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www.resiliencehc.com

RESILIENCE HEALTH CENTER

NEUROPATHY INTAKE FORM

HELLO AND WELCOME TO RESILIENCE HEALTH CENTER!
Who may we thank for referring you / how did you hear about us? _____
Have you received care for your neuropathy in the past? ❑ No ❑ Yes (from whom?) _____

Please fill out the following information completely and to the best of your ability.
Remember to initial the bottom of each page.

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____
Preferred Name: _____ Gender: ❑ Male ❑ Female
Email: _____ Marital Status: ❑ S ❑ M ❑ D ❑ W
Street Address: _____ City/State/Zip: _____
Cell Phone: _____ Home Phone: _____
Occupation/Employer: _____ Work Phone: _____
Spouse's Name: _____ Phone Number: _____
Your Occupation: _____ Retired? ❑ No ❑ Yes
Emergency Contact: _____ Relationship to You: _____
Cell Phone: _____ Hobbies: _____

PERSONAL HEALTH HISTORY

List your current:
Height: ____ ft. ____ in.
Weight: _____lbs.

What is your typical daily work activity?
❑ Sitting ❑ Standing ❑ Light Lifting ❑ Heavy Lifting ❑ Driving
❑ Working at a Computer ❑ Manual Labor ❑ Other: _____

Do you have any genetic disorders or disabilities? ❑ No ❑ Yes (If yes, *explain*): _____

Indicate if you have experienced any of the following:
❑ N/A
❑ Serious illnesses, operation, or health emergency
❑ Been in a motor vehicle accident
❑ Been unconscious due to an illness or injury
❑ Fractured a bone
Explain (include year(s)): _____

SOCIAL HISTORY

Do you smoke? ❑ Never ❑ In the Past ❑ Occasionally ❑ Daily
Are you exposed to secondhand smoke? ❑ Never ❑ In the Past ❑ Occasionally ❑ Daily
Do you drink alcohol? ❑ Never ❑ In the Past ❑ Occasionally ❑ Daily
Do you use recreational drugs? ❑ Never ❑ In the Past ❑ Occasionally ❑ Daily
How often do you exercise? ❑ Never ❑ In the Past ❑ Occasionally ❑ Daily

CHIEF COMPLAINT / HISTORY OF PRESENTING ILLNESS

What is the MAIN symptom/pain/reason you are seeking chiropractic care?

PROBLEM/CONCERN #1: _____

- WHEN did this problem begin? _____ Is it constant or intermittent? _____
- Did you do something / did something happen that aggravated the problem? ❑ No ❑ Yes
  Explain: _____
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____
- Does the problem RADIATE outward from a source? _____
- What RELIEVES the problem? _____
- What makes the problem WORSE? _____

Are there any SECONDARY health concerns you wish to bring to our attention? ❑ No ❑ Yes

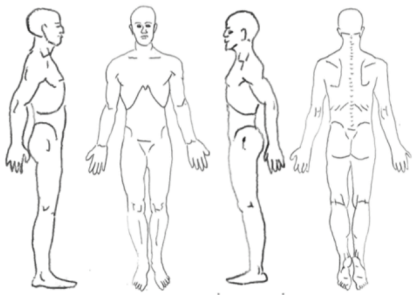
PROBLEM/CONCERN #2: ❑ N/A _____

- WHEN did this problem begin? _____ Is it constant or intermittent? _____
- Did you do something / did something happen that aggravated the problem? ❑ No ❑ Yes
  Explain: _____
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____
- Does the problem RADIATE outward from a source? _____
- What RELIEVES the problem? _____
- What makes the problem WORSE? _____

DIRECTIONS: CIRCLE the area(s) on the diagram that relate to your pain/symptom(s)/issue(s):

How would you describe the problem(s)?

❑ Dull ache ❑ Burning ❑ Stiff/Tight
❑ Tingling ❑ Radiating ❑ Deep, boring
❑ Pounding ❑ Numb ❑ Sharp/Stabbing
❑ Other: _____



PAST HISTORY

How long have you been diagnosed with Neuropathy? ❑ Months_____ ❑ Years_____

- What sort of treatment did you seek before? ❑ N/A _____
- What were the results of your previous treatment? ❑ N/A _____

Help us identify past conditions or procedures that could be related to your main issue:

❑ Past surgeries ❑ Childhood diseases ❑ Past injuries ❑ N/A *Explain*: _____

_____

Have you experienced or been diagnosed with any of the following? ❑ N/A

❑ Pain that wakes you up at night ❑ Night Sweats ❑ Stroke ❑ Heart Attack ❑ Diabetes
Explain: _____

QUADRUPLE VISUAL ANALOG SCALE

Name: _____ **Date:** _____

PLEASE READ CAREFULLY

DIRECTIONS: Fill in your problem(s)/concern(s) from the previous page. *Regarding these problem(s)/concern(s)*, please CIRCLE the number that best describes the question being asked.

PROBLEM/CONCERN #1: _____

1. What is your pain RIGHT NOW?

No Pain _____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

2. What is your TYPICAL or AVERAGE pain?

No Pain _____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain _____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

PROBLEM/CONCERN #2: ❑ N/A _____

1. What is your pain RIGHT NOW?

No Pain _____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

2. What is your TYPICAL or AVERAGE pain?

No Pain _____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain _____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10 Possible

OTHER COMMENTS: _____

Examiner Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

(OFFICE USE ONLY) 1 ____ 2 _____

PATIENT INITIALS ____

ACTIVITIES OF DAILY LIVING

DIRECTIONS: Assess your ability / lack of ability to complete the following activities.

Activity	***Without*** Pain or Difficulty	***With Minimal*** Pain or Difficulty	***With Significant*** Pain or Difficulty	***CANNOT COMPLETE*** *Due to pain or injury*	N/A
Bathe/Shower	❑	❑	❑	❑	❑
Groom Hair	❑	❑	❑	❑	❑
Brush Teeth	❑	❑	❑	❑	❑
Use Toilet	❑	❑	❑	❑	❑
Dress Upper Body	❑	❑	❑	❑	❑
Dress Lower Body	❑	❑	❑	❑	❑
Daily Physical Activities	❑	❑	❑	❑	❑
Stand	❑	❑	❑	❑	❑
Walk	❑	❑	❑	❑	❑
Sit	❑	❑	❑	❑	❑
Squat	❑	❑	❑	❑	❑
Kneel	❑	❑	❑	❑	❑
Reach Overhead	❑	❑	❑	❑	❑
Bend Forward	❑	❑	❑	❑	❑
Turn Left	❑	❑	❑	❑	❑
Turn Right	❑	❑	❑	❑	❑
Move from Seated to Standing	❑	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	❑
Eat	❑	❑	❑	❑	❑
Go Up/Down Stairs	❑	❑	❑	❑	❑
Get In/Out of Car	❑	❑	❑	❑	❑
Drive	❑	❑	❑	❑	❑
Use Computer	❑	❑	❑	❑	❑
Focus/Concentrate	❑	❑	❑	❑	❑
Prepare Food	❑	❑	❑	❑	❑
Household Chores	❑	❑	❑	❑	❑
Lift Children	❑	❑	❑	❑	❑
Carry Bag/Purse	❑	❑	❑	❑	❑
Run/Hike	❑	❑	❑	❑	❑
Sexual Activity	❑	❑	❑	❑	❑

PATIENT INITIALS _____

REVIEW OF SYSTEMS & ORGAN DYSFUNCTION

DIRECTIONS: Please check all that apply:

❑ Arthritis in Hands	❑ Arthritis in Feet	❑ Tingling in Hands	❑ Tingling in Feet
❑ Numbness in Hands	❑ Numbness in Feet	❑ Tremors	❑ Swelling of Legs/Feet
❑ Carpal Tunnel Syndrome	❑ Pacemaker/ Defibrillator	❑ Poor Circulation	❑ Vascular Problems
❑ Foot Pain	❑ Hand Pain	❑ High Blood Pressure	❑ Low Blood Pressure
❑ High Cholesterol	❑ Dizziness/Vertigo	❑ Headaches	❑ Migraines
❑ Difficulty Sleeping	❑ Anxiety/Depression	❑ Allergies/Sinus Problems	❑ Acid Reflux/ Heartburn/GERD
❑ Asthma/Difficulty Breathing	❑ Cancer Type: _____	❑ Chemotherapy	❑ Diabetes
❑ Morton's Neuroma	❑ Irritable Bowel Syndrome	❑ Chest Pain	❑ TMJ/Jaw Pain
❑ Mid-Back Pain	❑ Leg Pain	❑ Low Back Pain	❑ Neck Pain
❑ Sciatica	❑ Degenerative Disc	❑ Disc Herniation	❑ Scoliosis
❑ Spinal Stenosis	❑ Plantar Fasciitis	❑Joint Replacement	❑ Poor Wound Healing

ORGANIC SYSTEM PROBLEMS

* **Select ALL that apply:**

❑ Digestive	❑ Gallbladder	❑ Heart	❑ Liver
❑ Stomach	❑ Pancreas	❑ Reproductive	❑ Lung/Respiratory
❑ Urinary	❑ Kidney	❑ Prostate	❑ Vision
❑ Thyroid	❑ Skin	❑ Sexual	❑ Other (s)

***Explain*:** _____

_____

PATIENT INITIALS ____

PREVIOUS HEALTH HISTORY

List ALL allergies/sensitivities to medication, food, and other items here:

Item you react to:	Reaction:

List the prescription drugs you are currently taking (or you may attach a list):

Name:	Dose (mg or IU):	Times Daily:

List all nutritional supplements (vitamins, herbs, homeopathic, etc. you are currently taking:

Name:	Dose (mg or IU):	Times Daily:

PATIENT INITIALS _____

Name: _____ Date: _____

TERMS OF ACCEPTANCE

Please read the below and if you have any questions, feel free to ask one of our staff members.

RESILIENCE HEALTH CENTER NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS: If you wish to make a formal complaint about how we handle your health information, please call Dr. Rob Michaud (269) 389-0345. If he is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201.

(Please see next page)

PATIENT INITIALS _____

RESILIENCE HEALTH CENTER NOTICE REGARDING YOUR RIGHT TO PRIVACY (CONTINUED)

I have received a copy of Resilience Health Center Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Name: _____ **Date:** _____

Signature: _____ **Date of Birth:** _____

AUTHORIZATION FOR X-RAYS

X-rays are utilized in the office to help location and analyze **vertebral subluxations**. These x-rays are not to be used to investigate for medical pathology. The doctors of Resilience Health Center do not diagnose or treat medical conditions; however if any abnormalities are found, they will be brought to your attention so that you can seek proper medical advice. By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Signature: _____ **Date:** _____

(***Women Only***) **Please check the box that applies to you -** To the best of my knowledge:

❏ I **AM** **NOT** pregnant at this time

❏ I **AM**/believe **I MAY BE** pregnant, therefore I **DO** **NOT** authorize Resilience Health Center to X-ray me at this time.

Signature: _____ **Date:** _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Resilience Health Center to release all necessary information concerning my health condition to my billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize Resilience Health Center to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Resilience Health Center to proceed with call necessary tests, diagnosis, analysis, and adjustments.

Signature: _____ **Date:** _____

PATIENT INITIALS _____

INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ **Signature:** _____ **Date:** _____

Parent or Guardian: _____ **Signature:** _____ **Date:** _____

Witness Name: _____ **Signature:** _____ **Date:** _____

PATIENT INITIALS _____