

North Shore Chiropractic

Dr Gregory Smith D.C.

530-546-8252

Please Print and fill out our Patient Intake Form, Please use blue or black ink and print clearly.



Patient Information: State Law requires this info

Name: _____

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

Sex: Female Male **Birthdate:** _____ **Height:** _____ **Weight** _____

Home Phone: (____) _____ Cell Phone: (____) _____ **E-mail:** _____

Do you consent to receiving calls, texts or e-mail for appointments and office communications: Yes I consent ~ NO

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip Code: _____

Spouse or parent's name: _____ Employer: _____ Work Phone: (____) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (____) _____

Patient Condition/Symptoms:

Reason for visit: _____ When did you first notice the symptoms? _____

Is the condition getting progressively worse? Yes No

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Other

Does the pain interfere with your- Work Sleep Daily Routine Recreation

***Type of pain:** Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other _____

***Circle the severity of your pain 1 thru 10.** (1 = mild pain or discomfort, to 10 = excruciating pain)

1 2 3 4 5 6 7 8 9 10

Is the pain present what % of the awake time? (0-25%) (26-49%) (50-75%) (76-90%) (100%)

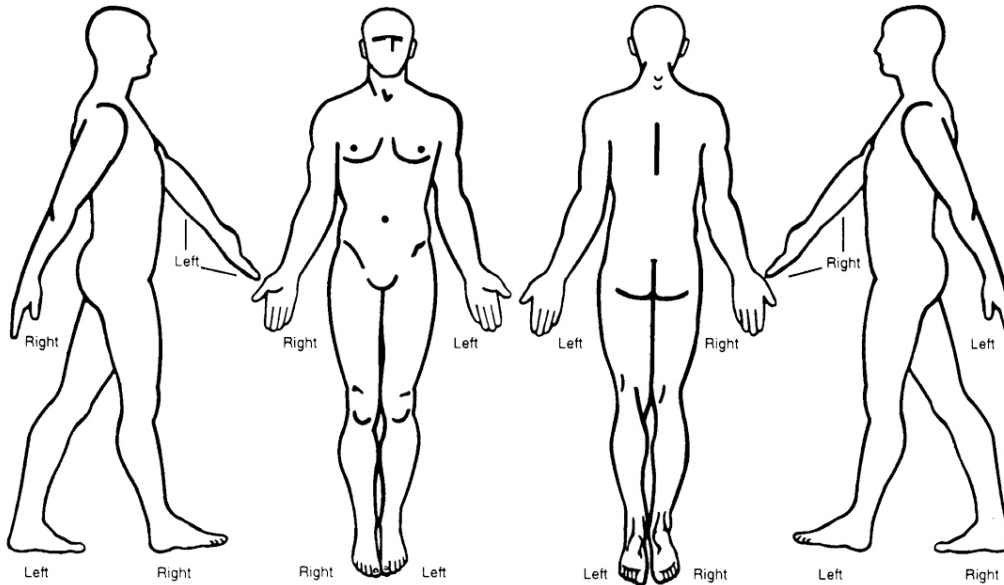
What treatment have you received for your condition?

Medication Surgery Physical Therapy Chiropractic Other _____

Name and address of other doctor(s) who have treated you for your condition: _____

Please indicate on the figures below, your areas of pain and label the type of pain

(eg. aching, burning, spasm)



Health History

Check all conditions that you have: _____

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Arm Pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Bone Weakness | <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Eye/Vision Problems |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Genetic Spinal Disorder |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gluten Sensitivity | <input type="checkbox"/> Gout | <input type="checkbox"/> Hand Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Heart (Mitral Valve) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Herniated disk | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Irritable Bowl Disease | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Leaky Gut Syndrome | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Lyme's Disease | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Mid Back Pain |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Minor Heart Trouble | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Parkinsons Disease |
| <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Shingles | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Significant Weight Change |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Sprain/Strain Injuries | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke (Heart or Brain) | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumor (s) |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> No Problems Reported |

History Continued:

Dates of last exams: _____

(Woman) Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Do you have breast implants? Yes No Surgical Prosthesis? Yes No

History Continued:

List any types of injuries or surgeries which you have had and the dates which they occurred: _____

Please list all medications you are currently taking: _____

Is your present condition due to an accident? Yes No (If Yes, please ask for the Personal Injury Forms)

If Yes – Type of Accident Auto Work Home Other Date of Accident: _____

Allergies(prescriptions or foods): _____

Daily Habits:

What type of exercise do you perform on a daily basis? None Moderate Heavy

What do your daily work habits include? _____

What vitamins do you currently take? _____

Nutritional supplements (if any)? _____

Do you smoke? Yes No How much per day? _____

How much liquor do you consume weekly? _____ How many caffeinated beverages do you consume daily? _____

Are you wearing: Shoe lifts Inner soles Arch supports Custom Orthotics

Are you dieting: No Yes Since ____/____/____

FINANCIAL ARRANGEMENTS:

Payment is required at the time the treatment is rendered. Fee schedule is based on face-to-face time with Dr. Gregory Smith DC in 20-minute increments. A standard New Patient office visit (40 to 50 minutes) is \$100.00 to \$195.00 and subsequent intermediate office visits (20 minutes) are \$70.00, this fee schedule is subject to additional charges incurred in the performance of additional procedures for a specific treatment time 10 minutes at \$45 and 20 minutes at \$70. Personal Injury and other complex issues require a more complete (60 minute) physical exam and treatment that are billed accordingly. Payment is required at the time for all nutritional supplements received. If you are covered by insurance for chiropractic care, we will provide you with a superbill for you to submit to your insurance. We are considered out of network with all providers, we do not guarantee payment by insurance companies. Medicare **does not** cover initial or follow up exam(s).

You are responsible financially for services rendered.

Appointments: On your 1st Visit you should plan to arrive early to complete your intake forms.

Please be on time for your appointment. Tardiness may have an effect on the length of your treatment time.

Certification and Assignment:

To the best of my knowledge, the above information is complete and correct. I have read, understand and agree to the policy of this office. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

→ _____
Print Name

Signature


Date

**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE
AT NORTH SHORE CHIROPRACTIC**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including examination and testing, various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Gregory Smith DC and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Gregory Smith DC, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with Dr. Gregory Smith DC the nature and purpose of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I understand and am informed that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications/risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, strain/or sprains, cervical myelopathy(spinal-cord), costovertebral (ribs) strains and separations. Some types of manipulation (adjustment) of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complication including stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have had the material risk of care explained verbally and in writing [], including the above explanation of the Chiropractic adjustment and related treatment or exams. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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.

North Shore Chiropractic 8611 N. Lake Blvd #200, Kings Beach, CA
Dr. Gregory Smith D.C.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

To be Completed by Patient:

Print Patient's Name

Signature of Patient

Date

To be completed by patient's representative, if necessary, e.g.,
if patient is a minor or physically or legally incapacitated:

Print Name of Patient's Representative

Signature of Patient's Representative

As: Relationship or Authority of Patient's Representative

Witness to Patient's Signature: Dr. Gregory Smith DC. 8611 N. Lake Blvd, Kings Beach, CA 96143

Gregory Smith DC

Date:

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

➔ I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

➔ _____
Patient

➔ _____
Signature

➔ _____
Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify) _____

Staff signature

Date