Albuquerque Alternative Health New Patient Intake Paperwork

1 Patient Information

Patient File #:

Legal Name: (Last) _____ (First) _____ (Middle Initial) _____

Email: _____ Primary Phone: _____ ☐ Home ☐ Cell ☐ Work

Phone Carrier (text alerts): _____ ☐ Opt-out of text alerts

Address: _____ City: _____

State: _____ Zip: _____ Sex: ☐ M ☐ F Age: _____ Birth Date: _____

Social Security # or DL# _____ ☐ Married ☐ Single ☐ Partnered ☐ Widowed ☐ Divorced

☐ Children How many: _____

Occupation: _____ Pt. Employer/School: _____ Phone: _____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

Have you seen a Chiropractor before? ☐ Yes ☐ No If yes, how many times (Approx.)? _____

2 Payment/ Insurance Information

If you have commercial health insurance, Albuquerque Alternative Health will verify your health insurance to see if there is any coverage for chiropractic care. ** Please note, we cannot guarantee coverage. **

Did you purchase a Groupon? ☐ Yes ☐ No

If yes, was it for 1 adjustment or 2 adjustments?

☐ 1 Adjustment ☐ 2 Adjustments

What is the # under the Groupon barcode (8 digits)?

_____

Other? ☐ Yes ☐ No

If so, please specify below:

_____

Did you receive a flyer? ☐ Yes ☐ No

Did you receive a Gift Certificate? ☐ Yes ☐ No

If so, who was the G.C. from? _____

What type of insurance do you have? (Check one) ☐ Commercial ☐ State Insurance *(we do not accept)* ☐ Medicare

Health Insurance Name: _____ ID# _____ Group # _____

Assignment and Release

On behalf of yourself and any patient for whom you are the parent or legal guardian, you 1) certify that the information on this form is accurate and up-to-date, 2) consent treatment by Albuquerque Alternative Health, 3) agree to be primarily responsible for all charges owed to Albuquerque Alternative Health (other than those included in any pre-paid offer), including attorney fees, court costs and other expenses of collections, 5) consent to Albuquerque Alternative Health releasing any "protected health information," as defined by federal HIPPA regulations, for the purposes allowed by law, and 6) acknowledge receipt of Albuquerque Alternative Health's Notice of Privacy Practices.

_____ _____

Printed name of Patient, Parent, Guardian of Personal Representative — Signature of Patient, Parent, Guardian of Personal Representative

Relationship: _____ Date: _____

Office Use Only:

Groupon ☐ Yes ☐ No Flyer: ☐ Yes ☐ No G.C.: ☐ Yes ☐ No

Groupon Verified: ☐ Yes ☐ No Flyer: Paid? ☐ Yes ☐ No G.C.: Canned Goods? ☐ Yes ☐ No

Other: _____ Verified: ☐ Yes ☐ No

Insurance Verification:

In network:				Out of Network:			
Benefits?	☐ Yes ☐ No	Coverage: _____		Benefits?	☐ Yes ☐ No	Coverage: _____	
Visit Limit:	☐ Yes ☐ No	If yes, how many? _____		Visit Limit?	☐ Yes ☐ No	If yes, how many? _____	
$ Limit:	☐ Yes ☐ No	If yes, how many? _____		$ Limit?	☐ Yes ☐ No	If yes, how many? _____	
Deductible:	☐ Yes ☐ No	$ _____ Met: _____		Deductible:	☐ Yes ☐ No	$ _____ Met: _____	
Out of pocket: $_____		Amount met: _____		Out of pocket: $_____		Amount met: _____	

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3 Medications

1) _____
2) _____
3) _____
4) _____

☐ None

Vitamins/ Supplements

1) _____
2) _____
3) _____
4) _____

☐ Daily ☐ Weekly ☐ Occasionally

☐ None

Allergies

1) _____
2) _____
3) _____
4) _____

How often do they occur?

☐ None

4 Family History

Autoimmune Dis.	☐ Yes ☐ No	Bleeding Disorder	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Migraines	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Clotting Disorder	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No	Cancer	☐ Yes ☐ No

Other: _____

5 Medical History

Name and phone number of other doctor(s):

_____

Date of Last: Physical Exam _____ Spinal X-ray _____ Spinal Exam _____ Chest X-ray _____

MRI, CT-Scan, Bone Scan _____ Blood Test _____ Urine Test _____

Mark "Yes" or "No" to indicate whether you have experienced each of the following and complete the information below:

AIDS/HIV	☐ Yes ☐ No	Chemical Depend./		Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No
Anxiety/Depress.	☐ Yes ☐ No	Clotting Disorder	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Eating Disorder	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	STD	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Autoimmune Dis.	☐ Yes ☐ No	Epilepsy/Seizure Dis.	☐ Yes ☐ No	MS	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? _____ ☐ Other: _____

5 Physical & Trauma Information

Please indicate any physical and/or trauma occurrences below, making sure to note any minor injuries as well by checking 'Yes'. Please describe when applicable.

Work Activities: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Retired _____

Work Injuries: ☐ Yes ☐ No If yes: _____

Sports Activities: _____

Sports Injuries: ☐ Yes ☐ No If yes: _____

Exercise: ☐ None ☐ Light ☐ Moderate ☐ Heavy _____

Habits: ☐ Nicotine ☐ Alcohol ☐ Coffee/Caffeine Drinks ☐ High Stress Level ☐ None

How much? _____ How often? ☐ Daily ☐ Weekly ☐ Occasionally

Falls: ☐ Yes ☐ No If yes: _____

Head Injuries: ☐ Yes ☐ No If yes: _____

Dislocations: ☐ Yes ☐ No If yes: _____

Broken Bones: ☐ Yes ☐ No If yes: _____

Surgeries: ☐ Yes ☐ No If yes: _____

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6 Primary Complaint

Please note ONE complaint in the following section. The Primary Complaint is your chief complaint or most problematic concern at this time that brought you in today.

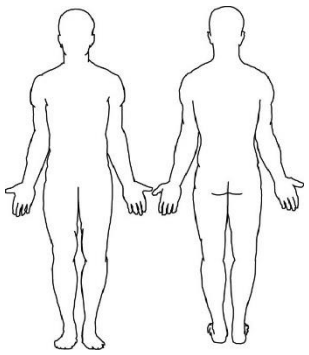
Primary complaint: _____

Please describe the condition: _____

When did your symptoms first appear? _____

What do you think caused this problem? _____

Mark an X on the picture where you have pain, numbness or tingling:



Rate the severity of your pain …at its worst: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

…at its least severe: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

(please circle) …at present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: _____

Does the pain travel from one location to another? From where to where? _____

How often do you have this pain? ☐ Constantly ☐ Comes and goes ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Sitting ☐ Standing

☐ Walking ☐ Bending ☐ Lying Down ☐ Other: _____

Past treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiro Services ☐ None ☐ Other: _____

Were they successful? ☐ Yes ☐ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

7 Additional Complaint

Please note ONE complaint in the following section. The Primary Complaint is your chief complaint or most problematic concern at this time that brought you in today.

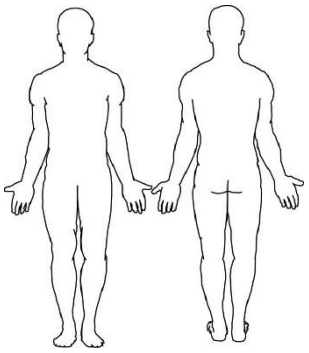
Primary complaint: _____

Please describe the condition: _____

When did your symptoms first appear? _____

What do you think caused this problem? _____

Mark an X on the picture where you have pain, numbness or tingling:



Rate the severity of your pain …at its worst: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

…at its least severe: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

(please circle) …at present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: _____

Does the pain travel from one location to another? From where to where? _____

How often do you have this pain? ☐ Constantly ☐ Comes and goes ☐ Infrequently ☐ Daily ☐ Weekly ☐ Monthly

Do activities make it worse in the AM or PM? ☐ AM ☐ PM ☐ N/A

Which activities are affected by this? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Sitting ☐ Standing

☐ Walking ☐ Bending ☐ Lying Down ☐ Other: _____

Past treatments: ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiro Services ☐ None ☐ Other: _____

Were they successful? ☐ Yes ☐ No

Pain worsens with: _____ Pain improves with: _____

Notes: _____

8 Is there anything else you would like Dr. Downs to know?

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