motion ☐ Stabbing with motion ☐ Electric-like with motion
   - ☐ Other: _____

5. **How are your symptoms changing with time?**
   - ☐ Getting worse ☐ Staying the same ☐ Getting better

6. **Using a scale from 1-10 (10 being the worst), how would you rate your problem?** (Please circle one.)
   - 0 1 2 3 4 5 6 7 8 9 10

7. **How much has the problem interfered with your work? Occupation:** _____
   - ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. **How much has the problem interfered with your social activities?**
   - ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. **Who else have you seen for your problem?**
   - ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
   - ☐ ER Physician ☐ Orthopedist ☐ Massage Therapist
   - ☐ Physical Therapist ☐ No one ☐ Other: _____

10. **How long have you had this problem?** _____

11. **How do you think your problem began?** _____

12. **Do you consider this problem to be severe?** ☐ Yes ☐ Yes, at times ☐ No

13. **What aggravates your problem?** _____

14. **What concerns you the most about your problem; what does it prevent you from doing?**
    _____

15. **What is your: Height:** _____ **Weight:** _____ **Date of Birth:** _____

16. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ ALS

19. For each of the conditions listed below, place a check in the "Past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco Use
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Knee Pain	☐	☐	Abnormal Weight Gain/Loss			
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite			**For Females Only**
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Birth Control Pills
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer	☐	☐	Hormonal Replacement
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Pregnancy
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder			
☐	☐	Cancer	☐	☐	General Fatigue			
☐	☐	Tumor	☐	☐	Muscular Uncoordination			
☐	☐	Asthma	☐	☐	Visual Disturbances	☐	☐	OTHER: _____
☐	☐	Chronic Sinusitis	☐	☐	Dizziness			_____

20. List all prescription medications you are currently taking:

_____

21. List all over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

23. What activities do you do at work?

☐ **Sit:**	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ **Stand:**	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ **Computer:**	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ **On Phone:**	☐ Most of the day	☐ Half the day	☐ A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? ☐ Yes ☐ No

If yes, why? _____

26. Have you had significant past trauma? ☐ Yes ☐ No

27. Anything else pertinent to your visit today? _____

Patient Signature: _____ **Date:** _____

Ultimate Health

Consent for Treatment

I _____ hereby agree to be treated by Dr. Brad Schapiro (Ultimate Health Chiropractic) for the diagnosis(es) explained to me for my condition and/or injuries. I hereby further agree to maintain and cooperate with Dr. Schapiro and/or staff recommendations for my Chiropractic Care for Rehabilitation of the spinal condition diagnosed from my exam.

In the event of excessive missed appointments without notification (No Show) to the above named Doctor or Clinic, it will be assumed that I have reached a point of stabilization and/or symptomatic relief that I am dismissing myself from care. Therefore, my Doctor or Staff can notify my employer, insurance agent, insurance carriers, and/or lawyers that I am no longer being treated, and I have returned to work without restrictions and/or limitations.

I hereby further agree upon such notifications by this office to my employer and/or insurance carriers that will pay upon demand, all bills incurred for my treatment to date. I clearly understand this "office policy" and that all past, present, and future bills incurred at this Clinic are my responsibility for payment. I hereby agree to pay all bills upon demand and my doctor will not be involved in any third-party disputes. Billing for all clinical and rehabilitation services is done as a courtesy and I understand there is no guarantee of third-party payment.

Consent to C-Ray

I hereby authorize Dr. Schapiro and whomever he designates as his assistant(s) to take X-Rays of myself (or said minor).

Pregnancy Warning

☐ I hereby understand that if I am pregnant and have X-Rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

☐ I have been advised that the 100 days following the onset of a menstrual period are generally considered to be safe for X-Ray examination.

With those factors in mind, I am advising my doctor that:

I am pregnant	☐ Yes	☐ No	☐ Don't Know
I could be pregnant.	☐ Yes	☐ No	☐ Don't Know
I have an IUD.	☐ Yes	☐ No	☐ Don't Know
I have a tubal ligation.	☐ Yes	☐ No	☐ Don't Know
I am late with my menstrual period.	☐ Yes	☐ No	☐ Don't Know
I am taking oral contraceptives.	☐ Yes	☐ No	☐ Don't Know
I have had a hysterectomy.	☐ Yes	☐ No	☐ Don't Know
I have irregular menstrual periods.	☐ Yes	☐ No	☐ Don't Know

With full understanding of the above and believing that I am not currently at risk, I wish to have an X-ray examination performed now.

_____ _____

Patient Signature Witness Signature

Authorization

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on the receipt. However, I clearly understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat any condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-Rays is for examination only and the X-Ray negatives will remain the property of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

_____ _____

Patient Signature Date Guardian or Parent Signature Authorizing Care Date

Ultimate Health

Consent for Use or Disclosure of Health Info.

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We many need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I have also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy for Protected Health Information).

_____ _____

Printed Name Authorized Provider Representative