Holland Chiropractic New Patient Intake – SoftWave Therapy

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ DOB: _____-_____-_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Cell: _____ Work: _____

Appointment reminder: ☐E-mail ☐Text Message ☐None Whom shall we thank for referring you? _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐ Male ☐ Female ☐ I prefer not to answer

Employer: _____ Occupation: _____

Spouse/Partner Name: _____ Spouse/Partner Employer: _____

Number of children and ages: _____

Emergency Contact Name: _____Relationship: _____ Phone: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: _____

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ Constant **OR** ☐ On and off during the day **OR** ☐ It comes and goes throughout the week

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ By whom? _____

How long were you under care: _____ What were the results? _____

What relieves your symptoms? _____ What makes your symptoms feel worse? _____

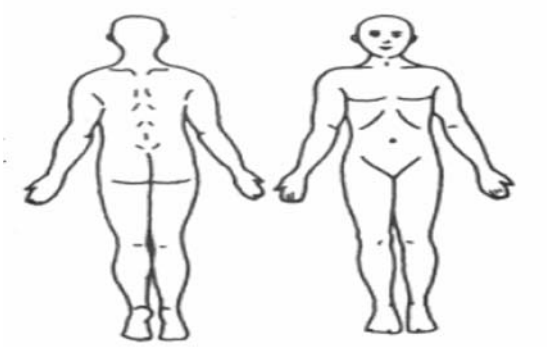
Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull

A = Aching **N = N**umbness

S = Sharp/**S**tabbing **T = T**ingling



PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
DISEASES →			

SOCIAL HISTORY

1. Smoking: ☐Cigars ☐ Pipe ☐ Cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

MEDICATIONS

Medication Name (Brand name or generic)	Dosage (i.e. 5 mg)	Frequency (i.e. once per day)

Do you have any allergies to medications? ☐ No ☐ Yes If yes, please list the medication(s) and reactions:

_____

_____

_____

_____

Patient Signature: _____ **Today's Date:** ___/___/___

ACTIVITIES OF DAILY LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing/Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Please mark **P** for in the **Past, C** for **Currently** have, or **N** for **Never**

___ Headache	___ Pregnant	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disabilty	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

PLEASE READ CAREFULLY

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

***Example*:**

Headache Neck Low Back

No pain _____ **worst possible pain**

0 (1) 2 3 (4) 5 6 7 (8) 9 10

1) What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2) What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3) What is your pain level AT ITS BEST? (How close to "0" does your pain get at its best?)

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4) What is your pain level AT ITS WORST? (How close to "10" does your pain get at its worst?)

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

_____

Extracorporeal Shockwave Therapy – Patient Consent Form

Suitability for ESWT (Extracorporeal Shockwave Therapy)

By answering the following questions, you will assist us in deciding if you are suitable for ESWT.

- Do you have a bleeding disorder/tendency? Yes / No
- Are you on NSAIDS or anti-coagulant treatment? Yes / No
- Have you been injected with cortisone this month? Yes / No
- Are you using a cardiac pacemaker? Yes / No
- Do you have cancer/a tumor? Yes / No
- Do you have a tear in the tendon? Yes / No
- Do you have any skin infection(s)? Yes / No
- Are you pregnant? Yes / No

RISKS OF PROCEDURE:

Pain and soreness are common. This is temporary and resolves after a week. The FDA has labeled this a "Non-Significant Risk" therapy.

CONSENT FOR PROCEDURE:

I, _____, the undersigned, do hereby consent to the application of Extracorporeal Shockwave Therapy (ESWT) for my condition of _____.

I have been fully informed of focal ESWT which use has been fully explained to me by my treating physician/staff, and I fully understand the nature of this treatment. I also confirm that I have been given the opportunity to discuss and clarify any concerns and that no guarantees have been made to me as to the result/outcome of the treatment.

I have been advised that the treatment with ESWT will be mostly for pain relief and may offer an improvement of function. I also understand foregoing treatment is not the first option for my condition and an alternate treatment has either already been provided or offered to me.

Patient Name (printed): _____ DOB:_____
Patient Signature: _____ Date:_____

Staff Witness Name (printed): _____
Staff Witness Signature: _____ Date: _____

Holland Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Rok Morin at 207-443-2635 if he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Holland Chiropractic *NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…*

I have received a copy of Holland Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me, and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name DOB

_____ _____

Patient's Signature Date

_____ _____

Witness (office only) Date

Holland Chiropractic

Medical Information Release Form (HIPAA Release Form)

Name: _____ **Date of Birth:** _____

Release of Information:
[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages:
Please call [ ] my home [ ] my work [ ] my mobile number: _____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____

Witness (office use only): _____ Date: _____

SoftWave Therapy Cancellation/No Show Policies and Fees

A **24-hour** notice is required to cancel or reschedule all appointments for SoftWave Therapy. It is also important to arrive to your scheduled appointment on time.

By signing below, you agree and understand that:

- If I do not arrive on time, the appointment may need to be rescheduled to a future date and/or time.
- If a 24-hour notice is not given, or I fail to show up to my appointment and do not call, I will be responsible for the missed/cancelled appointment fee of $75.00.

This fee will be applied to my account and payment for the missed/cancelled appointment will be charged to the card on file.

PLEASE NOTE: text reminders are a courtesy and not a guarantee. It is highly advised that you enter your appointments on a calendar or in your phone as a back-up. HCWC is not responsible for the delivery of text message.

Patient Name (printed): _____

Signature: _____ Date: _____

Witness (office use only): _____ Date: _____

Holland Chiropractic
A Maine Vitality Center
36 School St. Bath, ME 04530 • 207.443.2635
myhcwc.com

Cash Practice® EZ-Pay Authorization – SoftWave Therapy

I, _____, hereby authorize **Holland Chiropractic** to initiate debit/credit card charges and/or corrections to previous debits/charges to my account with the financial institution identified by me on this form for payment of services/products rendered to me in the amount of the **balance due**.

- I understand that SoftWave Therapy is not a covered service under any insurance company and that these services, including consults and treatments, are not being billed to my insurance company.
- I understand that payment is **due at the time of service** and my debit/credit card will be charged after each visit.
- I understand that having this form of payment on file is REQUIRED by policy.
- The authorization is to remain in effect indefinitely and may be withdrawn by me at any time by written request.

CREDIT CARD: _____ _____ _____ _____ Visa® MasterCard® Discover® American Express®

Expiration: _____/_____ **CVV/Security Code:** _____

Card Holder Name (exact): _____

Card Holder Signature: _____ **Date:** _____