Keystone Chiropractic

330 S. Lawrence Blvd.

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:_____
Insurance: _____ (dd/mm/yr)
Date of birth:_____ ☐ male
Address:_____ ☐ female
_____ Marital status____
Phone #'s home:_____Cell:_____
E-mail address: _____
Occupation:_____ Employer:_____

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
- ☐ Tonsillitis
- ☐ Vision Problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulitis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24 hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow hear 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___ Length 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 mammogram:_____
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 medication you are currently taking and why:

_____
_____
_____
_____

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Give a brief detailed description of the problem you are currently experiencing, listing your 2 primary concerns:

_____

_____

_____

_____

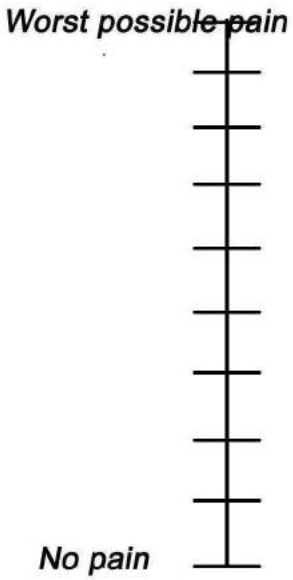
How long have you had this condition?_____ Is it getting worse? ☐ yes ☐ no

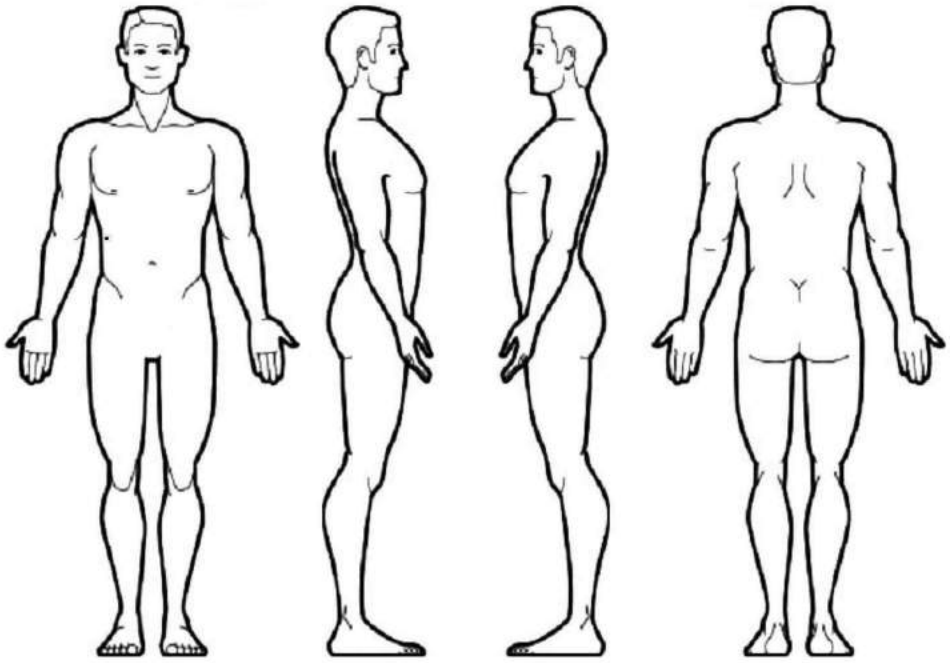
Does it bother you (check appropriate box) ☐ work ☐ sleep ☐ other _____

What seemed to be the initial cause? _____

Please mark your area(s) of pain on the figures 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 briefly
... been hospitalized in the last 5 years?	☐	☐	_____
... 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 mattress?_____

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? _____

_____

Keystone Chiropractic Dr. Jin Stephan Notice of privacy

This notice describes how chiropractic and medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

In the course of your care as a patient at Keystone Chiropractic Inc., we may use or disclose personal and health related information about you in the following:

Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you. Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to present care, or other health related information that may be of interest.

You have a right to request restrictions on our use of your protected health information for treatment, payment, operation purposes. Such requests are not automatic and require the agreement of this office. Your name address, telephone number, email address and health records may be used to contact you regarding appointment reminders. Information about alternatives to your present care of other health related information may be of interest to you. If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communication and to request restrictions related to such contacts. You also have the right to be contacted by alternative means or at alternative locations. We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances: If we provide health care services in an emergency, if we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so, if there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care, if we are ordered by courts or another appropriate agency. You have a right to receive an accounting of any such disclosures made by this office, any use or disclosure of your protected health information other than outlined above will only be made upon your written authorization. If you provide an authorization for release of information, you have a right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a specific form, please advise us in writing as to your preferences. You have the right to inspect and or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health-related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of your patient file and the protected health information they are in. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to the privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaints to Patricia Aldridge of Keystone Chiropractic. You also have the right to lodge a complaint with the secretary of health and human services. If you choose to lodge a complaint with this office or with the secretary, your care will continue and you will not be disadvantaged by this office or the staff in any manner. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have read this notice and fully understand it's details.

_____ _____

Signature Date

Keystone Chiropractic Dr. Jin Stephans

Patient Name: _____
To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign, if there is anything that is unclear.

The Nature of the Chiropractic Adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon you body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack"your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures. Patient should initial each procedure they are consenting to:

____ Spinal Manipulative Therapy
____ Range of Motion Testing
____ Muscle Strength Testing
____ Hot/cold Therapy
____ Vital Signs
____ Palpation
____ Orthopedic Testing
____ Postural Analysis
____ Basic Neurological Testing
____ EMS

The Material Risks inherent in Chiropractic Adjustment

As with any health care procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck lending to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness the first few days following treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition; that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of those risks occurring

Fractures are rare occurrences and generally result form some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceeding rare and are estimated to occur between one and five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of other treatment options

Other treatment options for your conditions may include: Self-administered over-the-counter analgesics and rest. Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers, hospitalizations and surgery. If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The Risks and Dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesion and reduce mobility, which may affect your pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. Please check the appropriate block and sign below.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Jinnifer Stephan, D.C. And have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risk, I hereby give my consent to that treatment.

Dated: _____ Dated: _____

_____ _____

Patient Name Doctor's Name

_____ _____

Signature Signature

_____

Signature of Parent or Guardian

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD:

I, _____being the parent or legal guardian of_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Keystone Chiropractic

7408 State Road 21

Keystone Heights Florida 32656

352-473-9777

CANCELLATION / MISSED APPOINTMENTS POLICY

I ACKNOWLEDGE THE FOLLOWING POLICY IN REFERENCE TO MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELLED PRIOR TO 24 HOURS OF THE APPOINTMENT TIME.

1. **ALL APPOINTMENTS MUST BE CANCELLED 24 HOURS PRIOR TO THE SCHEDULED APPOINTMENT SO WE CAN HAVE TIME TO FILL YOUR APPOINTMENT TIME.**

2. **ALL MISSED APPOINTMENTS WILL BE SUBJECT TO THE CANCELLATION FEE**

3. **THE FEE WILL BE PAID AT THE NEXT VISIT PRIOR TO SEEING THE DOCTOR.**

4. **IN THE EVENT THAT 2 MISSED APPOINTMENT FEES HAVE BEEN ACCESSED, THE BALANCE WILL BE REQUIRED TO BE PAID IN FULL BEFORE ANOTHER APPOINTMENT CAN BE MADE.**

MISSED OR CANCELLED APPOINTMENTS FEE $50.00

PATIENT'S NAME _____

SIGNATURE _____ Date: _____