

**EXISTING PATIENT INTAKE FORM**

(For patients treated within the past 3 years)

Exam Date: \_\_\_\_\_

Legal Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Preferred or nickname: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Gender:  M  F Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status  S  M  W  D  O

Spouse's Name: \_\_\_\_\_ Spouse DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Local Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Work( ) \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_ Your Occupation: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Care Physician's Name (PCP): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Does your insurance require a referral?  No  Yes

If Yes, was today's visit pre-approved by your Physician?  Yes  No

Who is the primary party responsible for the payment of your bill?

- Self-Pay/Cash  Major Medical Health Ins.  MaineCare  Medicare Part B  
 Medicare Advantage Plan  Employer/Workers Compensation  Automobile/Accident Policy  
 Personal Liability Ins.  Other: \_\_\_\_\_

**Check  if today's problem was caused by:**

**Auto Accident/Personal Injury?**  Auto Accident  Pedestrian Accident  Personal Injury

a. Date and time of the injury: Date: \_\_\_\_\_ Time: \_\_\_\_\_  A.M.  P.M.

b. Where did the injury occur? \_\_\_\_\_

c. Insurance Company: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

Claims Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

Claim Number: \_\_\_\_\_ Adjuster: \_\_\_\_\_

d. Do you have an attorney?  No  Yes, Attorney's Name: \_\_\_\_\_

e. Attorney's address and contact number: \_\_\_\_\_

**Workman's Compensation Injury?**  No

f. Was a claim/incident/injury report filed with your employer?  No  Yes, date filed; \_\_\_\_\_

g. Who was your injury reported to: \_\_\_\_\_ Position: \_\_\_\_\_

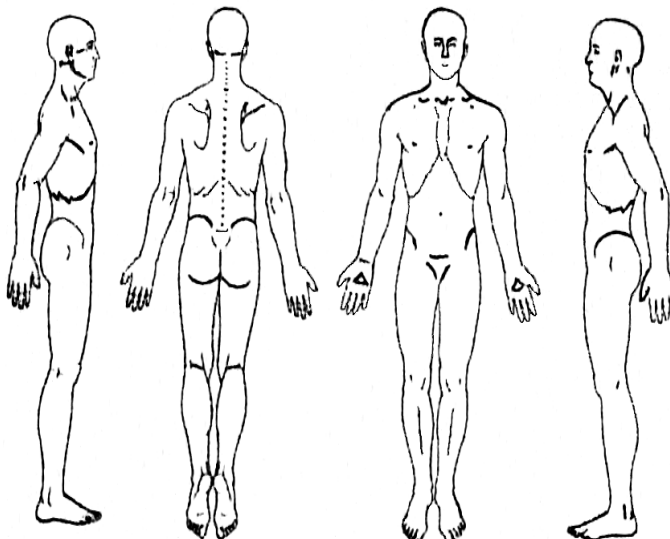
h. Date and time of the injury: Date: \_\_\_\_\_ Time: \_\_\_\_\_  A.M.  P.M.

i. Where did the injury occur? \_\_\_\_\_

Exam Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age \_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F

*\* Pain = basic bodily sensation characterized by physical discomfort (throbbing, aching) often leads to evasive action or behavior*

| SYMPTOM LOCATION   | Doctor's Notes:  |
|--|--|
|         | _____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ |
| Mark on the figure above using a circle or an <b>X</b> mark the location of each symptom |  |

| <b>SYMPTOM INTENSITY SCALE</b> | <b>NONE</b><br>Normal Activities<br>No Restriction | <b>MILD</b><br>1 - 2 - 3<br>Annoying, some discomfort able to do normal activities | <b>MODERATE</b><br>4 - 5 - 6<br>Hurting, very sore, limited motion, slows your normal activities | <b>SEVERE</b><br>7 - 8 - 9<br>Sharp, stabbing, can't do some of your normal activities | <b>WORST</b><br>10/10<br>Unbearable, unable to do any normal activities |
|--------------------------------|--|--|--|--|---|
|--------------------------------|--|--|--|--|---|

**DESCRIBE EACH SYMPTOM (1 SYMPTOM PER LINE) AND USING THE SCALE ABOVE RATE THE INTENSITY OF EACH SYMPTOM AND THE AVERAGE % OF THE DAY THAT YOU ARE AWARE OF EACH SYMPTOM.**

|  |     |     |     |     |     |     |     |     |     |      |
|--|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|
| <b>1<sup>st</sup> Symptom Description:</b> |     |     |     |     |     |     |     |     |     |      |
| <b>Symptom Intensity</b>                   | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10   |
| <b>Frequency</b>                           | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
| <b>2<sup>nd</sup> Symptom Description:</b> |     |     |     |     |     |     |     |     |     |      |
| <b>Symptom Intensity</b>                   | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10   |
| <b>Frequency</b>                           | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
| <b>3<sup>rd</sup> Symptom Description:</b> |     |     |     |     |     |     |     |     |     |      |
| <b>Symptom Intensity</b>                   | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10   |
| <b>Frequency</b>                           | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
| <b>4<sup>th</sup> Symptom Description:</b> |     |     |     |     |     |     |     |     |     |      |
| <b>Symptom Intensity</b>                   | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10   |
| <b>Frequency</b>                           | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |

**VITAL SIGNS:**

Height: \_\_\_\_\_' \_\_\_\_\_"      Weight: \_\_\_\_\_ lbs.      Dominant Hand:  Left  Right  
 Left BP: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      Left Pulse: \_\_\_\_\_/Min      Respiration: \_\_\_\_\_/Min  
 Right BP: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      Right Pulse: \_\_\_\_\_/Min      Temperature: \_\_\_\_\_° (ear)      Staff Initials: \_\_\_\_\_

**PATIENT CONDITION HISTORY UPDATE**

1. **When did your symptoms begin (most recent episode)?** \_\_\_\_\_  
Caused by:  A new injury  Lifting  Prolonged Sitting  Driving/Travel  Fall  Illness  Exercise  
 \_\_\_\_\_
2. **Have you had similar symptoms in the in the past?**  No  Yes,  1-2  3-4  5+ Times before
3. **How are your symptoms changing with time?**  Getting Worse  Staying the Same  Getting Better
4. **Who have you seen for your problem(s)?**  No other providers  Primary Physician  Chiropractor  
 ER Physician  Neurologist,  Orthopedist  Physical Therapist  Massage Therapist  
 Other: \_\_\_\_\_
- Name and date treated \_\_\_\_\_
5. **If you received treatment, what was the result?**  Better  Same  Worse
6. **How much has your problem(s) interfered with:**  
a. **Your work duties?**  Not at all  A little bit  Moderately  Quite a bit  Extremely  
b. **Your social activities?**  Not at all  A little bit  Moderately  Quite a bit  Extremely
7. **How would you rate your health?**  Excellent  Very Good  Good  Fair  Poor
8. **Do you exercise regularly?**  No  Yes,  Strenuous  Moderate  Light  None
9. **What type(s) of exercise?** (Walking, gym, weights, swimming, aerobics, etc.): \_\_\_\_\_
10. **What duties or activities do you do during a normal/average day?**  
 **Sitting:**  1-2 hrs/day  3-5 hrs  6 + hrs  
 **Standing:**  1-2 hrs/day  3-5 hrs  6 + hrs  
 **Computer work:**  1-2 hrs/day  3-5 hrs  6 + hrs  
 **On the phone:**  1-2 hrs/day  3-5 hrs  6 + hrs  
 **Manual Labor/Hvy Lifting**  1-2 hrs/day  3-5 hrs  6 + hrs  
 **Clerical/Light Duty**  1-2 hrs/day  3-5 hrs  6 + hrs  
 **Other:** \_\_\_\_\_  1-2 hrs/day  3-5 hrs  6 + hrs
11. **Are you taking any prescription medications:**  None  I am taking - \_\_\_\_\_
12. **Are you taking any over-the-counter medications, vitamin or supplement?**  None  
If yes, list \_\_\_\_\_
13. **Do you have any allergies?**  No  
 Yes, I'm allergic to: \_\_\_\_\_
14. **Have you had any surgeries in the past 3 years?**  None  
 If Yes, describe (Approx. date and reason) \_\_\_\_\_
15. **Have you had any hospitalizations in the past 3 years?**  None  
If Yes, describe (Approx. date and reason) \_\_\_\_\_
16. **Have you had any major illnesses in the past 3 years?**  None  
If Yes, describe (Approx. date and type) \_\_\_\_\_
17. **Have you had any significant injuries, traumas or falls in the past 3 years?**  None  
If Yes, describe (Approx. date and type) \_\_\_\_\_
18. **Have you had any recent medical tests?**  None  
 X-Ray  CAT Scan  MRI  Bone Scan  EMG  Blood Work  Osteoporosis  Urine test  
 Colonoscopy  Other: \_\_\_\_\_ Results: \_\_\_\_\_
19. **Family Medical History:** Describe any illness or major medical condition by a member of your immediate family since you were last in this office.  No Change If yes, list condition and relationship \_\_\_\_\_
20. **Social Habits:**  
1. Tobacco Use?  Never  Current  Past  
2. Alcohol Use?  Never  Social  Moderate  Heavy  
3. Caffeine Use?  Never  < 3 Cups/Day  4-6 Cups/Day  > 6 Cups/Day  
4. High Stress? Reason: \_\_\_\_\_
21. **Medical History:** Have you been diagnosed with any disease, illness or condition since you were last seen?  
 None  If Yes, Please describe what and when, \_\_\_\_\_

**DISCLOSURE & CONSENT**  
**CHIROPRACTIC ADJUSTMENTS AND CARE**  
**TO THE PATIENT: PLEASE READ COMPLETELY**  
**PRIOR TO MEETING WITH DR. BRUNS OR DR. RAMIREZ**

*You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

**Richard M. Bruns, D.C. - Jose G. Ramirez, D.C.**

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. 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 on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

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I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**To Be Completed By The Patient**

Patient's Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

**X** \_\_\_\_\_

**Patient's Signature**

**Date:** \_\_\_\_\_

**To Be Initialed By the Doctor**

Richard M. Bruns, D.C. (RMB)

Date: \_\_\_\_\_

Jose G. Ramirez, D.C. (JGR)

**AUTHORIZATION AND ASSIGNMENT TO PAY CLAIMS DIRECTLY TO DOCTOR**

To: (Attorney, Insurer, Employer, Other): \_\_\_\_\_

In consideration of the undertaking, by Bruns Chiropractic Clinic (Bruns Inc.):

Richard M. Bruns, D.C. – Jose G. Ramirez, D.C.

I,  Do  Do Not

understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to that point, will be immediately due and payable.

- A. In consideration of the chiropractic services rendered and to be rendered by Bruns Chiropractic Clinic (Bruns Inc.), I authorize the direct payment of benefits to Bruns Inc., in the amount of any sum I now or hereafter owe by my attorney or out of the proceeds from any settlement of any liability case or by any insurance company obligated to make payment to me or Bruns Inc. based in whole or in part, on the charges accrued for said services.
- B. If a liability claim exists and my attorney or insurance carrier refuses assignment, I acknowledge my personal financial responsibility for the payment in full of my outstanding balance.
- C. I further agree that this Authorization and Assignment is irrevocable until all monies owed to Bruns, Inc. has been paid in full.

**PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY ACT**

I,  Do  Do Not

Hereby acknowledge the receipt (at my request) or opportunity to review the Notice of Privacy Practices Act (HIPAA) for **Bruns Chiropractic Clinic** (Bruns Inc.), regarding my personal health care information. I am or have been informed and clearly understand the manner in which my health information shall be maintained, utilized and disclosed by the clinic and the respective rights contained within.

I also understand that the Notice of Privacy Act that is available upon my request is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting or making a written request to:

|  |
|--|
| Steve Provost - Compliance Officer<br>371 Union Street Bangor, ME 04401<br>Phone #: (207) 947-1199 Fax #: (207) 942-8729 |
|--|

My signature herein below constitutes full acknowledgement that I have been furnished the opportunity to review or obtain a copy of the Notice of Privacy Practices for: **Bruns Chiropractic Clinic (Bruns Inc.)**

**I have reviewed the medical information provided and I believe it to be true and accurate to the best of my knowledge.**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Patient Signature Exam Date: \_\_\_\_\_

\_\_\_\_\_  
Patient's Legal Representative (If Required) Date: \_\_\_\_\_

If signed by legal representative, indicate relationship: \_\_\_\_\_

Bruns Chiropractic Clinic  
 Richard M. Bruns, D.C. – Jose G. Ramirez, D.C.  
 371 Union St., Bangor, ME 04401 Ph (207) 947-1199  
**ASSESSMENT OF FUNCTIONAL CAPACITY**

**This form is intended to quantify the affect your symptoms have on your normal daily activities**  
**CIRCLE** or **X** THE BOX THAT DESCRIBES HOW YOU FEEL ON AVERAGE FOR EACH ACTIVITY LISTED BELOW

|   |                                |   |   |   |  |
|---|--------------------------------|---|---|---|--|
| <b><u>Work Duties</u></b><br><i>(Home Chores if not working)</i>            | Normal work capacity Full Duty | Usual duties but no extra work                  | Up to 50% of usual work duties                        | Up to 25% of usual duties                         | Unable to do any kind of work            |
| <b><u>Transportation</u></b><br><i>(travel, driving or riding)</i>          | No pain 3 hr trip              | Mild pain 3 hour trip                           | Moderate pain 3 hour trip                             | Moderate pain ½ hour trip                         | Severe pain ½ hour trip                  |
| <b><u>Personal Care</u></b><br><i>(bathing, dressing, tying your shoes)</i> | Personal care causes no pain   | Mild pain but no issues or restrictions         | Moderate pain causes you to move slowly               | Moderate pain, you require some assistance        | Severe pain, you require full assistance |
| <b><u>Sleeping</u></b>  | Normal sleep                   | Pain mildly disrupts sleep 10-25%               | Pain moderately disrupts sleep 25-50%                 | Pain greatly disrupts sleep 50-75%                | Pain totally disrupts sleep 75-100%      |
| <b><u>Lifting</u></b>   | Can do my normal lifting       | Increased pain w/ heavy weight                  | Increased pain w/ moderate weight                     | Increased pain w/ light weight                    | Increased pain with any lifting          |
| <b><u>Standing</u></b>  | Can do my normal standing      | Pain after standing up to 2-3 hours             | Pain after standing up to 1 hour                      | Pain after standing up to 1/2 hour                | Pain with any standing                   |
| <b><u>Walking</u></b>   | Can do my normal walking       | Increased pain walking 1 mile                   | Increased pain walking ½ mile                         | Increased pain walking ¼ mile                     | I experience pain with any walking       |
| <b><u>Recreation</u></b><br><i>(golf, biking, exercise)</i>                 | I can do my normal activities  | Able to do most recreational activities         | Able to do some recreational activities               | Able to do a few recreational activities          | Unable to do any recreational activities |
| <b><u>Stairs</u></b>  | No pain using stairs           | Mild pain w/ 1 flight of stairs or more         | Mild to moderate pain w/ 1 flight of stairs or more   | Moderate pain with 1 flight of stairs or less     | Severe pain w/any stairs I require aid   |
| <b><u>Bending</u></b>   | No pain when I bend            | Mild pain                                       | Moderate pain   | Severe pain                                       | Cannot bend without pain                 |
| <b><u>Sitting</u></b>   | Can do my normal sitting       | I can sit over one hour with minimal discomfort | I can sit for up to 1 hour with mild to moderate pain | Able to sit up to 30 min. moderate to severe pain | Severe pain with any sitting             |

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Score: \_\_\_\_\_ %