



Confidential Patient Intake Information

Today's Date _____

These forms are legal documents and are necessary to bill insurance and are part of your medical chart. They must be completed in detail so please take your time and ask for assistance if you need help.

First and Last Name: _____

Date of Birth: _____

Address: _____

Apt/Ste/Unit # _____ City: _____

Zip Code: _____

Cell Phone: _____

Email: _____

Sex: ☐ M ☐ F / Marital Status: ☐ S ☐ M ☐ W ☐ D / Number of Children _____

Occupation: _____

Spouse's Name: _____

1. Is this condition the result of an injury that happened at work? Y____ N____

2. Is your condition the result of auto accident? Y____ N____

3. Who referred you to our office? _____

I understand and agree that health insurance policies are an arrangement between my insurance carrier and myself. I understand that **Greenberg Swaffer Chiropractic Corporation DBA Hand Crafted Chiropractic** will prepare my billings to assist me in making collections from the insurance company. I clearly understand and agree that I am responsible for the payment of all services rendered to me if my insurance company, for whatever reason, does not pay for treatments rendered to me. I also understand that if I terminate my care, any professional fees for services will become due and payable and charged your payment method on file.

Patient's / Guardian Signature

Today's Date

PRESENT COMPLAINT(S)

1. What is the main complaint? When did it begin, and what do you believe caused it?

2. Please describe the quality of your pain (check all that apply): ☐ Sharp/Stabbing ☐ Sharp ☐ Dull ☐ Achy
☐ Sore ☐ Weakness ☐ Throbbing ☐ Numbness ☐ Shooting ☐ Gripping/ Constricting ☐ Burning ☐ Tingling

3. How often are the complaints present? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%)
☐ Intermittent (25% or less)

4. Please indicate the severity of your pain? (0 being no pain and 10 being the worst pain you've ever felt)

0 1 2 3 4 5 6 7 8 9 10

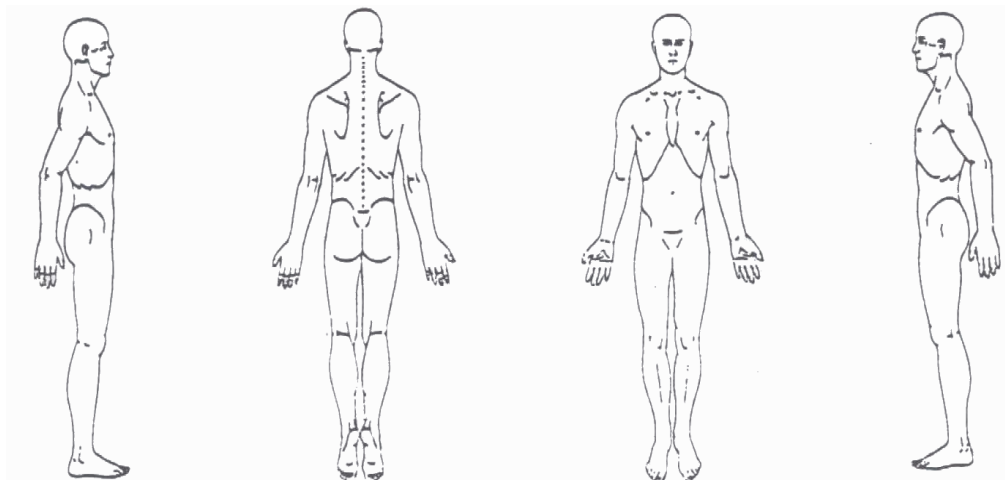
5. Since your problem began the pain is: ☐ Increasing ☐ Decreasing ☐ Not Changing

6. What treatments have you received for this present condition? ☐ Previous Chiropractor ☐ Surgery ☐ Spinal Injections ☐ Physical Therapy ☐ Back Support ☐ If none check here ☐ Other (please specify below)

7. What activities or positions help relieve your pain? ☐ Ice ☐ Heat ☐ Laying Down ☐ Walking ☐ Sitting ☐ Standing ☐ Movement/Exercise ☐ Inactivity ☐ Nothing Helps ☐ Other (please specify below)

8. What activities or positions increase your pain? ☐ Laying Down ☐ Walking ☐ Sitting ☐ Standing ☐ Movement/Exercise ☐ Inactivity ☐ Nothing helps ☐ Other (please specify below)

9. Mark an X below where you have pain or other symptoms, include radiation (movement) of pain, numbness, or tingling with an arrow



Past and Present Medical History

If you have ever had a listed symptom in the past; please check that symptom in the *Past* column. If you are presently troubled by a particular symptom, check that symptom in the *Present* column.

Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Joints (Specify Joints) _____
<input type="checkbox"/>	<input type="checkbox"/>	Stiffness of Joints (Specify Joints) _____
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Coordination Abnormalities
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ringing in Ears)
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Rate
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis

Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal Symptoms
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bowel Control
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Rash
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis or Eczema
<input type="checkbox"/>	<input type="checkbox"/>	HIV
Please check all of the following that apply to you		
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use
<input type="checkbox"/>	<input type="checkbox"/>	Medications (please list) _____
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Surgical Procedures (please list) _____

Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Illness
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia/Bulimia

Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema: Chronic lung disorders
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Patient's Signature: _____

Date: _____

Informed Consent for Chiropractic Care

Please read the entire document prior to signing it. It is important that you understand the information contained herein. Please ask questions before you sign if there's anything that is unclear.

The Nature of The Chiropractic Adjustment

The primary treatment we use as Doctor of Chiropractic is spinal manipulative therapy. We may use our hands or a mechanical instrument in such a way as to move your joint. This may cause an audible sound and you may also feel a sense of movement.

Analysis / Examination / Treatment

I authorize the doctors of Greenberg Swaffer Chiropractic Corporation DBA Hand Crafted Chiropractic to administer such care that is necessary for my case. This care may include consultation, examination, adjustments, and/or any other procedure that is advisable and necessary for my healthcare. I further understand that a fee for service rendered will be charged and that I am responsible for the fee regardless of the results.

Material Risks Inherent with Chiropractic Adjustments

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include but are not limited to headaches, muscle strains, disc injuries, stroke, dislocation, fractures, myelopathy, and separations. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctors at Greenberg Swaffer Chiropractic Corporation DBA Hand Crafted Chiropractic 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 the doctor's attention, it is your responsibility to inform the doctor. The risk of injuries or complications from Chiropractic treatments are substantially lower than that associated with many medical or other treatments, medication, and surgical procedures given for the same treatment.

The Availability and Nature of Other Treatment Options

Alternatives to chiropractic treatments include medication's, physical therapy, other medical treatments, and surgery provided by physicians and surgeons. If you have any questions regarding other treatment options, the doctor will be happy to discuss them with you.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I, _____ (Patient/Guardian Name) have read the above explanation of the chiropractic adjustment and related treatment. I understand the potential risks and hereby give my consent to chiropractic treatment.

Signature _____

Date _____

Consent to Treat a Minor

I, _____ am the parent or legal guardian of _____ (Child). I have read and understand the above explanation of treatment, I understand the potential risks, and I hereby grant permission for my child/children to receive chiropractic care

Signature of Parent/Guardian _____

Date _____

Notice of Privacy Practices & HIPPA

This notice of privacy practices and authorizes Hand Crafted Chiropractic / Greenberg Swaffer Chiropractic Corporation to use and/or disclose protected healthcare information in accordance with the following specific authorizations:

I give permission to Hand Crafted Chiropractic Corporation / Greenberg Swaffer Chiropractic Corporation to use my name, address, phone numbers, and clinical records to contact me with health-related emails and information about treatment alternatives or other health related information.

We understand that medical information about your health is personal, and we are committed to protecting this information. When you receive Chiropractic treatment from Hand Crafted Chiropractic / Greenberg Swaffer Chiropractic Corporation, a record of the treatment you receive typically contains treatment plan, your history and physical exam, any x-ray/test results you provide us, and billing record. This record serves as the basis for planning your treatment and a tool for assessing ways to improve the care rendered.

We are required by law to:

1. Maintain privacy and security of your medical information.
2. Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you.
3. Abide by the of terms of this notice.

We may use and disclose medical information about you for purposes related to treatment, payment, health care operations, contacting you, appointment reminders, as required by law, health oversight activities, lawsuits and disputes, law-enforcement with court order/subpoena, and electronic disclosure.

Your rights regarding your medical information:

1. Right to inspect and copy.
2. Right to amend.
3. Right to an accounting of disclosures.
4. Right to request restrictions.
5. Right to revoke an authorization.
6. Right to receive a copy of this document.

We reserve the right to change our practices and to make new provisions effective for all medical information we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may contact us if you wish to request a copy of Greenberg Swaffer Chiropractic Corporation Notice of Privacy Practices.

I understand and have been provided with a notice of information practices that provide me a more complete description of information uses and disclosures. I understand my rights and privileges. By signing the following I am giving Greenberg Swaffer Chiropractic Corporation DBA Hand Crafted Chiropractic permission to use and disclose my protected health information in accordance with the directives listed above.

Signature of Patient / Legal Guardian: _____ **Date** _____

Terms and Conditions

Please initial the following:

1. **Personal Information Updates:**

_____ Patient agrees to timely notify Hand Crafted Chiropractic of any changes in the patient's personal information, including mailing address, insurance policy, telephone number, and credit/debit card information. We reserve the right to suspend services while such information is pending from the patient.

2. **Personal Belongings:**

_____ I understand that Hand Crafted Chiropractic is not responsible for lost or stolen articles or goods.

3. **Payment Policy:**

_____ A valid credit or debit card will be kept on file. Payment is required at the time services are rendered.

4. **Appointment Cancellations:**

_____ I agree to notify Hand Crafted Chiropractic at least 24 hours in advance if I need to cancel a scheduled appointment. I understand that failure to provide timely notice may result in a fee of \$50.00 for missed or canceled 30-minute follow-up appointments, shockwave therapy, or decompression therapy sessions, and \$75.00 for missed or canceled 60-minute appointments. These fees will be charged to my account.

5. **Dispute Resolution:**

_____ In the event of any dispute, controversy, or claim arising out of or relating to these Terms and Conditions, the agreement, your treatment, or the services received at Hand Crafted Chiropractic / Greenberg Swaffer Chiropractic Corporation, you, as the patient, understand and agree that both parties will first attempt, promptly and in good faith, to resolve the dispute through mediation. Failure by you, the patient, to deliver a formal mediation notice prior to initiating a legal claim or lawsuit will serve as prima facie evidence for Greenberg Swaffer Chiropractic Corporation DBA Hand Crafted Chiropractic to seek a motion to dismiss the lawsuit. If the parties are unable to resolve the dispute through mediation within a reasonable time (not to exceed 60 days), the dispute shall be resolved exclusively through binding arbitration before the American Arbitration Association, under its then-current consumer arbitration rules, unless otherwise mutually agreed by the parties. Any arbitration between you and Greenberg Swaffer Chiropractic Corporation DBA Hand Crafted Chiropractic will take place in Huntington Beach, California, and will be conducted on an individual basis. By agreeing to arbitration, you understand and agree that you are waiving certain legal rights, including the right to sue in court, the right to have the dispute decided by a judge or jury, and the right to participate in a class action lawsuit. In the event of any arbitration and/or legal action, all arbitration and legal fees of any type (attorney's fees, court costs, etc.) shall be paid by the filing party.

6. **Explanation of Insurance Coverage:**

_____ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will submit claims to your insurance provider for services rendered in this office. However, payment of any deductibles (if not yet met), copayments, and any remaining balance after insurance payment is your responsibility. Your copay is due at the time of service. Additionally, you are responsible for any portion of your bill that exceeds the coverage limits of your insurance policy.

7. **Assignment of Benefits:**

_____ By signing this form, you authorize that all medical benefits payable under your insurance policy for services rendered by this office will be made directly to Greenberg Swaffer Chiropractic Corporation. If your insurance carrier sends any payments directly to you for services provided by this office, you agree to forward those payments to our office immediately upon receipt. All payments issued to you by your insurance carrier must be forwarded to Hand Crafted Chiropractic and endorsed on the back with the statement, "Pay to the order of Greenberg Swaffer Chiropractic Corporation." Alternatively, you may submit a personal check for the exact amount of the insurance payment. If doing so, please include a copy of the Explanation of Benefits (EOB) to ensure proper application of your payment to the relevant date of service. This payment, along with all corresponding EOBs, is due within fifteen (15) days of receipt. If payment is not received from your insurance carrier within 15 days, the outstanding balance will be automatically charged to the payment method we have on file for you.

Signature of Patient or Legal Guardian: _____ **Date:** _____