Mitchell Chiropractic
2098 Teron Trace, Suite 300
Dacula, GA 30019

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:______________________ M.I.___ **Last Name:**______________________

Email address: _______________@_______________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** __________________

Current Address: ____________________________________ **City:** __________________________

State: _____ **Zip:** __________ **SS#:** _______________________ **Home #:** ______________________

Cell #: ____________________ **Employer:** ___________________ **Occupation:** _________________

Work #: ___________________ **Marital Status:** ____________ **Spouse's Name:** __________________

Spouse Phone #: __________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): ________________

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (__________)	Offspring: (__________)
Example: Low Back, Hip, Neck pain/ muscle pain				

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications?	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Medication	Reaction

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Present Health

My present symptoms are: ____

____

Purpose of this appointment: ____

When did the condition begin: ____

Job Related: _____ Auto Related: _____ Date of Accident: ____________________

List any recent major traumas: ____

List any recent surgeries: ____

List any medical conditions/ issues: ____

____

If applicable, are you pregnant: _____ Yes _____ No

Describe your current exercise regimen: ____

____

MITCHELL CHIROPRACTIC

PRIMARY INSURANCE INFORMATION

Primary Insurance Company:______________________ Phone:__________
Address:____________________ City:____________ State:____ Zip:________
Relationship of insured to the patient: ____ Self ___ Spouse ___ Child ___ Other
Name of insured person:________________ Insured date of birth:__________
Address:____________________ City:____________ State:____ Zip:________
Phone # of insured:____________ SS# of insured:______________
Insurance Group Name:__________ Group #:__________ Policy #:________

SECONDARY INSURANCE INFORMATION

Insurance Company:______________________ Phone:__________
Address:____________________ City:____________ State:___ Zip:________
Relationship of insured to the patient: ____ Self ___ Spouse ___ Child ___ Other
Name of insured person:________________ Insured date of birth:__________
Phone # of insured:____________ SS# of insured:______________
Insurance Group Name:__________ Group #:__________ Policy #:________

INSURANCE INFORMATION FOR AUTOMOBILE ACCIDENTS

Insurance Company: ______________________ Phone:__________
Address:____________________ City:____________ State:____ Zip:________
Name of Claim Adjuster:____________ Claim Number:______________
Is this a Med-pay or Liability Claim?:__________

Attorney:____________________ Attorney Phone:____________

ATTENTION: Auto Claims- I hereby authorize the staff at Mitchell Chiropractic to discuss with the attorney above any information pertaining to my auto case. **Initials:**____

I understand that insurance is being filed as a courtesy for me. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered and that any amount authorized to be paid directly to Mitchell Chiropractic will be credited to my account upon receipt. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Co-pays, coinsurance, or any amounts applied to your deductible are due at time of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

PATIENT SIGNATURE:______________________ DATE:__________

GUARDIAN SIGNATURE:______________________ DATE:__________

Mitchell Chiropractic

2098 Teron Trace, Suite 300
Dacula, Ga. 30019
Phone: (770)614-4060
Fax: (678)482-7788

Informed Consent to Medical or Chiropractic Treatment and Care

I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment or soreness after a massage. If that happens, I will apply ice to the area and rest it. If I am concerned about the discomfort or develop any new symptoms, I can call the number listed above during office hours for an emergency appointment. If any tests were performed outside the office (laboratory or other diagnostic procedures), I understand that if available, the doctor will notify me of the results at my next appointment.

I hereby request and consent to the performance of chiropractic adjustments and other treatment procedures, including various modes of physiological therapies and, if necessary diagnostic x-rays on by my doctor. I have had an opportunity to discuss with the doctor(s), and/or with other office of clinic personnel, the nature and purpose of chiropractic and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, included but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interest.

I have read the above consent to chiropractic and/or medical treatment as indicated by my signature. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this form to cover the entire course of treatment for my present and for any future conditions for which I seek treatment.

Patient's Signature: ______________________________ Date: ________________

Patient's Name: __________________________________ Date: ________________

Please Circle the appropriate letter next to each item based on the following:

Y= a condition you have now N= never had P= a condition you have had in past

Condition	
Neck Pain	Y P N
Back Pain	Y P N
Lower Back Pain	Y P N
Extremity Pain	Y P N
Chest Pain	Y P N
R/L Arm Pain/ Tingling	Y P N
R/L Leg Pain/Tingling	Y P N
R/L Foot Pain/Tingling	Y P N
R/L Hand Pain/Tingling	Y P N
Fingers/Toes Pain/Tingling	Y P N
Spasms	Y P N
Dizziness	Y P N
Vision Disturbance	Y P N
Motion Restriction	Y P N
Radiating Symptom	Y P N
Sleep Disruption	Y P N
Anxiety	Y P N
Night Sweats	Y P N
Headaches	Y P N
Head Injury	Y P N
Impaired Vision	Y P N
Corrected Vision	Y P N
Depression	Y P N
Tearing/Dryness	Y P N
Double Vision	Y P N
Pallectomy	Y P N
Cataracts	Y P N
Impaired Hearing	Y P N
Ear Ringing	Y P N
Earaches	Y P N
Frequent Colds	Y P N
Sinusitis	Y P N
Postnasal Drip	Y P N
Change in Taste	Y P N
Goiter	Y P N
Cough	Y P N
Sputum	Y P N
Spit up Blood	Y P N
Asthma	Y P N
Bronchitis	Y P N
Pneumonia	Y P N
Emphysema	Y P N
Difficulty Breathing	Y P N
Shortness of Breath	Y P N
Heart Disease	Y P N
Angina	Y P N
High Blood Pressure	Y P N
Fasciotomy	Y P N
Edema	Y P N
Arthroplasty (prosthetic replacement)	Y P N
Nausea	Y P N
Vomiting	Y P N
Constipation	Y P N
Blood in Stool	Y P N
Gas/Bloating	Y P N
Liver Disease	Y P N
Hemorrhoids	Y P N
Abdominal Pain	Y P N
Peptic Ulcer	Y P N
Gall Bladder Disease	Y P N
Pain on Urination	Y P N
Urinary Frequency	Y P N
Ligament or Tendon repair, not arthroscopy, Arthrotomy	Y P N
Kidney Stones	Y P N
Blood in Urine	Y P N
Joint Pain/Stiffness	Y P N
Arthritis	Y P N
Broken Bones	Y P N
Muscle Spasms	Y P N
Deep Leg Pain	Y P N
Thrombophlebitis	Y P N
Aspiration of Hematoma	Y P N
Fainting	Y P N
Seizures	Y P N
Paralysis	Y P N
Muscle Weakness	Y P N
Numbness/Tingling	Y P N
Coordination Difficulties	Y P N
Depression	Y P N
Anxiety	Y P N

Mood Swings Y P N
Memory Loss Y P N
Drug/Alcohol Abuse Y P N
Difficulty Sleeping Y P N
Phobia Y P N
Thyroid Problem Y P N
Extremity Pain – Numbness Y P N
Arthrotomy, Meniscectomy, cruciate Y P N
Excessive Thirst Y P N
Excessive Hunger Y P N
Anemia Y P N
Easy Bleeding Y P N

Females Only

Age menses began ______
Age menses ended ______
Average cycle length ______
Average bleeding length ______
Spotting Y P N
Irregular Cycles Y P N
Painful Menses Y P N
Birth Control Y P N
Sexual Difficulties Y P N
STD Y P N
Breast Lumps Y P N
Breast Pain Y P N
Nipple Discharge Y P N
PMS Symptoms Y P N
Menopausal Symptoms Y P N
Vaginal Dryness Y P N
Vaginal Discharge/Sores Y P N
Number of pregnancies ______
Number of live births ______
Number of miscarriages ______

Males Only

Hernias Y P N
Testicular Masses Y P N
Testicular Pain Y P N
Sexual Difficulties Y P N
STD Y P N
Penile Discharge/Sores Y P N
Prostate Disease Y P N

Are there any additional health concerns or questions you have?

____
____
____
____
____
____
____

Please describe a poor experience with a health practitioner you have had in the past.

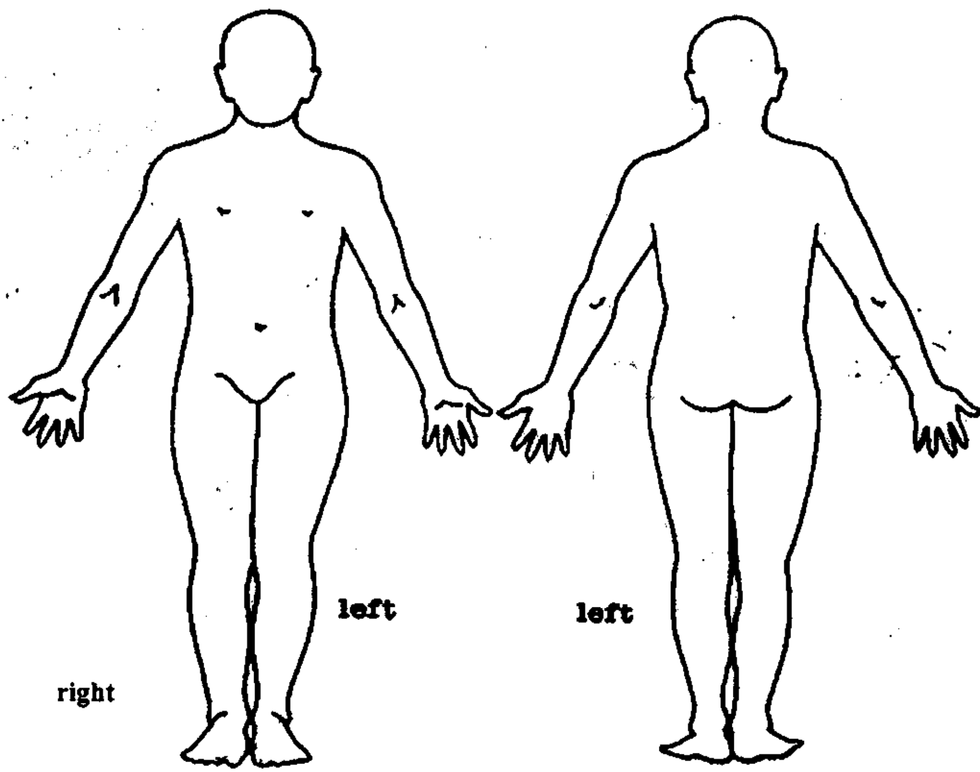
____
____
____
____
____

Please describe a good experience with a health practitioner you have had in the past.

____
____
____
____

Use the pictures below to indicate your problem areas. Use the appropriate symbol to indicate numbness, pins & needles, burning, stiffness, aching, or stabbing pain.

Numbness: □ Stabbing pain: ↑ Pins & Needles .-.
Aching pain: + Burning: # Stiffness: u



Please rate your discomfort on a scale of 1-10.
(1= mild pain, 10=the worse pain you've ever felt).

	Location	Pain rating	Duration
1			
2			
3			
4			
5			
6			
7			
8			