ABOUT YOU:

Name: _____ DOB: _____ Age: _____ Date: _____

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

Contact Number: _____ Email: _____

Emergency Contact: _____ Phone Number: _____

PAST MEDICAL HISTORY:

Circle all that apply: Heart Problem Kidney Problem Liver Problem Tuberculosis
Thyroid Problem Respiratory Problem Sinus Problem Digestive Problem
Rheumatic/Scarlet Fever Venereal Disease TMJ/TMD Cancer/Tumors
Hepatitis HIV/AIDS Arthritis/Rheumatism Lupis Shingles Anemia
Leukemia Diabetes/Hypoglycemia High/Low BP Chemotherapy
Fainting/Seizures Epilepsy Artificial Joint/Implants

List any surgeries, procedures, or medical conditions: _____

_____

SOCIAL AND PREVENTATIVE HISTORY:

Occupation: _____ Employer: _____
Marital Status: Single Married Divorced Widowed
Children: Yes No How Many: _____

Do you use tobacco products? Yes No How Long: _____ How Often: _____
Do you drink alcohol? Yes No How many drinks per month? _____
Do you exercise? Yes No How Often: _____

Do you have any allergies (Latex, Foods, Etc.)? _____
Women, please circle any that apply: Taking Birth Control Pregnant Nursing

Do you currently take any supplements? Yes No List: _____
Are you interested in a FREE analysis of your current supplementation regimen? Yes No
Are you interested in learning more about the benefits of WHOLE FOOD supplementation? Yes No

REASON FOR YOUR VISIT:

(Please include ALL issues and complaints experienced within the last six (6) months for insurance purposes; our office can provide additional paper if needed.)

What is the patient's **PRIMARY** complaint? _____ Intensity of pain 0-10: ____

Onset (when did it begin?): _____ How did it begin? _____

Character (circle): Dull Ache Sharp Stabbing Burning Throbbing Stiffness Pounding Other: _____

Duration: Intermittent Occasional Frequent Constant

Aggravating Factors: Cough/sneeze Lifting Sitting Standing Pushing Pulling Driving Walking Bending Lying Sleeping Bright lights Noise Other: _____

Relieving Factors: Rest NSAIDS Pain Meds Ice/Heat Sitting Standing Lying Sleeping Exercise

What is the patient's **SECONDARY** complaint? _____ Intensity of pain 0-10: ____

Onset (when did it begin?): _____ How did it begin? _____

Character (circle): Dull Ache Sharp Stabbing Burning Throbbing Stiffness Pounding Other: _____

Duration: Intermittent Occasional Frequent Constant

Aggravating Factors: Cough/sneeze Lifting Sitting Standing Pushing Pulling Driving Walking Bending Lying Sleeping Bright lights Noise Other: _____

Relieving Factors: Rest NSAIDS Pain Meds Ice/Heat Sitting Standing Lying Sleeping Exercise

---

Patient: *Date:*

OFFICE USE ONLY.

X-Rays: _____

Orthos: _____

Function Leg Length Difference:

Neurological: _____

Muscle Testing: _____

Previous Spinal Surgery: _____

Subluxations: _____

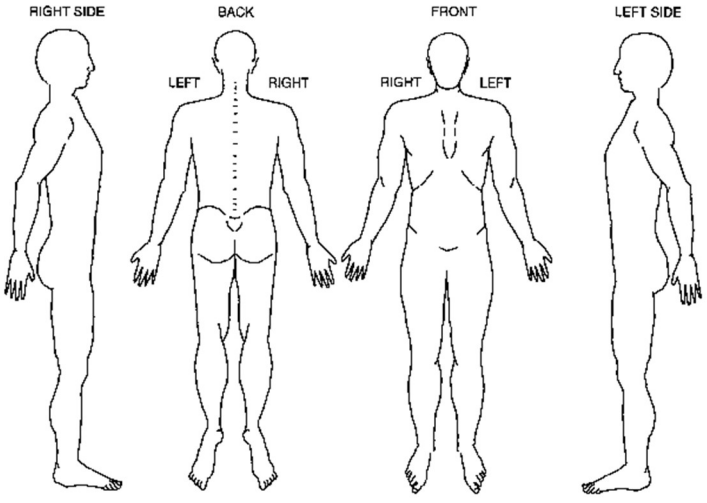
Grip Strength: R ☐ ☐ ☐ = ___

L ☐ ☐ ☐ = ___

ROM: Cerv ___ ___

Thoracic___ ___

Lumbar ___ ___



*Disclaimer: This written exam form may not contain all detailed information about this patient's exam findings. Detailed information is available upon request after our physician has completed his documentation in our digital records.

Electronic Health Records Intake Form

In Compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email Address:_____@_____

Preferred method of communication for patient reminders (circle one): Email / Phone / Mail

DOB: ___/___/____ Gender (Circle One): Male / Female **Preferred Language: _____**

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

NOTICE OF PRIVACY PRACTICES:

I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent.
- The right to object the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I authorize Milo Chiropractic to speak to the following people about my treatment or account information:

Name: _____ Phone: _____

Name: _____ Phone: _____

I understand that I can revoke the above authorization at any time by submitting a request in writing to Milo Chiropractic.

CONSENT TO TREAT:

I voluntarily consent to the care and any diagnostics being recommended by my treating physician here at Milo Chiropractic. Of course, any and all treatment/diagnostics will be explained prior.

- ✓ **INITIAL**(Female patients only) VERIFICATION OF NON-PREGNANCY:

I do hereby state that to the best of my knowledge I am not pregnant at this time_____

MEDICARE & MEDICAID CONSENT TO RELEASE:

I certify that the information given by me, in applying for payment under the Social Security Act, is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or it's intermediary earners.

By signing below I acknowledge that I have read and understand **ALL** of the above information.

Print Patients Name:_____DATE:_____

Signature of Patient or Guardian:_____

Financial Policy Summary

Notice

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- We are a network provider in a DMPO that you may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.

As part of our compliance plan, as of January 1st, 2021 our office will be unable to extend any type of discounts other than those listed above.

Acknowledged by: _____Date: _____

Massage No Show Policy

Due to an increase in patients not attending scheduled massage appointments, we feel it necessary to strictly enforce our **No Show Policy**.

You are required to contact our office **twenty-four (24)** hours in advance to cancel or reschedule. In the event that you contact the office the day of, or more than **twenty (20)** minutes late for a scheduled massage, you will be charged a $75 **No Show Fee.**

FIRST OFFENSE No Show Fee May be waived as a courtesy

SECOND OFFENSE You will be required to prepay for massage appointment at time of scheduling.

EXCEPTIONS: Medical or legal documentation excusing a **No Show**.

I have read and understand the above policy and agree to the terms.

Print Name: _____ Date: _____

Signature:_____ Date:_____

Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 *Unbearable Pain*

Name: _____ Date: _____

Instructions: Please circle only **ONE NUMBER** in each section which mostly describes your problem.

Section 1 – Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, dressing, etc.)

0. I do not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, ie: on a table.
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking

0. I have no pain when walking.
1. I have some pain when walking, but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 - Sitting

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes
5. I avoid sitting because it increases pain immediately.

Section 6 - Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping

0. I have no pain in bed.
1. I have pain in bed, but it does not prevent me from sleeping well.
2. Because of my pain my normal night's sleep is reduced by less than ¼.
3. Because of my pain my normal night's sleep is reduced by less than ½.
4. Because of my pain my normal night's sleep is reduced by less than ¾ .
5. Pain prevents me from sleeping at all.

Section 8 – Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, ie: dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 - Traveling

0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it worse.
2. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
3. I get extra pain while traveling which compels me to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates, but is definitely getting better.
2. My pain seems to be getting better, but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Neck Pain Scale

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 *Unbearable Pain*

Name: _____ Date:_____

Instructions: Please circle the **ONE NUMBER** in each section that most closely describes your problem.

Section 1 – Pain Intensity

0 I have no pian at the moment.
1 The pain is very mild at the moment
2 The pain is moderate at the moment
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

Section 2 – Personal Care (washing, dressing, etc.)

0 I can look after myself normally without causing extra pain
1 I can look after myself but it causes extra pain
2 It is painful to look after myself if I am slow and careful
3 I need some help but can manage most of my personal care
4 I need help every day in most aspects of self care
5 I do not get dressed, wash with difficulty and stay in bed

Section 3 – Lifting

0 I can lift heavy weights without extra pain
1 I can lift heavy weights but it gives me extra pain
2 Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently placed
3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed
4 I can only lift very light weights
5 I cannot lift or carry anything

Section 4 - Reading

0 I can read as much as I want with no neck pain
1 I can read as much as I want to with only a slight increase in neck pain
2 I can read as much as I want to with moderate increase in my neck pain
3 Pain prevents me from reading as much as I want to
4 I can hardly read at all because of neck pain
5 I cannot read at all because of neck pain

Section 5 – Headaches

0 I have no headaches at all
1 I have mild headaches that come infrequently
2 I have moderate but infrequent headaches
3 I have moderate and frequent headaches
4 I have severe and frequent headaches
5 I have a headache almost all the time

Section 6 – Concentration

0 I can concentrate fully and with no difficulty
1 I can concentrate fully but with slight difficulty
2 I can concentrate fully but only for short periods of time
3 I have a fair degree of difficulty concentrating
4 I have a lot of difficulty concentrating
5 I cannot concentrate at all

Section 7 – Sleeping

0 My sleep is never disturbed by pain
1 My sleep is occasionally disturbed by pain
2 Because of pain I have less than 6 hours sleep at night
3 Because of pain II have less than 4 hours sleep at night
4 Because of pain I have less than 2 hours sleep at night
5 I can't sleep at all because of the pain

Section 8 – Work

0 I can do as much work as I want to
1 I can only do my usual work but no more
2 I can do most of my usual work but with difficulty
3 I cannot do my usual work
4 I can hardly work
5 I cannot work at all

Section 9 – Social Life

0 My social life is normal and gives me no extra pain
1 My social life is normal but increases my pain
2 Pain limits only my more energetic interests, ie: sports
3 Pain has restricted my social life and I do not go out as often
4 Pain has restricted my social life to home
5 I have no social life because of pain

Section 10 – Traveling

0 I can travel anywhere without pain
1 I can travel anywhere but it gives me extra pain
2 Pain is bad but I manage trips longer than 2 hours
3 Pain restricts me to trips of less than 1 hour
4 Pain restricts me to trips of less than 30 minutes
5 Pain prevents me from traveling