OLYMPIC HEALTH CHIROPRACTIC

NEW PATIENT INTAKE

Welcome to Olympic Health Chiropractic!

Please provide the following information. *Only mark what applies to you.* *Thank you!*

Personal Information

Full Name: _____ Email: _____

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

Cell Phone _____ Home Phone _____ Work Phone _____

D.O.B. _____ **Age:** _____

❒ Male ❒ Female | **Pregnant?** ❒ Yes ❒ No

Number of Children: _____

Marital status:

❒ Single ❒ Married ❒ Divorced ❒ Widowed

Spouse name: _____

Occupation: _____ Employer: _____

Person responsible for account: _____ Method of payment _____

How did you find out about our office? ❒ Walk-in ❒ Referral ❒ Yellow Pages ❒ Internet ❒ Other _____

Emergency Contact:

Contact Name: _____ **Contact Phone #** _____

Relation to you: (*parent/spouse/boss/friend/etc.*) _____

MEDICARE PATIENTS ONLY

Relationship to Insured: ❒ Self ❒ Spouse ❒ Child ❒ Other _____

Insurance Company _____ Phone # _____

Address _____ City _____ State ____ Zip _____

Insured's ID # _____ Group # _____

Insured's D.O.B. ____/____/_____ Insured's Employer _____

MAJOR COMPLAINTS:

_____

_____

_____

_____

_____

_____

_____

If this is an injury, what happened? _____

_____

_____

_____

Have you had the same symptoms previously?

❒_ No ❒ Yes Date of onset: _____/ ____/ _____

Explain: _____

Is this getting ❒ better ❒ worse ❒ staying the same?

Have you seen a doctor for this problem? ❒ No ❒ Yes

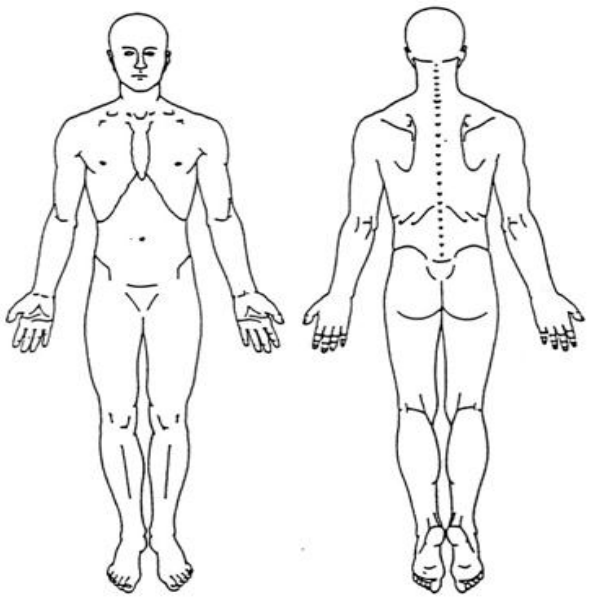
Doctor's Name _____

Practice Name _____

Phone Number _____

Mark the areas on your body where you feel the described sensations

Numbness ^^^^^^^^ Burning xxxxxx Stabbing //////////// Pins/Needles oooooooo



Use the appropriate symbol to mark all affected areas.

Olympic Health Chiropractic
618 South Marion Ave # 103, Lake City FL, 32025
Tel: 386-319-7909 | Fax: 386-319-7998 | Email: OlympicHealthChiropractic@gmail.com

OLYMPIC HEALTH CHIROPRACTIC

List any medications, prescription, OTC, vitamins, etc. _____

_____

Have you consulted a chiropractor in the past? ❒ Yes ❒ No If yes, Chiropractor's Name:_____
Practice Name:_____Ph #_____
Date Consulted: __/__/_____ For what problem? _____

Healing occurs during sleep; essential to a proper immune system, please mark if you have any of the following:

1. Trouble falling asleep? ❒ Yes ❒ No
2. Not enough restful sleep? ❒ Yes ❒ No
3. Waking in the middle of the night? ❒ Yes ❒ No
4. Waking earlier than you normally would? ❒ Yes ❒ No

CHECK THE ACTIVITIES DURING WHICH YOU EXPERIENCE DIFFICULTY OR PAIN:

❒	lying on side with knees bent	❒	lying on back	❒	turning over in bed	❒	lying flat on stomach
❒	getting in/out of car	❒	gripping	❒	sleeping	❒	sitting
❒	bending forward	❒	climbing	❒	pushing	❒	walking
❒	bending backward	❒	dressing self	❒	pulling	❒	sneezing
❒	standing for one hour or more	❒	sexual activity	❒	reaching	❒	coughing
				❒	stooping	❒	other

HEADACHES

Do you have a family history of headaches? ❒ Yes ❒ No
Do you get headaches? ❒ Yes ❒ No
Do you experience pain or cracking of jaw with your headaches? ❒ Yes ❒ No
Do you experience abnormal blood pressure? ❒ Yes ❒ No ❒ High ❒ Low
Do you experience nausea, vomiting or visual disturbances? ❒ Yes ❒ No

LOWER BACK PAIN

Do you ever experience ripping or tearing sensations in your back? ❒ Yes ❒ No
Does pain radiate to your abdomen? ❒ Yes ❒ No
Do you ever have impairment of bowel or urinary function? ❒ Yes ❒ No Explain: _____

NECK PAIN

If you have neck injury, does it effect: ❒ hearing ❒ vision ❒ balance ❒ ringing in ears ❒ grating sounds in ears
Do you feel pressure or pain behind your eyes? ❒ Yes ❒ No
Do you feel ripping or tearing? ❒ Yes ❒ No If yes, where? _____
Do you have difficulty lifting or turning your head? ❒ Yes ❒ No If yes, in what direction? _____

ADDITIONAL COMPLAINTS:

❒	headache	❒	numbness in fingers/arm/leg	❒	excess perspiration		**Pain radiating into:**
❒	head seems too heavy	❒	pins/needles in arms/legs	❒	digestive disorder	❒	right arm
❒	loss of memory	❒	upper back pain/stiffness	❒	nausea, vomiting	❒	left arm
❒	tension	❒	low back pain/stiffness	❒	diarrhea	❒	both arms
❒	irritability	❒	neck motion restricted	❒	constipation	❒	right leg
❒	anxiety	❒	neck pain/stiffness	❒	difficulty lifting	❒	left leg
❒	insomnia	❒	loss of taste/smell	❒	difficulty standing	❒	both legs
❒	sinus trouble	❒	dizziness	❒	difficulty walking	❒	neck
❒	eye strain	❒	fainting	❒	difficulty sitting	❒	base of skull
❒	pain behind eyes	❒	equilibrium problems	❒	difficulty bending	❒	shoulders
❒	tremors	❒	eyes sensitive to light	❒	extreme fatigue	❒	hips
❒	palpitations	❒	ears buzzing/ringing	❒	shortness of breath	❒	other
❒	chest pain	❒	extreme nervousness	❒	difficulty swallowing	❒	other

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Height _____ Weight _____ Recent weight loss/gain?_____ Are you dieting? ❒ Yes ❒ No
If yes, explain: _____ How often do you have a bowel movement?_____
Do you smoke/use tobacco? ❒ Yes ❒ No If yes, what? _____ How often?_____ Since when? _____
Do you drink alcohol? ❒ Yes ❒ No If yes, what? _____ How often?_____ Since when? _____

Have you had any surgeries or been hospitalized? ❒ Yes ❒ No
Type of Hospitalization/surgery: _____ Date: _____
Type of Hospitalization/surgery: _____ Date: _____
Type of Hospitalization/surgery: _____ Date: _____
Type of Hospitalization/surgery: _____ Date: _____

Review of Systems: Please check any symptom or condition that you either have had now (N) or in the past (P):

N	P	Weight	N	P	Skin	N	P	G-I System	N	P	Conditions
❒	❒	Weight loss	❒	❒	Rash	❒	❒	Gas	❒	❒	Anemia
❒	❒	Weight gain	❒	❒	Easy bruising	❒	❒	Heartburn	❒	❒	Osteopenia
		Head	❒	❒	Itching/Peeling	❒	❒	Indigestions	❒	❒	Osteoporosis
❒	❒	Headache	❒	❒	Changes in moles	❒	❒	Ulcers	❒	❒	Osteoarthritis
❒	❒	Dizziness			**Vascular**	❒	❒	Vomiting/Nausea	❒	❒	Cataracts
❒	❒	Head trauma	❒	❒	Chest pain	❒	❒	Abdominal pain	❒	❒	Pneumonia
❒	❒	Fainting	❒	❒	Palpitations	❒	❒	Diarrhea	❒	❒	Tuberculosis
❒	❒	Blacking out	❒	❒	Ankle swelling	❒	❒	Constipation	❒	❒	Gallbladder Disease
		Eyes	❒	❒	Cold feet/hands	❒	❒	Blood in Stool	❒	❒	Liver Disease
❒	❒	Changes in vision	❒	❒	Leg cramps	❒	❒	Hemorrhoids	❒	❒	Urinary infection
❒	❒	Light sensitivity	❒	❒	Calf pain			**G-U system**	❒	❒	Genital infection
❒	❒	Spots in vision	❒	❒	Varicose veins	❒	❒	Difficulty urinating	❒	❒	Diabetes
		Mouth	❒	❒	Low Blood pressure	❒	❒	Pain urinating	❒	❒	Thyroid Condition
❒	❒	Bleeding Gums	❒	❒	High Blood pressure	❒	❒	Blood in urine	❒	❒	Rheumatoid Arthritis
❒	❒	Cold sores			**Neurologic**	❒	❒	Incontinence	❒	❒	Glaucoma
❒	❒	Dentures	❒	❒	Seizures/Epilepsy	❒	❒	Increase urination	❒	❒	Alcoholism
❒	❒	Jaw pain	❒	❒	Stroke	❒	❒	Decreased urination	❒	❒	Tumors
❒	❒	Changes in taste	❒	❒	Tingling sensation			**Muscle/Bone**	❒	❒	Multiple Sclerosis
❒	❒	Hoarseness	❒	❒	Numbness	❒	❒	Joint Pain	❒	❒	Parkinson's Disease
		Nose	❒	❒	Weakness	❒	❒	Stiffness	❒	❒	Gout
❒	❒	Nosebleeds	❒	❒	Difficulty walking	❒	❒	Muscle ache	❒	❒	High Cholesterol
❒	❒	Sinus problems	❒	❒	Poor coordination	❒	❒	Arthritis	❒	❒	Migraine Headaches
		Lungs	❒	❒	Seizures/Epilepsy	❒	❒	Bone Pain	❒	❒	TIAs
❒	❒	Difficulty breathing	❒	❒	Stroke	❒	❒	Fracture	❒	❒	Cancer
❒	❒	Asthma	❒	❒	Tingling sensation	❒	❒	Dislocation	❒	❒	Other:
❒	❒	Wheezing	❒	❒	Other:	❒	❒	Other:	❒	❒	Other:
❒	❒	Persistent cough	❒	❒	Other:	❒	❒	Other:	❒	❒	Other:

Please List any other conditions that you have ever been diagnosed with or are currently being treated for:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT AND CARE

I have been informed that is not uncommon that patients have some increased discomfort after an adjustment. If that happens, I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I can call the office of Olympic Health Chiropractic and get immediate attention. If I am out of town or unable to contact the doctor, I will present myself to an emergency room. If any tests were performed outside of Olympic Health Chiropractic (laboratory or other diagnostic procedures), I understand that the doctor can notify me of the results at my next scheduled appointment.

Patient's signature	Doctor's signature

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and if necessary, diagnostic x-ray, on me by Dr. James W. Haley, D.C. I have had the opportunity to discuss with Dr. James W. Haley, D.C. the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscles strains and sprains, disc injuries, physical therapy burns, rib injury, and strokes. Strokes are the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 no. 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments. 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 the doctor feels at the time, based upon the facts then known, as in my best interests.

Patient's signature	Doctor's signature

I have read the above consent, witnessed by the doctor, as indicated by our signatures. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient's signature	Doctor's signature

Name of Patient _____ Date Signed _____
Please Print

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OLYMPIC HEALTH CHIROPRACTIC

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I,_____ have received and read a copy of
(Print Name)

Olympic Health Chiropractic's Notice of Privacy Practices.

Sign _____ Date _____
(Sign Name)

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OLYMPIC HEALTH CHIROPRACTIC

RECEIPT OF APPOINTMENT CANCELLATION & TARDINESS POLICY WRITTEN ACKNOWLEDGEMENT FORM

CANCELLATION POLICY:

- **24 HOURS' ADVANCED NOTICE REQUIRED** - You **MUST call our main office line (386) 719-7909** prior to **24 hours before** your appointment.

NO-SHOW POLICY:

- **NO SHOWS WILL BE CHARGED 100% OF THE APPOINTMENT FEE. $50 for existing patients; $95 for new patients.**
- **New patients who fail to show for their initial visit will NOT be rescheduled.**
- Existing patients who fail to show for their appointment will charged a **$50.00 fee** *the FIRST time*, **$75.00 fee** *the SECOND time*, and a **$100 fee** *the THIRD time.*

LATE ARRIVALS POLICY:

- Patients who are over 15 minutes late will be asked to reschedule.
- Patients who arrive *over 15 minutes late* will charged a **$25.00 fee** *the FIRST time*, **$50.00 fee** *the SECOND time*, and **$75 fee** *the THIRD time.*

We reserve the right to **discontinue treatment** of patients who are habitually late, fail to show for their appointments or usually cancel with less than 24 hours' notice.

We cannot reschedule you for another appointment until applicable fees are paid in full.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who *may* be able to waive the **No Show fee**. You may contact Olympic Health Chiropractic during normal business hours between 8:30 am – 6 pm, M-F. Should it be after regular business hours, you may leave a message. ***A message left WITHOUT 24 hour's notice does not prevent incurring fees.****

Olympic Health Chiropractic Main Office (386) 319-7909

All Patients:

I understand and agree to the terms of *Olympic Health Chiropractic's* Appointment Cancellation Policy and agree to comply with any applicable penalty fees if incurred.

Signature of Parent/Guardian	Name of Minor Patient	Date	Doctor's signature	Date

For parents of minors:

I understand and agree to the terms of *Olympic Health Chiropractic's* Appointment Cancellation Policy and agree to comply with any applicable penalty fees on behalf of my child.

Signature of Parent/Guardian	Name of Minor Patient	Date	Doctor's signature	Date

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OLYMPIC HEALTH CHIROPRACTIC

APPOINTMENT CANCELLATION & TARDINESS POLICY

Thank you for trusting your chiropractic care to Olympic Health Chiropractic. When you schedule an appointment with Olympic Health, we set aside enough time to provide you with the highest quality care. Should you need to **cancel or reschedule an appointment,** please contact our office **24 hours BEFORE** your appointment time. This enables us to schedule other patients who are waiting for an appointment.

Arrival to the Office:

Please arrive for your appointment **10 minutes prior** to your scheduled appointment time to ensure a complete session. This allows you the time to fill out any appropriate forms, change clothing if necessary, and prepare for your treatment. It will also help you slow down and catch your breath from your busy day!

Please understand that Olympic Health Chiropractic **does not** over-book our schedule to cover for patients who cancel at the last minute or fail to show up.

If you cancel with less than 24 hours notice, fail to show up, or arrive very late (more than 15 minutes after your appointment start time) – that is lost opportunity that another patient could have used to be treated and lost revenue for the practice.

At Olympic Health Chiropractic, we understand that unanticipated/emergency events happen occasionally in everyone's life and the need may arise to cancel an appointment (i.e.: business meetings, car problems, illness, etc…)

In our desire to be fair to all patients and maintain a viable practice, the following policies will be honored:

24 HOURS' ADVANCED NOTICE REQUIRED FOR CANCELLING/RESCHEDULING APPOINTMENTS.

- To cancel/reschedule - **call our main office line (386) 719-7909** at least 24 hours prior to your appointment.

We reserve your appointment time for you specifically.

NO-SHOW POLICY:

- A No-Show is a patient who **misses their appointment** and **fails to call** our office to notify us.
- **NO SHOWS WILL BE CHARGED $50 FOR EXISTING PATIENTS; $95 FOR NEW PATIENTS**

LATE ARRIVALS POLICY:

- Patients arriving late will have their appointment shortened to the remainder of the originally scheduled end time. *Practitioners may try to accommodate for the change* ***if they are able****.*
- *Patients over 15 minutes late* ***will be asked to reschedule****.*
- Patients who are *over 15 minutes late* will be charged a **$25.00 fee** the FIRST time; **$50.00 fee** the SECOND time and **$75.00 fee** *the THIRD time.*

If more than **three (3)** appointments are **no-shows**, **missed**, **exceedingly late**, or **continued failure to cancel/reschedule** with at least **24 hours' notice**, Olympic Health Chiropractic reserves the right to **discontinue treatment**.

We cannot reschedule you for another appointment until applicable fees are paid in full.

We understand that sometimes life is a little out of your control and that unforeseen circumstances happen. Call our office as soon as you anticipate any issues and we will do our best to accommodate if at all possible.

Thank you for your cooperation. We look forward to helping you to Stop Letting Pain … Affect Your Game!

Appointment Scheduling: *Due to miscommunication and missed appointments, patients are not allowed to make appointments for other patients.*

Parents/Guardians: *The parent(s) or guardian(s) of minors are responsible for their child's schedule, making and keeping their appointments and are also subject to any applicable fees as stated in this notice.*

Please Note: *Not receiving a reminder is NOT an acceptable excuse for missing an appointment. We are looking into an automated reminder system. Even when we get this operating efficiently, it is the patient's sole responsibility to know of and show up to appointments in a timely manner.*

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