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.

Name: ______________________ **Date:** ________ (dd/mm/yr)

Insurance: ______________________

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

Address: ______________________

____

____

Marital status

S	M	W	D	SEP

Phone #: home: ______________ **work:** ______________

E-mail address: ______________________

Occupation: ______________ **Employer:** ______________

Mark (c) for current problems, 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
- ☐ Tonsilitis
- ☐ Vision problems

Childhood
- ☐ Birth Trauma
- ☐ Childhood accidents
- ☐ Childhood illnesses
- ☐ Forceps birth
- ☐ C-section birth

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
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Stress incontinence
- ☐ Overnight more than twice
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitations
- ☐ 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: ____ Lenght 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 mamogram: ______________

☐ 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 prescribed or OTC medication you are currently taking and why:

____

____

____

____

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Patient Intake Form (side 2)

Give a breif detailed description of the problem you are currently experiencing: ______________________________

____

____

____

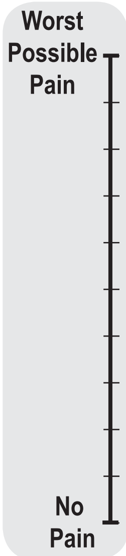
How long have you had this condition? ____________ Is it getting worse? □ yes, □ no ______________________________

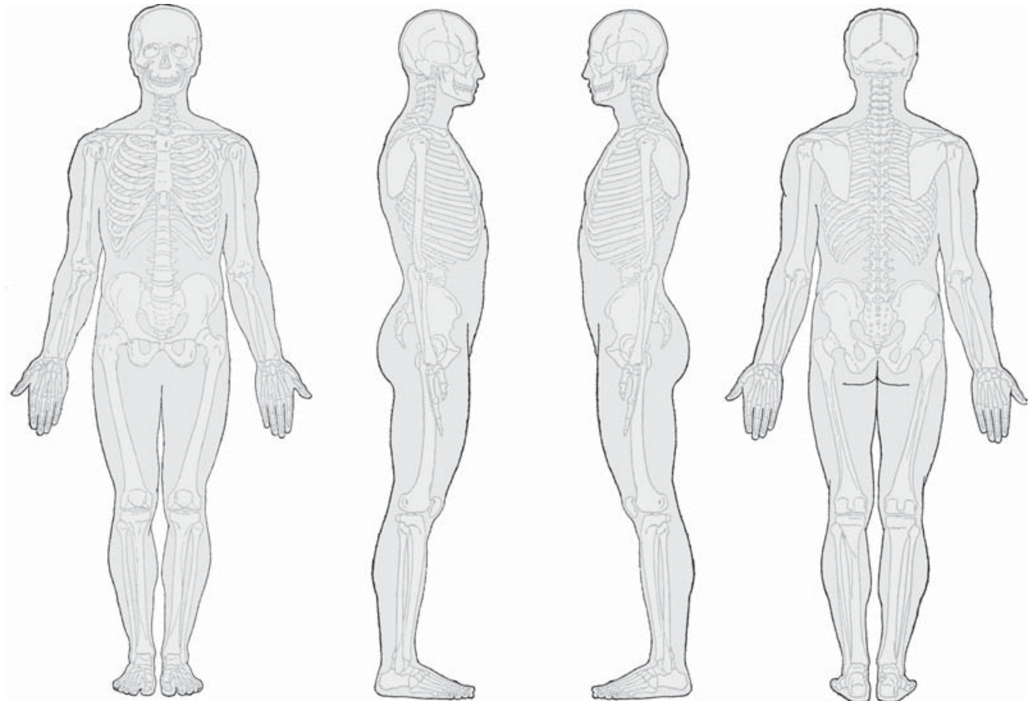
Does it bother you (check appropriate box): □ work, □ sleep, □ other: ______________________________

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:





Past health history

Have you...	Yes	No	If yes, explain breifly
... 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 matress? ____________

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? ______________________________

____

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2203 Jordan Avenue
Juneau, AK 99801

Valley Chiropractic
Alaska Chiropractic Rehab

Office: (907) 789-9549
Fax: (907) 798-3520
vccalaska@yahoo.com

HIPPA POLICIES AND PROCEDURES

PATIENT CONSENT

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

By initialing and signing this consent, I acknowledge and agree as follows:

______ • Valley Chiropractic Clinic's (VCC) Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information necessary for VCC to provide treatment to me, to obtain payment for that treatment, and to carry out day-to-day health care operations. VCC explained to me that the Privacy Notice would be available to me in the future at my request. VCC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

______ • VCC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

______ • I understand, and consent to, the following communications by VCC: postcards, folding postcards, letters, monthly patient newsletters, telephone reminders, or electronic reminders such as email or text, unless I choose not to receive these reminders/patient education.

______ • I understand, and consent, that VCC may use or disclose my protected health information, including my health or condition and the treatment provided to me, in order for VCC to treat me, obtain payment, and conduct day-to-day health care operations.

______ • I understand that I have a right to request that VCC restrict how my protected health information is used and/or disclosed to carry out treatment, payment and/or health care operations. However, VCC is not required to agree to any restrictions that I have requested. If VCC agrees to a requested restriction, then the restriction is binding on VCC.

______ • I understand that this Consent is valid for 7 years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any suck revocation shall not apply to the extent that VCC has already taken action in reliance on this Consent.

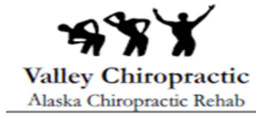
______ • I understand that I revoke this consent at any time, VCC has the right to refuse to treat me.

______ • I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then VCC will not treat me.

I HAVE READ AND UNDERSTAND THE FORGOING NOTICE, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY FULL SATISFACTION IN A WAY THAT I CAN UNDERSTAND.

______________________________	______________________________
PRINTED NAME OF PATIENT	PRINTED NAME OF LEGAL REPRESENTATIVE
______________________________	______________________________
PATIENT'S SIGNATURE	SIGNATURE OF LEGAL REPRESENTATIVE
______________________________	______________________________
DATE SIGNED	RELATIONSHIP TO PATIENT
______________________________	
WITNESS	

2203 Jordan Avenue
Juneau, AK 99801



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INFORMED CONSENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the relationship the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one of more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon facts then known to him or her, is in my best interest. I also understand that if during the course of care, a non-chiropractic or unusual finding is evident, I will be advised and it will be recommended that I seek the services of another health care provider with my chiropractor's referral.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

______________________________	______________________________	____________________
PRINT NAME	SIGNATURE	DATE

CONSENT TO EVALUATE AND TREAT A MINOR CHILD (AGE 17 & YOUNGER):

I, ______________________________ being the parent or legal guardian of ______________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE FOR X-RAY EVALUATION:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____________________________________

______________________________	______________________________	____________________
PRINT NAME	SIGNATURE	DATE

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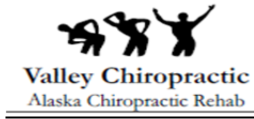

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PATIENT AUTHORIZATIONS

AUTHORIZATION TO RELEASE INFORMATION

I authorize Dr. Tom Gundelfinger, D.C. and whomever he may designate as his assistant(s) and/or staff, to release any information deemed appropriate concerning my physical condition and treatment to any insurance company, attorney, or adjuster in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered at Valley Chiropractic Clinic, and hereby release him/her of any consequence thereof. I agree that a photo static copy of this agreement shall serve as the original.

____
PRINTED NAME OF PATIENT

____
PRINTED NAME OF LEGAL REPRESENTATIVE

____
SIGNATURE OF PATIENT

____
SIGNATURE OF LEGAL GARDIAN

____
PATIENT SOCIAL SECURITY NUMBER

____
RELATIONSHIP TO PATIENT

____
DATE

____
WITNESS

AUTHORIZATION TO PAY DOCTOR/CLINIC

I hereby authorize and direct payment of any medical expense benefits allowable and/or claim for reimbursement for charges incurred by me as a result of professional services rendered by Dr. Tom Gundelfinger, D.C. and/or his staff at Valley Chiropractic Clinic. I understand that this payment will not exceed my indebtedness, nor personal responsibility for payment in full of services rendered by Dr. Tom Gundlefinger, D.C. and the staff of Valley Chiropractic Clinic for any portion therein which my insurance company many not cover entirely, apply to my annual deductible, or deny as not medically necessary. I agree that a photo static copy of this agreement shall serve as the original.

____
SIGNATURE

____
RELATIONSHIP

____
DATE

____
WITNESS