ADVANCED MOTION CHIROPRACTIC and sports medicine
6824 E Brown Rd Suite 101 Mesa, Az 85207

Dr. Tyson Adair D.C., M.S.
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New Patient Intake Form

Patient Information
Name: _____ Time of visit: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ □ Home □ Cell □Work Email: _____
Can we leave a confidential message on this number □ Yes □ No
***Date of Birth**: _____ Social Security #: _____
Gender: □ Male □ Female ***Marital Status:** □ Single □ Married □ Divorced □ Widowed
How did you hear about our office? _____
*Is this your first time seeing a chiropractor for anything? **Y/N** When: _____ Outcome: _____

Employment Information
Current Employment: □ Employed □ Retired □ Homemaker □ Student □ Other
Employer's Company Name: _____ Job Title: _____
Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact
Name: _____ Relationship: _____
Telephone #: _____ Email :_____

Health Insurance Information (if applicable – Please provide us with a current copy of your card and ID)
Do you have insurance which covers chiropractic care? □ Yes □ No *(If No skip this section)*
Insurance Carrier Name: _____ Group #:_____ I.D. #:_____
Insured Name: _____ Insured's Date of Birth_____

Do you have secondary insurance? □ Yes □ No *(If No skip this section)*
Secondary Insurance Carrier: _____ Group #:_____I.D. #:_____
Insured's Name: _____ Insured's Date of Birth_____

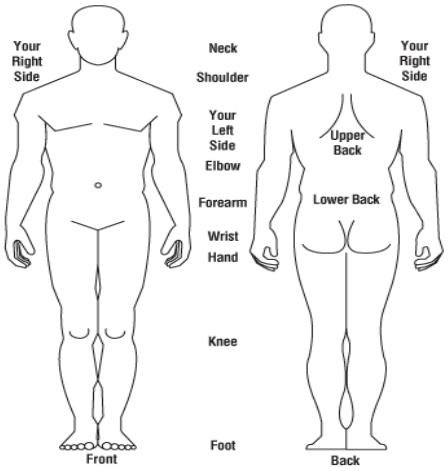
Current Medical Provider: _____ **Clinic Name:** _____
Can we contact them to discuss your care? □ Yes □ No If no, Why? _____

Previous health problems
Please check any of the following you have had or presently have: *(List estimated date/ year that apply)*
Example : □ Fractured Bones 01/01/1995

□ Fractured Bones	□ Slipped Spinal Disc	□ Pacemaker	□ Diabetes
□ Dislocations	□ Pinched Nerve	□ High Blood Pressure	□ Memory Lapse
□ Joint Replacement	□ Spinal Surgery	□ Electronic Implant	□ Fainting
□ Metal Screws/Implants	□ Spinal Injections	□ Aneurysm	□ Birth Defects
□ Cervical Whiplash	□ Epidural	□ Heart Disease	□ Alcoholism
□ Concussion	□ Spinal Taps	□ Lung Disease	□ Tumor
□ Knocked Unconscious	□ Scoliosis	□ Convulsions/Seizures	□ Cyst
□ Ruptured Spinal Disc	□ Osteoporosis	□ Dizziness	□ Stroke

Pregnancy: *Are you Pregnant? Y/N If Yes, how far along are you? _____ Are you High risk? Y/N

Is this visit related to?
□ Non-Injury Symptoms □ Sports or Recreation Injury □ Home Injury □ Work-Injury □ Auto Injury
□ Other_____ Onset: Gradual or Sudden Date of Injury (if any):_____



Draw your pain pattern: (*Please read carefully)* Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below:

Ache	>>>>>
Burning	XXXXX
Numbness	=====
Stabbing	/////
Pins & Needles	- - - - -
Throbbing	^^^^^
Shooting	******
Sharp	+++++++++
Tight/Stiff	)))))))))

Notes: (*fatigue, fever, weak, constipation, migraines, blurry vision etc…)*

_____
_____
_____
_____

Starting date of symptoms: _____
Duration of symptoms? _____
Symptoms: Better, Worse or Same?

***Rate pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)**

PERSONAL HEALTH HISTORY ***Height** _____ ***Weight** _____
Medications & Dosage, including over the counter, you currently take: _____
_____
*List any drug **allergies** you have: _____Reaction: _____
*Vitamins you currently take: _____
*List any serious illness you have had: _____
*Date of last physical examination: _____ Abnormal findings: _____
*Have you ever been diagnosed with cancer? **Y/N** If yes, what kind? _____

Family health history:** describe any conditions/diseases (i.e. heart disease, diabetes, and other inherited diseases) suffered by family members (list family members on Mother/Fathers side), i.e **MM** (Mom's Mother), **MF**(Mom's Father), **FM** (Father's Mother), **FF** (Fathers Father) or sibling) ***Please list age:_____
_____

Have you noticed any changes in your urinary and bowel function? (Y/N)_____
Are you experiencing muscle atrophy / muscle wasting? (Y/N)_____

***Smoking Status**: Y/ N Current Daily: ____ Former: ____ Never ____ How long? _____ Quit Date: _____
Alcohol:** Y/N ***(circle one) Daily/Weekly/Special Occasion How much? _____

Goals for my care:

- □ Relief Care: Symptomatic relief of pain or discomfort.
- □ Rehabilitative Care: Correcting and relieving the cause of the problem as well as the symptoms.
- □ Wellness Care: Bring the body to the highest state of health possible through nutrition, exercise, stress Relief, and Chiropractic care.

****** Notice to Medicare Patients:** Medicare only covers a limited amount of adjustments per year, as medically necessary. Medicare will NOT pay for the first visit New Patient Exam ($55) and therapies, see ABN form for further details. **The patient is responsible for any services rendered by Advanced Motion Chiropractic not covered by Medicare, including deductibles and copays.***

I, the undersigned patient/guardian, agree to pay for all services rendered and or products sold to me immediate upon demand by Advanced Motion Chiropractic. I further agree that in the event of 90 days past due payments to Advanced Motion Chiropractic, will be charged a **20%** late fee in addition to the past due amount.

Patient Signature: _____ Date: ___/____/_____

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HIPAA Privacy Act

Our Notice of Privacy Practice regarding the Health Insurance Portability and Accountability Act of 1996 is posted in our lobby in the binder titled HIPAA. The notice contains a patient's rights section containing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

You have the option to restrict the distribution of treatment, payment or healthcare operations information at any time; however, these restrictions and/or revocation must be in writing to your doctor's office. The doctor will be unable to honor your request in the event the health information has already been released.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not reflect the treatment we provide to you or the methods we use to obtain reimbursement for your care. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

By signing the form, I understand that:

- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree with those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon completion of this consent.
- We may phone, email or send a text to confirm appointments.
- We may leave a message on your answering machine at home or cell.

If you would like us to be able to discuss your medical condition with any member of your family, please list their names.

_____

_____

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of the authorization and that I have had the opportunity to view the complete HIPAA Act.

_____

Patient Name DOB

_____ _____

Patient Signature Effective Date

_____ _____

Parent/Guardian Signature (if for minor) Effective Date

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WELCOME TO OUR OFFICE

We are committed to providing you the best care and are pleased to discuss our professional fees with you at any time. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/ or procedures. Our office gladly accepts Visa, MasterCard, American Express, checks, and cash. We bill insurance as a courtesy to our patients, any services not covered by the patient's insurance are ultimately patient responsibility.

We do our best to have a flexible schedule, respectfully we ask our patients to communicate with us when schedule changes arise. We do not charge a fee for missed appointments, we do prefer a 24-hr notice to cancel an appointment.

CONSENT FOR EXAMINATION AND TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy on me (or the patient names below, for whom I am legally responsible) by the doctor of chiropractic, Dr. Tyson Adair and/or other licensed doctors of chiropractic who now or in the future work at the office listed above.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an 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(s) for which I seek treatment.

_____ ___/___/_____

Patient Name DOB

_____ ___/___/_____

Patient Signature Date

_____ ___/___/_____

Parent/Guardian Signature (if for minor) Date