# Patient Intake Form

**Name:** _____ **Date:** _____

**Date of Birth:** _____ ☐ **male** ☐ **female**

**Address:** _____

_____

**Social Security #:** _____

**Phone #:** mobile: _____ work: _____

**E-mail address:** _____

**Emergency Contact #1:**_____

Phone:_____Relationship:_____

Address:_____

State/Zip:_____

**Marital status**

| S | M | W | D | SEP |
|---|---|---|---|---|

**Height:** _____

**Weight:**_____

**Patient Occupation:**_____

**Patient Employer:** _____

How did you hear about us? _____

***Check ☑ and indicate the age when you had any of the following:***

**Check any of the conditions you have or have had:**

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Bronchitis
☐ Cancer
☐ Chicken pox
☐ Cold sores
☐ Diabetes
☐ Eczema
☐ Edema
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart burn
☐ Heart disease
☐ Hepatitis
☐ Herpes
☐ High cholesterol
☐ HIV/AIDS
☐ Influenza
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps
☐ Numbness/tingling
☐ Pace maker
☐ Osteoporosis
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers

**General**

☐ Allergies
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fatigue
☐ Fever
☐ Headaches
☐ Loss of sleep
☐ Mental illness
☐ Nervousness
☐ Tremors
☐ Weight loss / gain

**Muscle / Joint**

☐ Arthritis / rheumatism
☐ Bursitis
☐ Foot trouble
☐ Muscle weakness
☐ Low back pain
☐ Neck pain
☐ Mid back pain
☐ Joint pain

**Women only**

☐ Congested breasts
☐ Hot flashes
☐ Lumps in breast
☐ Menopause
☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps

Days of flow: ____ Length of cycle: _____
Date - 1st day last period: _____

Are you pregnant? ☐ yes, ☐ no
If yes, how many months? _____
How many children do you have? _____
Birth control method: _____
Date of last PAP test: _____

☐ normal, ☐ abnormal

Date of last mammogram: _____

☐ normal, ☐ abnormal

**Please list any medication you are currently taking and why:**

_____

_____

_____

_____

## Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

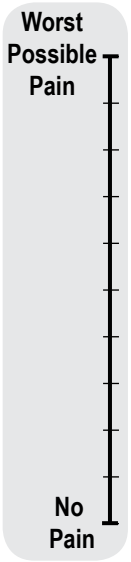
Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

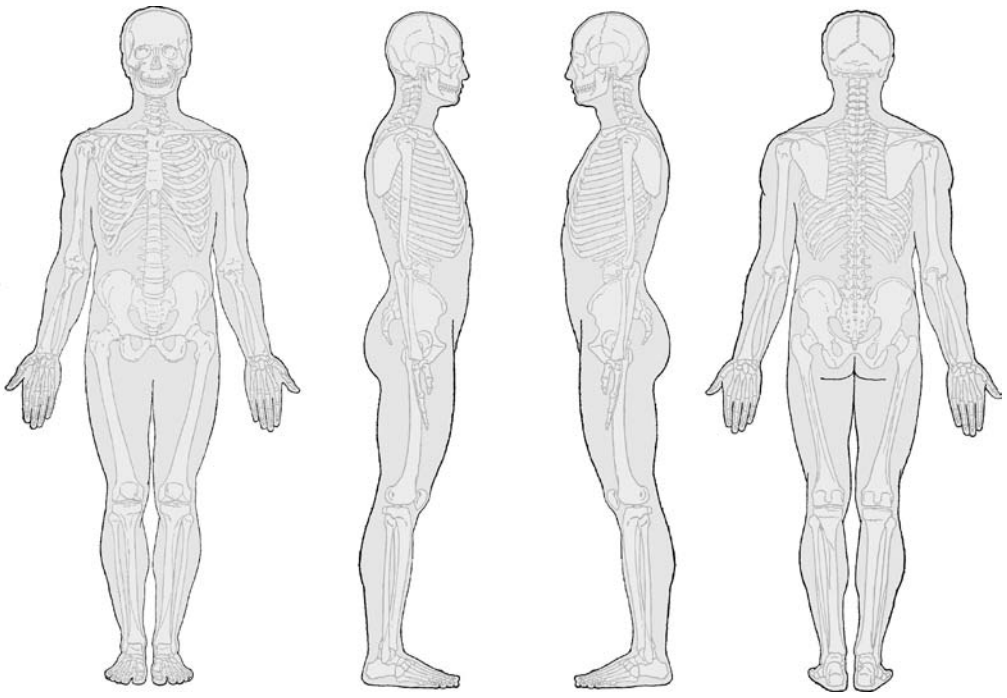
What seemed to be the initial cause: _____

Have you had this before? □ yes, □ no If yes, what treatment did you seek? _____

***Please mark you area(s) of pain on the figure below***

***Please place a mark at the level of your pain on the scale below:***



### Past health history

| Have you... | Yes | No | If yes, explain briefly |
|---|---|---|---|
| ... been hospitalized in the last 5 year? (Include Urgent Care and E.R. Visits) | □ | □ | _____ |
| ... had any mental disorders? | □ | □ | _____ |
| ... had any broken bones? | □ | □ | _____ |
| ... had any strains or sprains? | □ | □ | _____ |
| ... ever used orthotics? | □ | □ | _____ |
| Do you take minerals, herbs or vitamins? | □ | □ | _____ |

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

| Habits | none | light | mod. | heavy |
|---|---|---|---|---|
| Alcohol | □ | □ | □ | □ |
| Coffee | □ | □ | □ | □ |
| Tobacco | □ | □ | □ | □ |
| Drugs | □ | □ | □ | □ |
| Exercise | □ | □ | □ | □ |
| Sleep | □ | □ | □ | □ |
| Soft drinks | □ | □ | □ | □ |
| Salty foods | □ | □ | □ | □ |
| Water | □ | □ | □ | □ |
| Sugar | □ | □ | □ | □ |

### Family history

***If any blood relative has had any of the following conditions, please check and indicate which relative(s)***

| | | |
|---|---|---|
| □ Alcoholism | □ Cancer | □ High blood pressure |
| □ Anemia | □ Diabetes | □ High cholesterol |
| □ Arteriosclerosis | □ Emphysema | □ Multiple sclerosis |
| □ Arthritis | □ Epilepsy | □ Osteoporosis |
| □ Asthma | □ Glaucoma | □ Stroke |
| □ Bleed easily | □ Heart disease | □ Thyroid disease |

**Do you have any other health issues or concerns that our staff should be made aware of?** _____

_____

Justin Merryman D.C
201 W. Lakeway Rd. Ste. 211
Gillette, WY 82718

Thank you for choosing Merryman Spinal and Sports. After an examination, we may recommend chiropractic care, dry needling and/or other modalities as part of your treatment plan. The purpose of this consent form is to help you understand the potential benefits and medically significant risks associated with the treatments we offer, so you can make informed decisions whether to give or withhold your consent to any particular treatment. We are unable to anticipate and explain all risks and complications that may be associated with chiropractic care and dry needling. The information below provides you with an overview of different types of treatment, but not limited too, and informs you of potential benefits and medically significant risks known to us, but is not intended to be exhaustive. We encourage you to ask questions regarding any treatments that may be recommended to you.

**Chiropractic**: The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of quick force directed over a very short distance to a specific vertebra or bone. Adjustments are usually performed by hand but may also be performed by hand-guided instruments to improve mobility and function, and reduced muscle spasm. Chiropractic treatments generally are considered safe, but as with most types of health care, there are associated risks. The most commonly reported reactions include soreness and discomfort, headaches, tiredness, radiating discomfort, and dizziness, all of which usually disappear within 48 hours. Rare, but medically significant, risks associated with chiropractic care include, but are not limited to, fracture, joint dislocation, disc hernia or injury, increased symptoms of pain, or stroke. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused or may be caused, by spinal adjustment or chiropractic treatment. It is also possible that a patient will feel no improvement in symptoms of pain.

**Trigger Point Dry Needling:** Trigger point dry needling (TDN) involves placing a small fusiform needle into the muscle at the trigger point in order to cause the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms. TDN is a valuable treatment for musculoskeletal pain. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment. Trigger point dry needling is not intended to stimulate any distal or auricular acupuncture points.

**Risks of the procedure**: The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. Other risks may include excessive bleeding (causing a bruise), infection and nerve injury. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of significant tissue trauma from TDN is unlikely. Please consult with your practitioner if you have any questions regarding the treatment above.

*I acknowledge that I have read and fully understand this patient consent form, I have had the opportunity to have questions answered by the doctor. Based on this information and discussion with my provider(s), I consent to the following treatment(s) I also understand that my consent is ongoing in the event that I choose not to accompany my child/minor to these events/sessions in the future. Consent may be revoked in writing at any time.*

**Chiropractic* **Trigger Point Dry Needling* **Tractioning* **Fascial Distortion Model*

*Print Patient Name:* _____ *Parent/Guardian* _____

*Patient/Parent/Guardian Signature:* _____ *Date:* _____

# FINANCIAL POLICY

Chiropractic is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy*as it applies to your particular situation.*

BLUE CROSS BLUE SHIEID OF WY PATIENTS We only accept BCBS insurance. When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

OTHER INSURANCE OR NO INSURANCE PATIENTS We request that 100% of the first visit be paid at the time of the visit unless other arrangements have been pre-arranged and agreed upon. A payment plan can be established in writing, including Credit Care. you have insurance outside of BCBS, we can submit your payments to your insurance for
possible reimbursement and to go towards your "out of network" deductible.

"ON THE JOB" INJURY (Worker's Compensation) If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within three months, or if you suspend or terminate care, any fees and services are due by you immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

MEDICARE We do not file Medicare or work with Medicare in any way. By signing this agreement, you agree to pay cash or file through BCBS or workers compensation.

SECONDARY INSURANCE Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

*I understand that my insurance is an arrangement between myself insurance company,NOT between Dr. Justin Merrymanand my insurance company. I request that Merryman Spinal and Sports prepare the customary forms at no charge so that I may obtaininsurance benefits. I also understand that if my insurance does not respond within 60days, or if I suspend or terminate my schedule of care as prescribed by Dr. Justin Merryman, that fees will be due andpayable immediately.*

Assignment of Benefits

*I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance or pre-paid health care plan, be made directly to: Merryman Spinal and Sports.*

Release of Information

*I authorize the release of any information concerning my health and health care services to my insurance companies or pre-paid health plan.*

Payment Agreement

*I understand that there is no guarantee that my insurance companies, pre-paid health plan, or workers compensation will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.*

Signature of Patient: _____ Date: _____

Signature of Guardian: _____ Date: _____

PRIVACY POLICY Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations. You may revoke this consent at any time by notifying Merryman Spinal and Sports in writing, except to the extent Merryman Spinal and Sports has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosures that Merryman Spinal and Sports may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request Merryman Spinal and Sports to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. Merryman Spinal and Sports is not required to agree to requested restrictions. If Merryman Spinal and Sports agrees to the requested restriction, Merryman Spinal and Sports will honor the request and it will be binding on the office.

*I hereby consent to the use and disclosure by Dr. Justin Merryman and Merryman Spinal and Sports' workforce, and its business associates of my protected health information for the purposes of treatment, payment, and health care operations.*

_____

Signature Date

_____

Guardian Signature Relation to Patient Date