



Patient Information Intake Form

Personal Info:

Last Name: _____ First Name: _____ Middle Initial: _____
DOB: _____ Gender: M / F
Weight: _____ Height: _____ Name Suffix: Jr. / Sr.
Marital Status: M / S / W / D Employer: _____ Title: _____
Preferred Language: Eng Span Smoker? Never Former Current Frequency: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Fax: _____ Preferred Phone: Cell Home
Email: _____ Reminder: Email Text
How did you hear about us? _____ Voice (Cell) Voice (Home)
If referred by friend, can we tell them thank you? Yes No Cell Carrier: Verizon At&t Other__

Emergency Contact Info:

Contact Name: _____ Relationship to Patient: _____
Phone #: _____ Home Cell

Accident/Injury:

Was this injury/illness caused by: Work Accident? Auto Accident? Date of Accident _____
Are you receiving any litigation for your injury/illness? Yes No
Are you receiving any litigation for any other injuries/illnesses? Yes No

Previous Chiropractic Care? Yes No Date of last Appt: _____

For Office Use Only: G CP MC Informed Consent
Medicare: ABN (2) Insurance Card

Patient Health History



**Mankey Family
Chiropractic**
Dr. Graham V. Mankey, D.C.
Dr. Allison Mankey, D.C.

Patient Name: _____ Date: _____

LIST EACH SYMPTOM/CONDITION THAT BROUGHT YOU INTO OUR OFFICE:

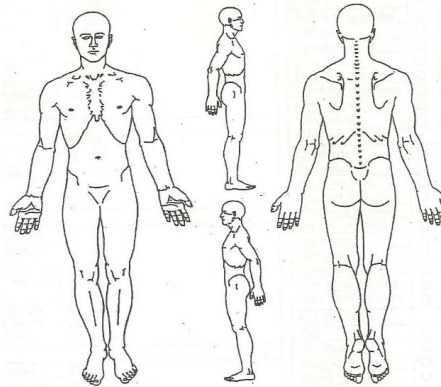
No Complaint/Wellness Care

#1: _____

#2: _____

#3: _____

Others: _____



Using the symbols below, mark on the pictures where you have symptoms:

- Numberness = = =
- Dull Ache OOO
- Sharp/Stabbing ////
- Pins, Needles + + +
- Other _____ ^ ^ ^

History of EACH Complaint: (Please answer each of the following questions for EACH symptom/condition)

Symptom #1: _____

Date symptom began: _____	Is it: <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Activity-related
What caused this condition/pain? _____	Is it getting: <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same
What aggravates this condition/pain? _____	Rating: (best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)
What lessens this condition/pain? _____	% of Day: <input type="checkbox"/> 0% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%
Does this pain shoot/radiate/travel? Y / N Where? _____	Frequency? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Is there numbness/tingling? Y / N Where? _____	Duration? <input type="checkbox"/> Secs <input type="checkbox"/> Mins <input type="checkbox"/> Hours <input type="checkbox"/> Days
Other Doctors seen for this condition: _____	Worse during: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Night
Any home remedies? _____	Interfere with: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Routine

Symptom #2: _____

Date symptom began: _____	Is it: <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Activity-related
What caused this condition/pain? _____	Is it getting: <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same
What aggravates this condition/pain? _____	Rating: (best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)
What lessens this condition/pain? _____	% of Day: <input type="checkbox"/> 0% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%
Does this pain shoot/radiate/travel? Y / N Where? _____	Frequency? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Is there numbness/tingling? Y / N Where? _____	Duration? <input type="checkbox"/> Secs <input type="checkbox"/> Mins <input type="checkbox"/> Hours <input type="checkbox"/> Days
Other Doctors seen for this condition: _____	Worse during: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Night
Any home remedies? _____	Interfere with: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Routine

Symptom #3: _____

Date symptom began: _____	Is it: <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Activity-related
What caused this condition/pain? _____	Is it getting: <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same
What aggravates this condition/pain? _____	Rating: (best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)
What lessens this condition/pain? _____	% of Day: <input type="checkbox"/> 0% <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%
Does this pain shoot/radiate/travel? Y / N Where? _____	Frequency? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Is there numbness/tingling? Y / N Where? _____	Duration? <input type="checkbox"/> Secs <input type="checkbox"/> Mins <input type="checkbox"/> Hours <input type="checkbox"/> Days
Other Doctors seen for this condition: _____	Worse during: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Night
Any home remedies? _____	Interfere with: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Routine

Patient Name: _____ Date: _____

Do you have any previous imaging? X-ray MRI CT Other _____

Place of Service _____

I authorize Mankey Family Chiropractic to online access of all images, reports and any other information relating to my condition. Please Sign _____

Please mark any of the following conditions/symptoms that you have now or have experienced:

- Headaches
- Migraines
- Lights Bother Eyes
- Pain in Hands or Arms
- Pain in Legs or Feet
- Loss of Consciousness
- Loss of Memory
- Loss of Smell or Taste
- Shortness of Breath
- Fainting Spells
- Recurring Fevers
- Painful Urination
- High Blood Pressure
- Chest Pains
- Heart Attack
- Stroke
- Unexplained Weight Loss
- Cancer
- Pain waking you up at night
- Difficulty breathing at night
- Double Vision
- Dizziness
- Drop Attacks
- Difficulty Speaking
- Difficulty Swallowing
- Loss of Balance
- Nausea
- Numbness
- Nystagmus

NONE OF THE ABOVE APPLY

Current Health Habits:

- Do you drink water? Yes No How much & how often? _____
- Do you eat a healthy diet? Yes No Special Diet? _____
- Exercise regularly? Yes No Type? _____
- Did/do you smoke? Yes No How much & how often? _____
- Did/do you drink alcohol? Yes No How much & how often? _____
- Did/do you drink caffeine? Yes No How much & how often? _____
- Daily time spent driving? _____
- Physical stress? Yes No Explain? _____
- Emotional/Mental stress? Yes No Explain? _____
- Occupational stress? Yes No Explain? _____
- Do you sleep well? Yes No Hours? _____
- Sleeping posture: Side Stomach Back All of the above

Past History:

- Any accidents/trauma? Yes No List: _____
- Any previous fractures? Yes No List: _____
- Any hobbies/sports injuries? Yes No List: _____
- Any major Illnesses? Yes No List: _____
- Any previous surgeries? Yes No List & Date: _____
- Any previous hospitalizations? Yes No List: _____
- Any medications? Yes No List: _____
- Any allergies? Yes No List: _____

Family History:

- Is there a family history of: No family history of the conditions listed below
- | | Arthritis | Heart/Blood Disease | Cancer | Diabetes | Other _____ | Unknown |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Father's side | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mother's side | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

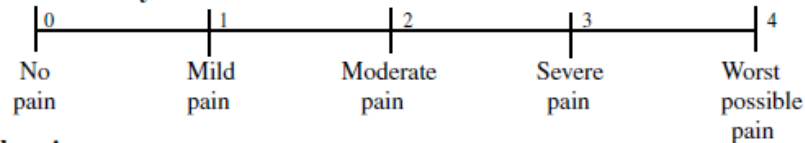
Patient Signature _____ Date _____

Functional Rating Index

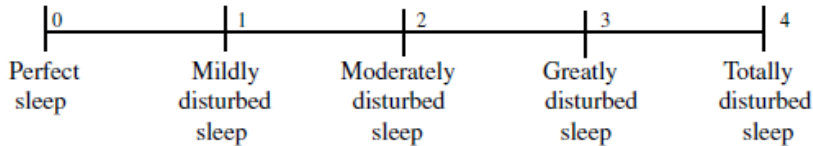
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

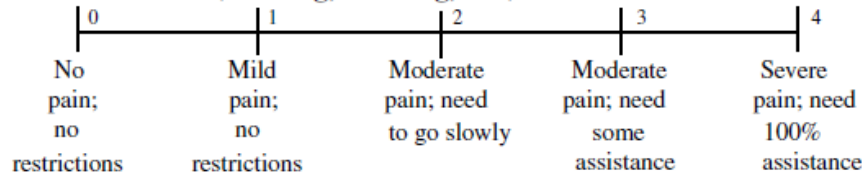
1. Pain Intensity



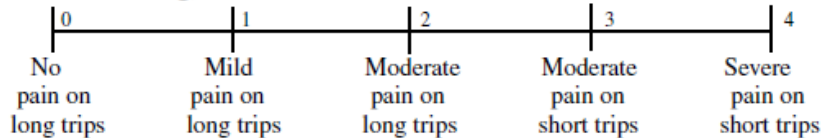
2. Sleeping



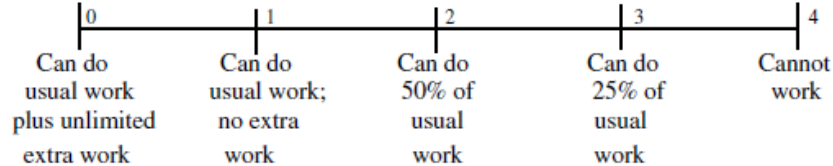
3. Personal Care (washing, dressing, etc.)



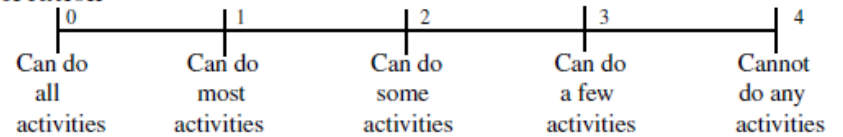
4. Travel (driving, etc.)



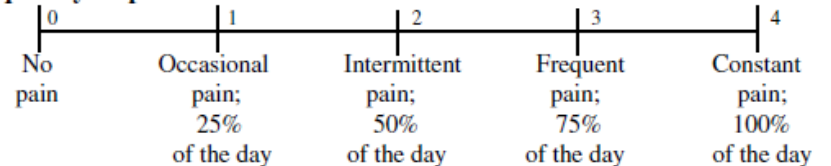
5. Work



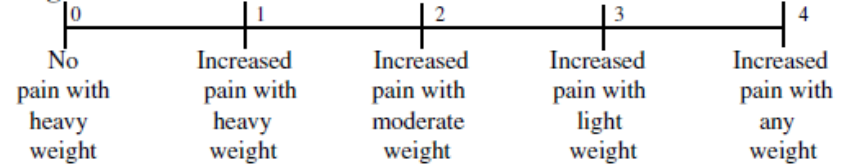
6. Recreation



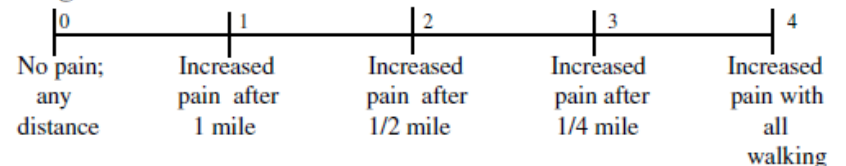
7. Frequency of pain



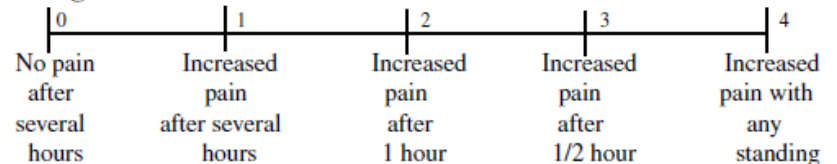
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Total Score _____

Signature _____

Date _____

Informed Consent for Chiropractic Treatment of your Pain

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*

Other options for the treatment of pain include: *do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery.* There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

Patient Name

Signature

Date

Witness Name

Signature

Date



FINANCIAL POLICY

Payment is expected at the time of service. We accept cash, check, or charge (Visa, Discover or Master Card). We do not accept AMEX. Our Cash Price is discounted and is to be paid at time of service. The discount is forfeited if services are not paid in full at time of service. If we have to send a bill, the charge will reflect our usual (non-discounted) fees. We encourage you to take advantage of time-of-service discount.

There will be an additional \$25 fee for checks submitted with insufficient funds. Balances over 60 days will incur an interest charge of 1.5% per month and after 90 days, an additional \$5.00 rebilling fee per statement will be charged

MISSED/CANCELLED APPOINTMENTS:

We ask for a 24-hour notice for appointment cancellations. There will be a cancellation fee (the cost of your visit) for each missed appointment and/or cancellation with less than 24 hours notice.

We understand that sometimes last-minute cancellations are unavoidable. Individual circumstances may be discussed with the office manager and/or the doctor.

INSURANCE:

We are a out of network provider with all health insurances. Our financial relationship is with you, not your insurance company. As a courtesy to our patients, our office will complete a superbill to help you collect from your insurance company. **You are responsible for payment of our services at the time of service.** If your insurance company pays any amount directly to our office, we will credit it back to your account or give you a refund.

As a courtesy to our patients, we can check your insurance benefits for you. Verification of benefits or eligibility is not a guarantee of payment. Payment can only be made after the claim has been received and reviewed in regards to eligibility, benefits, medical necessity, and other limitations and/or exclusions. Your insurance is an agreement between you and your insurance company and you are responsible to know and understand your insurance benefits.

IT IS IMPORTANT THAT YOU UNDERSTAND YOUR HEALTH OR ACCIDENT INSURANCE.

I HAVE READ AND UNDERSTAND MY RESPONSIBILITY CONCERNING THE PAYMENT OF SERVICES.

SIGNATURE: _____ **Date:** _____



Mankey Family

Chiropractic

Dr. Graham V. Mankey, D.C.
Dr. Allison Mankey, D.C.

Health Insurance Portability and Accountability Act Form (HIPAA)

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, “I” and “my” refer to the patient, and “Chiropractor” refers to Dr. Mankey or Mankey Family Chiropractic.

I consent to the use or disclosure of my protected health information by the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of the Chiropractor.

I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractor is not required to agree to the restrictions that I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except that the Chiropractor has taken action in reliance on this Consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have a right to review the Notice of Privacy Practices prior to signing this document. This page is a modified version of our Notice of Privacy Practices. A full copy can be obtained upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Chiropractor.

The Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy be sent in the mail, email, or asking for one at the time of my next appointment.

Patient Signature: _____

Date: _____