NORTH IDAHO PHYSICAL THERAPY

PATIENT NAME ______________________________ MALE_______ FEMALE________

HOMEPHONE________________CELLPHONE________________EMAIL________________

ADDRESS ________________________ CITY ____________________ STATE _____ ZIP _________

BIRTHDATE ______________ SS# ____________________ SINGLE________ MARRIED __________

PATIENT'S EMPLOYER ______________________________________ PHONE __________________
(or name of school if patient is a student)

SPOUSE'S NAME ____________________________ SPOUSE'S EMPLOYER ______________________
(or name of parent patient resides with if patient is a minor and parent employer)

RESPONSIBLE PARTY (if different from patient)

NAME ____**BIRTHDATE**__________________

ADDRESS_____________________________________ **PHONE#**______________________

Name of relative or friend to contact for emergency:________________________ phone:______________ relation:__________

Whom may we thank for referring you to North Idaho Physical Therapy? ______________________________

REFERRING PHYSICIAN ______________________________ FAMILY PHYSICIAN__________________

DATE OF LAST DR VISIT ____________________ DATE OF NEXT DR VISIT ______________________

WHAT CONDITION ARE WE TREATING YOU FOR: ____

IS THIS CONDITION THE RESULT OF AN INJURY OR ACCIDENT? **yes no**

If no injury involved, please continue to Health Insurance Information in Block 3

WHAT WAS THE DATE OF INJURY: ______________ **HOW WERE YOU INJURED:** ____________________

DID THE INJURY OCCUR AT WORK? yes no HAVE YOU FILED A CLAIM WITH YOUR EMPLOYER? yes no
(if you answered yes to this please complete blocks 1 and 3 below)

INJURY DUE TO AUTO ACCIDENT? yes no **(if yes, complete blocks 2 & 3 below)** STATE MVA OCCURRED ____________

1.) WORK COMP INSURANCE INFORMATION

Name of employer who work related claim is filed with ______________________________ phone __________

Insurance Carrier for this work related claim ____

Claim Number for this claim ____________________________ Claim Adjuster ____________________

2.) AUTO INSURANCE INFORMATION - Have you filed this with your own auto insurance? yes no

Patient's Automobile Insurance ______________________________________phone#__________________

Policyholder Name ______________________________________ Claim # ______________________

Responsible Party's Insurance ____________________________ Policyholder name ____________________

3.)

HEALTH INSURANCE INFORMATION

BLUE SHIELD * BLUE CROSS * MEDICARE * MEDICAID * GROUP HEALTH * UHC * OTHER

Name of Insurance if not listed above: ________________________SUBSCRIBER NAME__________________

SUBSCRIBER DATE OF BIRTH: ____________________ RELATIONSHIP TO PATIENT __________________

SUBSCRIBER ID# __________________________________GROUP # ______________________________

I AUTHORIZE MY INSURANCE COMPANY (OR ATTORNEY IF APPLICABLE) TO MAKE PAYMENT DIRECTLY TO NORTH IDAHO PHYSICAL THERAPY. I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS MY CLAIM AND I ACKNOWLEDGE I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND IT IS MY RESPONSIBILITY TO HAVE ANY PRECERTIFICATION IN PLACE IF SO REQUIRED BY MY INSURANCE. I ACCEPT FULL RESPONSIBILITY FOR THE CHARGES INCURRED.

CREDIT TERMS: BALANCES REMAINING UNPAID ON ACCOUNT AFTER THE 1ST DAY OF THE MONTH FOLLOWING THE MONTHLY BILLING STATEMENT DATE ARE SUBJECT TO FINANCE CHARGE AT THE PERIODIC RATE OF 1.5% PER MONTH, WHICH IS ANNUAL PERCENTAGE RATE OF 18%. WE COMPUTE THE FINANCE CHARGE BY APPLYING THE PERIODIC RATE TO THAT PORTION ON YOUR ACCOUNT WHICH IS OVER 90 DAYS. I HAVE BEEN OFFERED A COPY OF THE HIPAA & NOTICE OF PRIVACY POLICY.

______________________________________ ______________________

PATIENT OR GUARDIAN SIGNATURE DATE

Patient Intake Form

Dr. Melissa Jacobson
Chiropratic Health
Practicing at
North Idaho Physical Therapy

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: ______________________ **Date:** ________ (dd/mm/yr)
Insurance: ______________________
Date of Birth: ______________________ ☐ Male ☐ Female
Address: ______________________
____
____

Marital status

S	M	W	D	SEP

Phone #: home: ____________ **work:** ____________
E-mail address: ______________________
Occupation: ____________ **Employer:** ____________

Mark (c) for current problems, check ☑ and indicate the age when you had any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsilitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defication
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow: ____ Lenght of cycle: _____
Date - 1st day last period: ______________
Are you pregnant? ☐ yes, ☐ no
If yes, how many months? _____
How many children do you have? _____
Birth control method: _______________
Date of last PAP test: _______________
☐ normal, ☐ abnormal
Date of last mamogram: ______________
☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Please list any medication you are currently taking and why:

____
____
____
____

Reproduction is permitted for personal use, not for resale or redistribution. **www.prohealthsys.com ©2005 by Professional Health Systems Inc. "Dedicated to Clinical Excellence."**

Patient Intake Form (side 2)

Give a breif detailed description of the problem you are currently experiencing: ______________________________

____

____

____

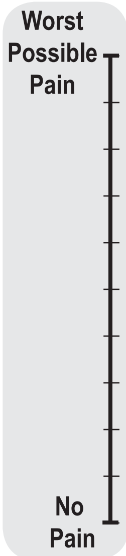
How long have you had this condition? ____________ Is it getting worse? □ yes, □ no ______________________

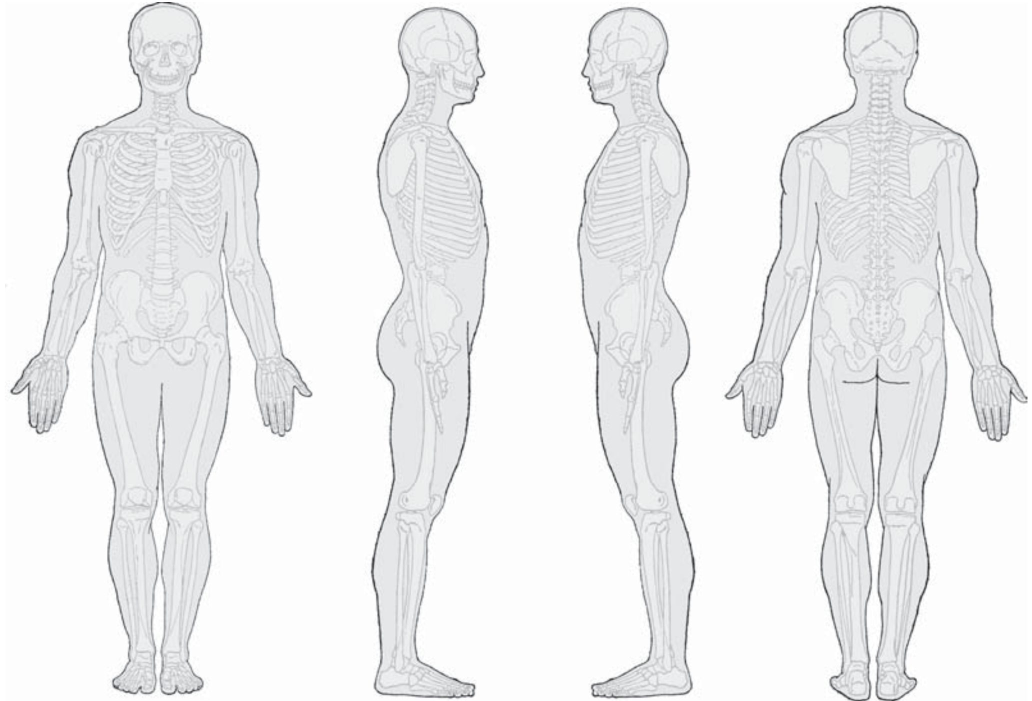
Does it bother you (check appropriate box): □ work, □ sleep, □ other: ______________________________

What seemed to be the initial cause: ______________________________

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain breifly
... been hospitalized in the last 5 year?	□	□	______________
... had any mental disorders?	□	□	______________
... had any broken bones?	□	□	______________
... had any strains or sprains?	□	□	______________
... ever used orthotics?	□	□	______________
Do you take minerals, herbs or vitamins?	□	□	______________

How is most of your day spent? □ standing, □ sitting, □ other: ______________

How old is your matress? ______________

When was your last physical exam? ______________

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? ______________________________

____

Reproduction is permitted for personal use, not for resale or redistribution. **www.prohealthsys.com ©2005 by Professional Health Systems Inc. "Dedicated to Clinical Excellence."**

Consent Form

To Our Patients:

Chiropractic examination and therapeutic (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 to 2 incidents per million adjustments for adjustments of the neck, and 1 per million adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

____

Patient Signature Date