New Patient Intake

Date:_____How did you hear about us?_____

Name:_____

Date of Birth_____ Age_____ Gender M or F

Address_____City_____State_____

Zip_____Personal Phone:_____Email_____

Occupation:_____ Employer:_____

Work Phone:_____ Spouse Name:_____

Spouse Occupation_____ # Children_____

Payment Information

Our initial evaluation fee is $50. We do not accept insurance or Medicare for this initial evaluation fee. It includes your consultation, chiropractic examination, and first x-ray. Dr. Hafner will discuss your treatment options and fees after reviewing your initial examination and health history.

Health Insurance Company (if applicable, please present cards):_____

Do you have MEDICARE? □No □Yes Medicare Supplemental Company:_____

If you have insurance, do you want us to bill them? □No □Yes

Payment Policies Agreement

I understand and agree that I am responsible for any uncovered charges for any services that the insurance doesn't pay for any reason. I understand and agree that if I ask that insurance be billed, that the office will generally use the State of Colorado workers comp fee schedule; and I hereby assign my insurance company/Medicare or their intermediaries to pay Dr Hafner health care benefits directly at his business address as determined under Colorado law C.R.S 10-16-106.7 (assignment of health insurance benefits), to bill insurance for each medical service performed, and assign Dr Hafner to release any administrative or medical information necessary to process insurance claims. I understand there is a $30 charge for returned checks.

Privacy Disclosure (Updated: 1/1/2017): This office conforms to the current HIPAA guidelines and policies for health information. A privacy policy is posted in the reception area at all times and you may request a printed copy if desired. I hereby authorize that my medical records may be forwarded to my other healthcare providers in the best interest of my healthcare or insurance payors in order to process claims information. I understand that Dr. Hafner provides regular care in an open, multiple-patient treatment area format and that if I have specifically confidential information to share, I will request and be provided private room consultation. I understand that omission of information on this health history, my compliance with care, and providing Dr. Hafner with accurate health condition updates will directly affect the ability of providers at Hafner Chiropractic to come to proper diagnoses and provide safe and standard care and I agree to hold harmless Dr. Hafner for any act of information omission on my part.

I hereby understand and agree to the privacy and payment policies and that the fee schedules are reasonable. I consent to chiropractic diagnostic and treatment procedures to be performed by Dr. Jay A. Hafner, D.C.

Patient Signature (or guardian)_____ Date _____

Version: 2.3.2017

PATIENT'S HEALTH HISTORY

Name_____ **Date**_____

What is the reason for your visit today? Please write down anything you want the doctor to know:_____

_____

_____

When did your symptoms start?_____ Have you had these symptoms before? □**Yes** □**No**

What caused your symptoms? _____

Is this an injury from Work or is this a Worker's Compensation claim? □**Yes** □**No**

How often are you feeling your symptoms? (circle one): Constantly Frequently Occasionally Rarely

Describe your symptoms (circle all applicable):

dull sharp throbbing burning deep aching tingling stabbing cramping numbness radiating stiffness

How are your symptoms progressing? Getting Worse Not changing Getting Better

TODAY How severe are the symptoms on a scale of 1-10? (circle) 1 2 3 4 5 6 7 8 9 10

AVERAGE IN THE PAST WEEK - how severe have the symptoms been? 1 2 3 4 5 6 7 8 9 10

How much are your work or daily activities affected? Extremely Quite-a-Bit Moderately Little-bit None

Who else have you seen for these symptoms? Chiropractor MD-Physician Physical Therapist Masseuse Other:_____

Do you consider your condition to be severe? Yes Yes, at times No

What makes it worse?_____ **What makes it better?**_____

What concerns you the most about this problem (circle one or more)? Affecting Relationships Affecting Work

Could be serious Isn't going away Affecting Leisure Activities It's Getting Worse Affecting Sleep

Other (please explain):_____

In general, how would you rate your current overall health? Excellent Very-good Good Fair Poor

When was your most recent Chiropractic Visit?

Year:_____ Reason:_____

When was your most recent spinal x-ray taken?

_____

Have you had any MRIs or CT scans taken of your problem areas? □No □Yes_____

When were your most recent blood or urine tests?

_____/____/_____

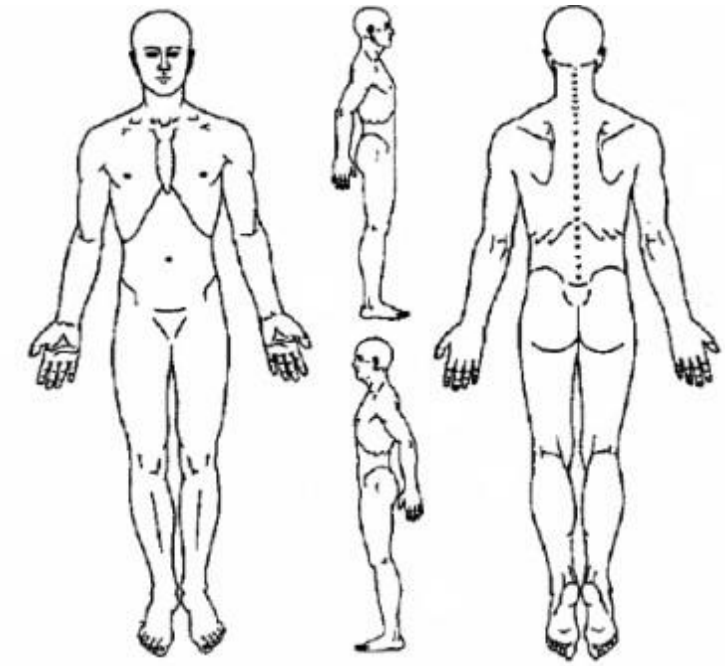
Name of Your Primary Medical Physician:

_____

Do you see other types of Providers REGULARLY?

(**Circle):** acupuncturist, personal trainer, naturopath, physical therapist, massage therapist, other:

Mark your problem areas on the drawing below



DOCTOR'S NOTES:

Tech:

PATIENTS HEALTH HISTORY PAGE

Name:_____

Last known: Height_____ **Weight**_____ **Blood Pressure** _____/_____ □**don't know**

What is your exercise routine? _____

***THESE ARE IMPORTANT RED-FLAG INDICATORS FOR THE DOCTOR. DO *NOT* SKIP ANY PORTION OF THIS PAGE!!!**

Circle P for PAST problem
Circle C for CURRENT problem

Are you pregnant? □Yes □No

Musculoskeletal & General

P C Degenerative arthritis
P C Rheumatoid arthritis or Gout
P C Compression fracture
P C Osteomyelitis or spondylitis
P C Osteoporosis
P C Psoriasis or psoriatic arthritis
P C Fibromyalgia

Musculoskeletal Spine

P C Neck problem
P C Mid-back problem
P C Low back problem
P C Poor Posture or Scoliosis
P C Disc Injury/Herniation/Bulge

Musculoskeletal Extremity

P C Hip or sacroiliac issue L R
P C Leg or Knee Issue L R
P C Ankle or foot L R
P C Shoulder problem L R
P C Arm,elbow,hand problem L R
P C Rib or chest pain

Nervous System

P C Recent progressive muscle weakness or shaking
P C Tingling or numbness
P C Pinched nerve or sciatica
P C Poor balance
P C Depression
P C Anxiety
P C Dizziness or vertigo
P C Seizures/Epilepsy
P C Sleeping trouble
P C Headaches or migraines

How many concussions have you had in your lifetime?_____

EENT

P C Asthma or Difficulty Breathing
P C Throat or swallowing problems
P C Vision Problems
P C Earache or ear infections
P C Jaw, TMJ or mouth problem
P C Chronic sinus problems
P C Allergies:_____
P C **Other:**_____

General Systems
(P)ast (C)urrent

C Diabetes
P C High blood pressure
P C Recent fever over 102°F
P C Thyroid problem
P C Abdominal pain
P C Constipation/Diarrhea
P C Heartburn/Acid Reflux/Ulcers
P C Leaky Bladder or Bowel
P C Inflammatory bowel disease
P C Menstrual problems or PMS
P C Menopause symptoms
P C Pregnancy problems
P C Pacemaker or implanted device
P C History of stroke or aneurysm
P C Concerns about Weight

Injuries and General Constitution

P C Car crash/whiplash injuries
P C Work or Sports Injuries
C Recent fall or accident
P C Smoking habit
P C Alcohol/Drug dependence or recovering
P C Unexplained weight loss
P C Cancer or Tumor
P C Blurred or double vision, dizziness, nausea or faintness when neck is moved
P C Medication Issue
P C **Other:**_____.

FAMILY HISTORY *(CIRCLE)*
(Parents, spouse or children)

□ Chronic Neck Problems
□ Chronic Back problems
□ Neck or Back Surgery
□ Significant Arthritis
□ Cancer
□ Bone or joint problem
□ Frequent headaches/migraines
Other:

LIST ALL MEDICATIONS/VITAMINS/ SUPPLEMENTS/HERBALS:

_____
_____
_____
_____

LIST ALL SURGERIES / PROCEDURES **Year**

_____ (____)
_____ (____)
_____ (____)
_____ (____)