

NEW PATIENT INTAKE FORM

Exam Date: _____

Name: First _____ MI _____ Last _____ Gender: M F

Preferred Name: _____ DOB: ____/____/____ Age _____ Marital Status S M W D O

Social Security #: _____ - _____ - _____ Your Occupation: _____

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

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

Employer's Name: _____ Work Phone #() _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Home Phone:() _____ Cell:() _____ Email: _____ @ _____

Spouse's Name: _____ Spouse DOB: ____/____/____

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 Primary Care Physician? Yes No

First time Patient? Who may we thank for referring you to our office? _____

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: _____

Complete 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: _____

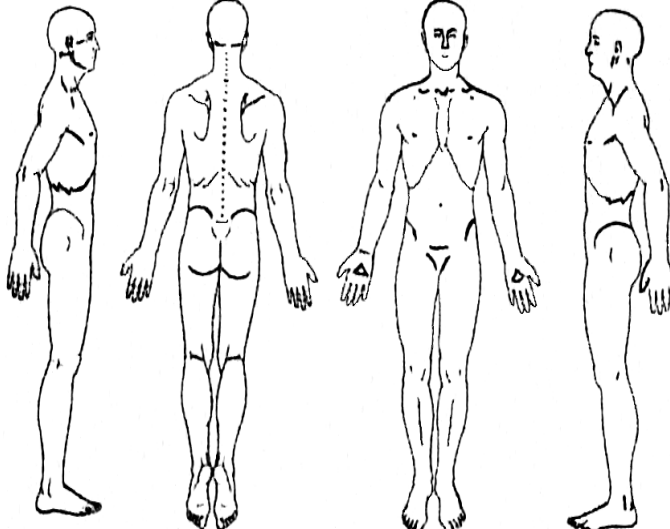
Workman's Compensation Injury? No

- 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:
	_____ _____ _____ _____ _____ _____ _____ _____
Mark on the figure above using a <u>circle</u> or an X mark the location of each symptom	

SYMPTOM /PAIN SCALE	NONE=0 Normal Activities No Restriction	MILD 1 - 2 - 3 Annoying, some discomfort able to do normal activities	MODERATE 4 - 5 - 6 Hurting, very sore, limited motion, slows your normal activities	SEVERE 7 - 8 - 9 Sharp, stabbing, can't do some of your normal activities	WORST 10/10 Unbearable, unable to do any normal activities
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DESCRIBE EACH SYMPTOM (1 SYMPTOM PER LINE) AND USING THE SCALE ABOVE RATE THE AVERAGE INTENSITY OF EACH SYMPTOM AND THE PERCENTAGE OF THE DAY/NIGHT THAT YOU EXPERIENCE IT.

1st Symptom Description:										
Symptom Intensity	1	2	3	4	5	6	7	8	9	10
Symptom Frequency	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
2nd Symptom Description:										
Symptom Intensity	1	2	3	4	5	6	7	8	9	10
Symptom Frequency	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
3rd Symptom Description:										
Symptom Intensity	1	2	3	4	5	6	7	8	9	10
Symptom Frequency	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
4th Symptom Description:										
Symptom Intensity	1	2	3	4	5	6		8	9	10
Symptom Frequency	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: _____

Bruns Chiropractic Clinic
Richard M. Bruns, D.C. – Jose G. Ramirez, D.C.
371 Union St., Bangor, ME 04401 Ph (207) 947-1199
PATIENT CURRENT AND PAST HISTORY

Exam Date: _____

Name: _____ DOB ____/____/____ Gender: M F

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, Dr. _____, Seen on: _____
 Chiropractor Dr. _____, Seen on: _____
 ER Physician @ _____, Seen on: _____
 Neurologist, Dr. _____, Seen on: _____
 Orthopedist, Dr. _____, Seen on: _____
 Physical Therapist: _____, Seen on: _____
 Massage Therapist Other: _____
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 day at work?**

<input type="checkbox"/> Sitting:	<input type="checkbox"/> 1-2 hrs/day	<input type="checkbox"/> 3-5 hrs	<input type="checkbox"/> 6 + hrs
<input type="checkbox"/> Standing:	<input type="checkbox"/> 1-2 hrs/day	<input type="checkbox"/> 3-5 hrs	<input type="checkbox"/> 6 + hrs
<input type="checkbox"/> Computer work:	<input type="checkbox"/> 1-2 hrs/day	<input type="checkbox"/> 3-5 hrs	<input type="checkbox"/> 6 + hrs
<input type="checkbox"/> On the phone:	<input type="checkbox"/> 1-2 hrs/day	<input type="checkbox"/> 3-5 hrs	<input type="checkbox"/> 6 + hrs
<input type="checkbox"/> Manual Labor/Hvy Lifting	<input type="checkbox"/> 1-2 hrs/day	<input type="checkbox"/> 3-5 hrs	<input type="checkbox"/> 6 + hrs
<input type="checkbox"/> Clerical/Light Duty	<input type="checkbox"/> 1-2 hrs/day	<input type="checkbox"/> 3-5 hrs	<input type="checkbox"/> 6 + hrs
<input type="checkbox"/> Other: _____	<input type="checkbox"/> 1-2 hrs/day	<input type="checkbox"/> 3-5 hrs	<input type="checkbox"/> 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 5 years?** None
 If Yes, describe (Approx. date and reason) _____
15. **Have you had any hospitalizations in the past 5 years?** None
If Yes, describe (Approx. date and reason) _____
16. **Have you had any major illnesses in the past 5 years?** None
If Yes, describe (Approx. date and type) _____
17. **Have you had any significant injuries, traumas or falls in the past 5 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: _____
Test Results: _____

19. Family History: Describe any family members with any major disease or condition including the following:
 (i.e. Rheumatoid Arthritis, Diabetes, Lupus, Heart Problems, Cancer, ALS, Osteoporosis)

Mother: _____
 Father: _____
 Brother: _____
 Sister: _____
 Maternal Grandmother: _____ Fraternal Grandmother: _____
 Maternal Grandfather: _____ Fraternal Grandfather: _____

20. Social Habits:

Tobacco Use? Never Current Past
 Alcohol Use? Never Social/Casual Moderate Heavy
 Caffeine Use? Never < 3 Cups/Day 4-6 Cups/Day > 6 Cups/Day
 High Stress? Reason: _____

21. Medical History: Have you been diagnosed or do you have a history of any of the following?

Mark each box YES or NO for each condition or symptom listed below. C=Currently P=In the past

Unusual Weight Gain/Loss	<input type="checkbox"/> Now <input type="checkbox"/> Past	Epilepsy	<input type="checkbox"/> Now <input type="checkbox"/> Past	Night Sweats	<input type="checkbox"/> Now <input type="checkbox"/> Past
Abdominal Pain	<input type="checkbox"/> Now <input type="checkbox"/> Past	Fractures	<input type="checkbox"/> Now <input type="checkbox"/> Past	Pacemaker	<input type="checkbox"/> Now <input type="checkbox"/> Past
AIDS/HIV	<input type="checkbox"/> Now <input type="checkbox"/> Past	Gall Bladder Disorder	<input type="checkbox"/> Now <input type="checkbox"/> Past	Parkinson's disease	<input type="checkbox"/> Now <input type="checkbox"/> Past
Anemia	<input type="checkbox"/> Now <input type="checkbox"/> Past	Glaucoma	<input type="checkbox"/> Now <input type="checkbox"/> Past	Polio	<input type="checkbox"/> Now <input type="checkbox"/> Past
Angina	<input type="checkbox"/> Now <input type="checkbox"/> Past	Gout	<input type="checkbox"/> Now <input type="checkbox"/> Past	Painful Urination	<input type="checkbox"/> Now <input type="checkbox"/> Past
Anorexia	<input type="checkbox"/> Now <input type="checkbox"/> Past	Heart Disease	<input type="checkbox"/> Now <input type="checkbox"/> Past	Prostate Problems	<input type="checkbox"/> Now <input type="checkbox"/> Past
Appendicitis	<input type="checkbox"/> Now <input type="checkbox"/> Past	Hepatitis	<input type="checkbox"/> Now <input type="checkbox"/> Past	Prosthesis	<input type="checkbox"/> Now <input type="checkbox"/> Past
Arthritis	<input type="checkbox"/> Now <input type="checkbox"/> Past	Hernia	<input type="checkbox"/> Now <input type="checkbox"/> Past	Rashes	<input type="checkbox"/> Now <input type="checkbox"/> Past
Asthma	<input type="checkbox"/> Now <input type="checkbox"/> Past	Herniated Disk	<input type="checkbox"/> Now <input type="checkbox"/> Past	Rheumatoid Arthritis	<input type="checkbox"/> Now <input type="checkbox"/> Past
Bulimia	<input type="checkbox"/> Now <input type="checkbox"/> Past	Herpes	<input type="checkbox"/> Now <input type="checkbox"/> Past	Rheumatic Fever	<input type="checkbox"/> Now <input type="checkbox"/> Past
Bladder Infections	<input type="checkbox"/> Now <input type="checkbox"/> Past	High Blood Pressure	<input type="checkbox"/> Now <input type="checkbox"/> Past	ringing in Ears/Tinnitus	<input type="checkbox"/> Now <input type="checkbox"/> Past
Bleeding Disorders	<input type="checkbox"/> Now <input type="checkbox"/> Past	High Cholesterol	<input type="checkbox"/> Now <input type="checkbox"/> Past	Sinusitis	<input type="checkbox"/> Now <input type="checkbox"/> Past
Bronchitis	<input type="checkbox"/> Now <input type="checkbox"/> Past	Fatigue	<input type="checkbox"/> Now <input type="checkbox"/> Past	Stroke	<input type="checkbox"/> Now <input type="checkbox"/> Past
Breast Lumps	<input type="checkbox"/> Now <input type="checkbox"/> Past	Frequent Urination	<input type="checkbox"/> Now <input type="checkbox"/> Past	Suicide Attempt	<input type="checkbox"/> Now <input type="checkbox"/> Past
Cancer _____	<input type="checkbox"/> Now <input type="checkbox"/> Past	Jaw Pain	<input type="checkbox"/> Now <input type="checkbox"/> Past	Systemic Lupus	<input type="checkbox"/> Now <input type="checkbox"/> Past
Cataracts	<input type="checkbox"/> Now <input type="checkbox"/> Past	Joint Pain/Stiffness	<input type="checkbox"/> Now <input type="checkbox"/> Past	Tonsillitis	<input type="checkbox"/> Now <input type="checkbox"/> Past
Chest Pains	<input type="checkbox"/> Now <input type="checkbox"/> Past	Kidney Stones	<input type="checkbox"/> Now <input type="checkbox"/> Past	Tuberculosis	<input type="checkbox"/> Now <input type="checkbox"/> Past
Chemical Dependency	<input type="checkbox"/> Now <input type="checkbox"/> Past	Kidney Disease	<input type="checkbox"/> Now <input type="checkbox"/> Past	Tumor/Growths	<input type="checkbox"/> Now <input type="checkbox"/> Past
Constipation	<input type="checkbox"/> Now <input type="checkbox"/> Past	Liver Disease	<input type="checkbox"/> Now <input type="checkbox"/> Past	Typhoid Fever	<input type="checkbox"/> Now <input type="checkbox"/> Past
Depression	<input type="checkbox"/> Now <input type="checkbox"/> Past	Loss of Bladder Control	<input type="checkbox"/> Now <input type="checkbox"/> Past	Ulcer	<input type="checkbox"/> Now <input type="checkbox"/> Past
Dermatitis/Eczema	<input type="checkbox"/> Now <input type="checkbox"/> Past	Loss of Appetite	<input type="checkbox"/> Now <input type="checkbox"/> Past	Vaginal Infections	<input type="checkbox"/> Now <input type="checkbox"/> Past
Diabetes	<input type="checkbox"/> Now <input type="checkbox"/> Past	Migraine Headaches	<input type="checkbox"/> Now <input type="checkbox"/> Past	Venereal Disease	<input type="checkbox"/> Now <input type="checkbox"/> Past
Diarrhea	<input type="checkbox"/> Now <input type="checkbox"/> Past	Miscarriage	<input type="checkbox"/> Now <input type="checkbox"/> Past	Vertigo	<input type="checkbox"/> Now <input type="checkbox"/> Past
Dizziness	<input type="checkbox"/> Now <input type="checkbox"/> Past	Multiple Sclerosis	<input type="checkbox"/> Now <input type="checkbox"/> Past	Visual Disturbances	<input type="checkbox"/> Now <input type="checkbox"/> Past
Empysema	<input type="checkbox"/> Now <input type="checkbox"/> Past	Musculoskeletal Pain	<input type="checkbox"/> Now <input type="checkbox"/> Past	Whooping Cough	<input type="checkbox"/> Now <input type="checkbox"/> Past
		Osteoporosis	<input type="checkbox"/> Now <input type="checkbox"/> Past	Other: _____	

For Female Patient's Only:

Hormone Replacement: No Yes Birth Control Pills: No Yes Are You Pregnant? No Yes, Due Date: _____

26. Is there anything else the Dr. should know about your visit today?

No Yes, _____

Name: _____ DOB ____/____/____ Gender: M F

Patient Signature: _____ Date: _____

DISCLOSURE & CONSENT

CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: PLEASE READ COMPLETELY PRIOR TO MEETING WITH DR. BRUNS

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.

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 ____/____/____ Gender: M F

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 371 Union Street Bangor, ME 04401 Phone #: (207) 947-1199 Fax #: (207) 942-8729
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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: _____

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

<u>Work Duties</u> <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
<u>Transportation</u> <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
<u>Personal Care</u> <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
<u>Sleeping</u>	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%
<u>Lifting</u>	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
<u>Standing</u>	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
<u>Walking</u>	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
<u>Recreation</u> <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
<u>Stairs</u>	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
<u>Bending</u>	No pain when I bend	Mild pain	Moderate pain	Severe pain	Cannot bend without pain
<u>Sitting</u>	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

Previous Score: _____ Current Score: _____

Patient's Name: _____

Patient Signature: _____ Date: _____