Basic Health Chiropractic and Rehab

The office of Raymond Uhlmansiek, D.C.

New Patient Intake Form

Please Print

Patient Demographic Information

Month - Day - Year

Patient's Full Legal Name: _____ **Visit Date:** _____

Preferred Name:_____ **Name of Patient's Legal Guardian:** _____
(If Applicable)

Birth Date: _____/_____/_____ **Age:** _____ **Gender:** ☐M ☐F **SSN (required for insurance):** _____

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

Phone Number: ☐Home Phone ☐Cell Phone **(**_____**)** _____ **Email:** _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated **Number of Children & Ages:** _____/_____

Employed: ☐Yes ☐No **Employer:** _____ **Student Status:** ☐Full Time ☐Part Time ☐Not a Student

Job Title: _____ **Name of School:** _____

Female Patients Only: I declare that, to my knowledge, I am not pregnant and if I were to become pregnant in the future, I will inform the doctor and staff prior to any x-rays are taken, as this could be harmful to the fetus/baby.

Initial Here: _____

Emergency Contact Information

Person to contact in emergency: _____ **Relationship to Patient:** _____

Home Phone: (_____**)** _____ **Cell Phone: (**_____**)** _____ **Work Phone: (**_____**)** _____

Primary Care Physician: _____ **Doctor's Phone Number: (**_____**)** _____

How Did You Hear About Our Office?

☐**Referral from:** _____ ☐**Internet** ☐**Other:** _____

Have you ever been to a chiropractor before? ☐No ☐Yes **If Yes, how was your experience?** ☐Good ☐Bad ☐Indifferent

Do you have any questions or concerns regarding your care here? ☐No ☐Yes: _____

Who is Responsible for Payment for the Patient's Treatment in This Office?

Relationship to the patient: ☐Patient/Self ☐Parent ☐Legal Guardian ☐Spouse ☐Other

***Guarantor Information if Other than Self*:**

First Name: _____ **M.I.** _____ **Last Name:** _____

Date of Birth: _____/_____/_____ **Phone: (**_____**)** _____

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

Patient Name: _____ **Visit Date:** _____

Symptom Questionnaire

Describe ONLY ONE SYMPTOM Per Questionnaire. If You Need Another Questionnaire, Please Ask the Staff.

Describe Your Symptom Here: _____

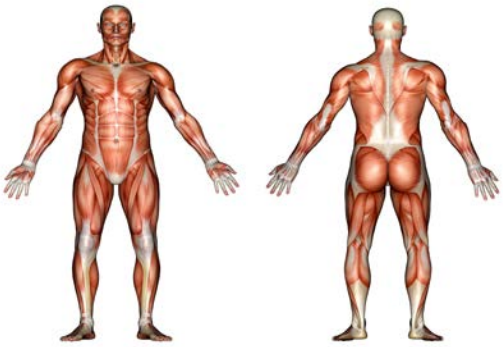
Describe the quality of the symptom, check all that apply:

☐Sharp ☐Shooting ☐Stabbing ☐Piercing ☐Stinging ☐Deep ☐Dull ☐Achy ☐Burning ☐Throbbing ☐Nagging ☐Tingling

☐Numb ☐Tight ☐Spasm ☐Cramp _____

Does the symptom radiate to another part of your body: ☐No ☐Yes _____

Use the picture to diagram your symptom:



Have you ever had this specific symptom before? ☐No ☐Yes: _____

How and When did the Current symptom begin? _____

Did you start to experience the symptom: ☐Suddenly ☐Gradually _____

Since it began, has it gotten: ☐Better ☐Worse ☐Stayed the Same _____

How often do you experience this symptom? _____

0-10, with 10 being the worst, circle the number that best describes the severity of the symptom at its worst:

0 1 2 3 4 5 6 7 8 9 10

0-10, with 10 being the worst, circle the number that best describes the severity of the symptom most of the time:

0 1 2 3 4 5 6 7 8 9 10

What makes the symptom worse? ☐Sitting ☐Standing ☐Walking ☐Laying ☐Overuse ☐Coughing ☐Sneezing ☐Straining

_____

Is the symptom worse at any certain times? ☐Morning ☐Afternoon ☐Evening ☐Night ☐Unaffected by time of day

_____

For this Symptom, have you seen any other health care providers? ☐No ☐Yes:

☐Chiropractor ☐Physical Therapist ☐Medical Doctor ☐Massage Therapist ☐Acupuncturist ☐Other _____

Did you receive any treatment? ☐No ☐Yes: _____

Did you have any diagnostic testing? ☐No ☐Yes: ☐X-rays ☐MRI ☐CT ☐Bloodwork _____

What have you tried that HAS Helped make the symptom better?

☐Rest ☐Ice ☐Heat ☐Stretching ☐Exercise ☐Massage ☐Pain medication ☐Muscle relaxers ☐Nothing Has Helped

_____

What have you tried that HAS NOT Helped to make this symptom better?

☐Rest ☐Ice ☐Heat ☐Stretching ☐Exercise ☐Massage ☐Pain medication ☐Muscle relaxers

_____

When will you feel that your chiropractic care has been successful with regards to this symptom?

_____

What type of care are you MOST interested in? ☐Symptom Relief Care ☐Postural Improvement Care ☐Wellness/Maintenance Care

Basic Health Chiropractic & Rehab, the office of Dr. Raymond Uhlmansiek, D.C.
5915 Merchants St. * Florence, KY * 41042 * 859-525-1695

Patient Name: _____ **Visit Date:** _____

Review of Systems

Read each of the following questions and answer them No or Yes. If Yes, then indicate and describe the issue in the spaces provided.

Have you had any of the following **pulmonary (lung-related)** issues? ☐No ☐Yes:
☐Asthma/difficulty breathing ☐COPD ☐Emphysema ☐Other _____

Have you had any of the following **cardiovascular (heart-related)** issues or procedures? ☐No ☐Yes:
☐Heart surgeries ☐Congestive heart failure ☐Murmurs or valve disease ☐Heart attacks/MIs
☐Heart disease/problems ☐ Hypertension ☐ Pacemaker ☐ Angina/chest pain ☐ Irregular heartbeat
☐Other _____

Have you had any of the following **neurological (nerve-related)** issues? ☐No ☐Yes:
☐Visual changes/loss of vision ☐One-sided weakness of face or body ☐History of seizures
☐One-sided decreased feeling in the face or body ☐Headaches ☐Memory loss ☐Tremors ☐Vertigo
☐Loss of sense of smell ☐Strokes/TIAs ☐Other _____

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures? ☐No ☐Yes:
☐Thyroid disease ☐Hormone replacement therapy ☐Injected steroid replacements ☐Diabetes
☐Other _____

Have you had any of the following **renal (kidney-related)** issues or procedures? ☐No ☐Yes:
☐Renal calculi/stones ☐Hematuria (blood in the urine) ☐Incontinence (can't control) ☐Bladder Infections
☐Difficulty urinating ☐Kidney disease ☐Dialysis ☐Other _____

Have you had any of the following **gastroenterological (stomach-related)** issues? ☐No ☐Yes:
☐Nausea ☐Difficulty swallowing ☐Ulcerative disease ☐Frequent abdominal pain ☐Hiatal hernia
☐Constipation ☐Pancreatic disease ☐Irritable bowel/colitis ☐Hepatitis or liver disease
☐Bloody or black tarry stools ☐Vomiting blood ☐Bowel incontinence ☐ Reflux/Heartburn
☐Other _____

Have you had any of the following **hematological (blood-related)** issues? ☐No ☐Yes:
☐Anemia ☐Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) ☐HIV positive
☐Abnormal bleeding/bruising ☐Sickle-cell anemia ☐Enlarged lymph nodes ☐Hemophilia
☐Hypercoagulation or deep venous thrombosis/history of blood clots ☐Anticoagulant therapy
☐ Regular aspirin use ☐Other _____

Have you had any of the following **dermatological (skin-related)** issues? ☐No ☐Yes:
☐Significant burns ☐Significant rashes ☐Skin grafts ☐Psoriatic disorders ☐Skin Cancer
☐Other _____

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues? ☐No ☐Yes:
☐Rheumatoid arthritis ☐Gout ☐Osteoarthritis ☐Broken bones ☐Spinal fracture ☐Spinal surgery
☐Joint surgery ☐Arthritis (unknown type) ☐Scoliosis ☐Metal implants ☐Other _____

Have you had any of the following **psychological** issues? ☐No ☐Yes:
☐Psychiatric diagnosis ☐Depression ☐Schizophrenia ☐Other _____

Pertinent Health History

Describe and Date All Surgeries You Have Ever Had:

_____

Foods, Medications or Other Substances to which you are or may be allergic to:_____

Medications/Nutritional Supplements: List all Prescription and Over the Counter medications and Nutritional Supplements that you are or have taken in the last 6 months and reasons for each.

_____

_____

_____

Patient Name: _____ **Visit Date:** _____

Family Health History

Do you have a family history of? Please check all that apply.

☐Cancer ☐Strokes/TIA's ☐Headaches ☐Cardiac disease ☐Neurological diseases ☐Adopted/Unknown ☐Diabetes ☐Psychiatric disease ☐Cardiac disease below age 40

☐Other _____

Deaths in your immediate family: _____

Cause of your parents or siblings death and their age at the time of death.

_____

_____

Social and Occupational History

Job Description – what are your daily activities like? _____

Work Schedule: _____ **Hobbies/Rec. Activities:** _____

Do you exercise? ☐Yes ☐No **How often?** _____

Where do you exercise? ☐Home ☐Local Gym ☐Personal Training Studio ☐Boot Camp ☐School Coach ☐Other

_____

What kind of activities? ☐Walking ☐Jogging ☐Running ☐Weight Training ☐Cycling ☐Yoga ☐Swimming

_____

Describe your Diet: _____

Meals Per Day: _____ **Do you use Antacids?** ☐No ☐Yes **If so, how many per day/week?** _____

Do you drink coffee/tea? ☐No ☐Yes **Cups per day?** ☐Less than 1 ☐1-2 ☐3-4 ☐5-6 or more

Do you drink soda? ☐No ☐Yes: ☐Regular ☐Diet **Glasses per day?** ☐Less than 1 ☐1-2 ☐3-4 ☐5-6 or more

Do you Drink alcohol? ☐No ☐Yes **Drinks per day?** ☐Less than 1 ☐1-2 ☐3-4 ☐5-6 or more ☐Socially

Do you Smoke/Use Tobacco Products? ☐No ☐Yes **Packs per day?** ☐Less than 1 ☐1-2 ☐3-4 ☐5-6 or more ☐Socially

How many hours do you sleep per night? _____hrs. **Do you sleep well?** ☐Yes ☐No: _____

What type of mattress do you sleep on? _____ **How old is it?** _____ **Is it comfortable?** ☐Yes ☐No:

_____

Sleeping position? ☐Flat on Back ☐Right Side ☐Left Side ☐Stomach, head turned Right ☐Stomach, head turned Left ☐All Over

What type of pillow do you use? _____ **How old is it?** _____ **Is it comfortable?** ☐Yes ☐No:

_____

Do you use: ☐Heel Lifts ☐Arch Supports ☐Specialized Footwear _____

Is there anything else in you past or present medical history that you feel is important to your care here? ☐No ☐Yes:

If yes, describe: _____

Patient Name: _____ **Visit Date:** _____

Consent, Assignment, Acknowledgements and Agreements

Before we begin any healthcare procedures or establish any Doctor-Patient relationship, we require that you read and sign this consent form. If you refuse to sign this agreement, then we reserve the right to, and may refuse to accept you as a patient.

► I acknowledge that I have received a copy of the Notice of Privacy Practices.

► I understand that care provided by this office is for the correction of the vertebral subluxation complex and its components via the chiropractic adjustment and ancillary procedures designed to augment the adjustment. I understand that this office does not diagnose, treat or prevent any other diseases or conditions; no cures or results are promised, implied or guaranteed and payment is due for services rendered regardless of results.

► I have been informed of and understand that the practice of chiropractic and adjunctive therapies carry some risks and these risks may include, but are not limited to: abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, heart attack, stroke, death, strains, sprains, joint dislocation or injury to intervertebral discs, nerves or the spinal cord, skin irritations and burns. I do not expect the physician to be able to anticipate and explain all risks and complications and I wish to rely on the physician to exercise judgment during the course of my care. I also understand that other treatment options may be available, such as over-the-counter medications, medical care and/or surgery and that I should consult with the appropriate provider for more information on the risks and benefits associated with those options.

► I give consent to treatment in an open room where other patients may also be receiving treatment and I am aware that other persons in the office may overhear some of my Private Health Information during the course of my treatment. I authorize the doctor and/or qualified staff, to perform any services, including any diagnostic x-rays, needed during my care in this office. I understand that written consent need only be obtained one time for all subsequent care given to a patient at this office. I understand that I have the right to refuse service or treatment at any time. I understand that it is my duty to fully cooperate with the recommendations of the doctor with regard to my care and if I fail to comply with the recommendations of the doctor, I agree to hold the doctor and staff harmless for any detrimental effects that I may suffer as a result of my actions. I also understand that the delay of chiropractic care may lead to the formation of adhesions, scar tissue and other degenerative changes, and that this could reduce mobility, induce chronic pain cycles and the delay of care may complicate the condition.

► If x-rays are taken, I understand that the amount paid to this office is for the technical component of taking the x-rays and for the interpretation of the x-rays only; the digital images are and will remain the property of this office. I also understand that if x-rays are taken, they may be sent to Brookside Radiology Consultants, Inc. or another outside radiologist chosen by the examining physician for professional reading and interpretation. I understand that there may be a separate or additional fee for this service and my insurance carrier or I may be billed for these services directly if required. Therefore, I hereby authorize the release of any x-rays and protected health information from Basic Health Chiropractic & Rehab, PLLC, to Brookside Radiology Consultants Inc. or any other outside radiologist chosen for the interpretation of my diagnostic imaging. If for any reason, at any time, I refuse to allow my x-rays to be sent out for interpretation by an outside radiologist, I agree to hold the doctor and/or staff of Basic Health Chiropractic & Rehab, PLLC harmless from any adverse consequences that may arise from not having a radiologist interpret my x-rays. This may include, but is not limited to a missed diagnosis or inaccurate diagnosis, etc.

► I swear or affirm that all statements related to my health or conditions, which I make in this office and on my patient forms, are true and correct to my knowledge. I also understand that it is my responsibility to inform the office of any changes to any of the information that I have provided or will, in the future, provide to this office. I also swear or affirm that I am not an agent or representative of any insurance company or any other business attempting to collect information and all symptoms/problems mentioned are true; and I am here solely for the treatment of the stated reasons for care.

► I understand that I am fully financially responsible for all services rendered to me at the this office and that payment for each service is due at the time of service, unless other arrangements have been made with the doctor. I understand that any arrangements for reimbursement from any third party payer (Health Insurance/Accident Insurance Policy, Etc.) is an arrangement between myself and the carrier and that I may be required to pay for some or all of the fees for services rendered. I understand that in the event of any non-payment to this office, for any reason, by my third party payer(s), I will be billed directly for those fees that are not paid to the provider within forty-five (45) days from the date(s) of service, or from the date that the provider received an explanation of benefits from my third party payer indicating an amount that I am responsible for to this office. I am aware that this may include, but is not limited to, any amounts that have been: denied, deemed non-covered, non-allowed, etc. I understand and agree that if I have a balance for services rendered to me, I will either pay the entire balance at once, or I will make a minimum payment of $50.00 each month until my balance is $0.00. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court and /or attorney fees accrued by Basic Health Chiropractic & Rehab, PLLC in the collection of my account. I also understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the current fee schedule regardless of the outcome of my case. I understand that if a check or debit is returned for insufficient funds, I will be charged a $25.00 service charge. Therefore, I hereby assign all benefits to be paid to this provider for services rendered to me by my third-party payer(s) and I authorize the use of my signature on all insurance submissions. I authorize Basic Health Chiropractic & Rehab, PLLC to release any and all information contained in my files as necessary, to any insurance company, attorney or adjuster, to process my claim(s). If my third-party payer(s) declines payment, I authorize Dr. Raymond Uhlmansiek, D.C. to file small claims on my behalf against my insurance company as a method of collection. I also agree that I will be present at the court date if needed.

► I understand that mail, email, text messages, social media communications/actions, faxes and voicemail messages sent between this office and myself may not be privacy protected according to HIPAA and/or the HITECH Act standards/regulations; and that any communication to or from this office, other than direct phone calls and/or priority mail, could jeopardize my protected healthcare information. In light of this information, I authorize the doctor(s) and staff of this office to communicate with me via mail, e-mail, text messages, social media communications/actions, faxes and voicemail messages, as they feel are pertinent to me, and I agree to hold this office, its doctors and/or staff, harmless should any of my protected health information become compromised as a result of communicating with this office via any of the above stated, non-approved methods. I also understand that I may provide a written request to revoke the consent for release of my protected health information at any time during care. This will not affect the use of records for care given prior to the written request to revoke consent.

I have read or have had read to me, the above information and I have had an opportunity to ask questions about this content. Any questions I had have been answered to my satisfaction. By signing below, I acknowledge that I agree to follow and abide by all of the statements listed above and I give my consent to care.

Patient's/Legal Guardian's Signature: _____ **Visit Date:** _____