

Prenatal Intake

Patient Name:	Date:
How many weeks/days pregnant:	Age:
OB/Midwife group:	Phone:
Name of Primary OB/Midwife:	
Estimated due date:	Gender (circle one): Male Female Not Finding Out
Delivering at:	
Whom may we thank for referring you to our practice?:	

Current Pregnancy

What is the reason for your visit today? _____

Are you currently seeing any other health care providers (massage therapists, acupuncturists, etc.)?

Do you plan to work with a doula? If yes, whom? _____

Have you had any health complications/concerns, or abnormal test results during this pregnancy?

What medications and/or supplements are you currently taking? _____

- Pregnant with multiples
- Morning sickness, nausea, vomiting
- Placenta previa
- Swollen hands or feet
- Gestational diabetes
- Vaginal spotting or bleeding
- Constipation
- Pubic pain
- High blood pressure
- Leg cramps, restless legs
- Premature labor
- Bladder or kidney infection
- Bed rest (or 'modified' best rest)
- Labeled as 'high risk'

What type of birth do you plan on having (circle one)? Vaginal VBAC Caesarian

Are there any other health concerns, problems, or questions you would like the doctor to know about or address? _____

Previous Pregnancy History

How many times have you been pregnant, including this one and any pregnancy losses? _____

Do you have concerns from a previous pregnancy, labor, birth, or postpartum period you would like to address during this pregnancy? _____

Please list all pregnancies that ended in birth below:

Birth Date	Name/ Gender	Gestational age at birth (weeks/days)	Length of Labor	Weight	Vaginal? (V) C-Section? (C)	Epidural? Spinal? (Yes/No)	Describe any complications below*	Living? (Yes/No)

* _____

Please list all pregnancies that ended in miscarriage or abortion below:

Date	Gestational Age (# of weeks)	Miscarriage (M) Abortion (A)	Ectopic? (Yes/No)	Describe any complications

Additional information: _____

For Breech presentation only:

Do you know what position your baby is currently in? _____

What was the date of your most recent Ultrasound? _____

Has your OB/Midwife discussed the possibility of an External Cephalic Version (ECV)? _____

Have you been scheduled for any upcoming tests/procedures (Ultrasound, ECV, C-Section, etc.)? _____

Patient Information

Name:			Date
Address/City/State/ZIP:			
Date of Birth:	Age:	Gender: M F	Social Security #:
Cell Phone:	Home:	Work:	
Email (for appointment reminders):			
Emergency Contact:	Phone:	Relationship:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Living with partner <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced			
Spouse/Partner Name:		# of Children:	
Primary Care Physician:		Phone:	
Whom may we thank for referring you to our practice?:			

Health Main condition/symptom: _____

History Other condition/symptoms: _____

How long have you had these symptoms? _____

Height: ___ ft ___ in Weight: ___ lbs. Last known Blood Pressure: ___ / ___

Hypertension: Yes No Diabetes: Yes* No *If Yes: ___ Type I ___ Type II

Surgeries: _____ Approx. dates: _____

Hospitalizations: _____ Approx. dates: _____

Major Illnesses: _____ Approx. dates: _____

Allergies: Cortisone Latex Other: _____

Food Allergies: _____

Medication Allergies: _____

Medication List (include regularly used over-the-counter medications.)

Medication Name	Dosage and Frequency

Family Medical History

Family Member	Diagnoses/Details

Social History

Smoking	Caffeine	Recreational Drug Use	Alcohol
<input type="checkbox"/> never	<input type="checkbox"/> never	<input type="checkbox"/> never	<input type="checkbox"/> never
<input type="checkbox"/> former	<input type="checkbox"/> fewer than 3 per day	<input type="checkbox"/> recreational	<input type="checkbox"/> 1-3 per week
<input type="checkbox"/> every day	<input type="checkbox"/> 3-6 per day	<input type="checkbox"/> addiction	<input type="checkbox"/> 4-6 per week
<input type="checkbox"/> occasionally	<input type="checkbox"/> more than 3-6 per day	<input type="checkbox"/> in recovery	<input type="checkbox"/> more than 6 per week

Occupation: _____ or full-time parent unemployed in school retired
 Employer: _____

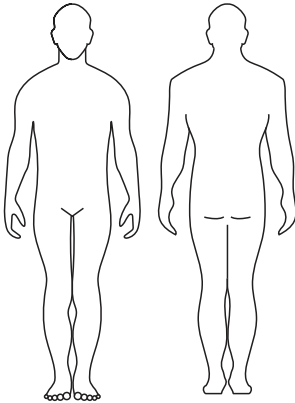
Have you been bothered by any of the following problems?

- 1) During the past month, have you felt down, depressed or hopeless? Yes No
- 2) During the past month, have you felt little interest or pleasure in doing things? Yes No

Current Complaints

Using the symbols below, please indicate the location of your discomfort on the body diagram.

- SHARP/STABBING † † † †
- DULL/ACHEY V V V V
- PINS/NEEDLES 0 0 0 0
- NUMBNESS \ \ \ \



Please circle your pain level: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Do you have pain every day? Yes No Does your pain wake you at night? Yes No

What increases your pain? _____

What decreases your pain? _____

Are your symptoms: Worsening Unchanged Improving

Have you had previous chiropractic care? Yes No

Have you seen other doctors for this condition? If so, who? _____

Do you perform neck/back exercises? Yes No Date of last physical exam: _____

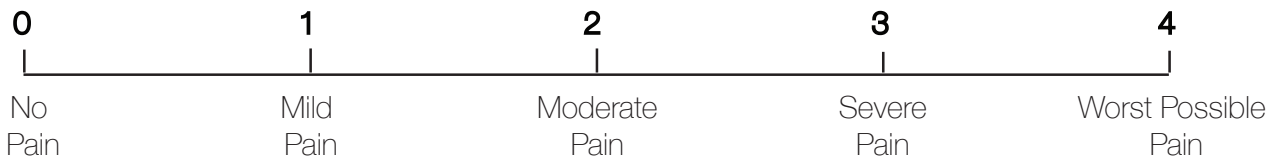
Date of last spinal X-RAYS/MRIs: _____ Date of last bloodwork: _____

Patient Signature: _____ **Date:** _____

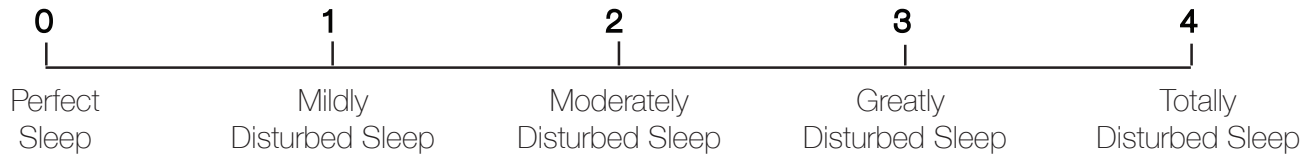
Functional Rating Index

Patient's Name:	Today's Date:
Please indicate area of discomfort: Neck Low Back Mid Back Other:	

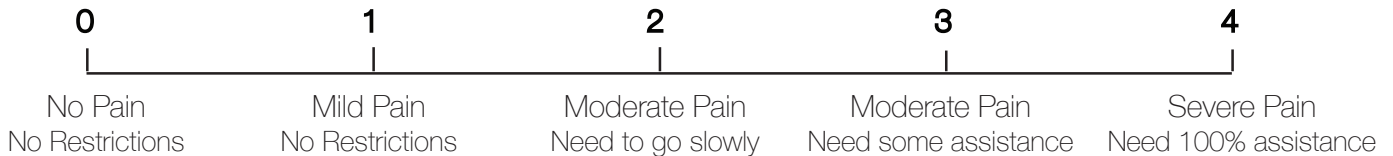
1. Pain Intensity



2. Sleeping



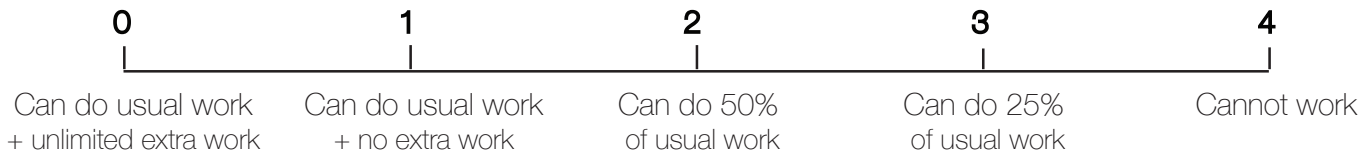
3. Personal Care (washing, dressing, etc.)



4. Travel (driving, etc.)

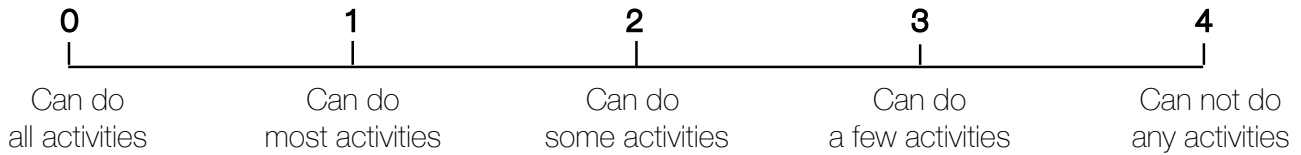


5. Work

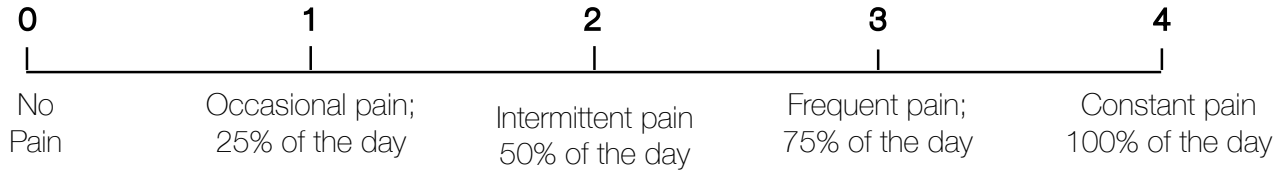


Functional Rating Index continued

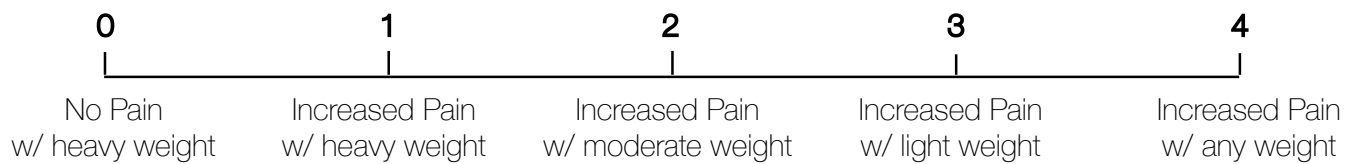
6. Recreation



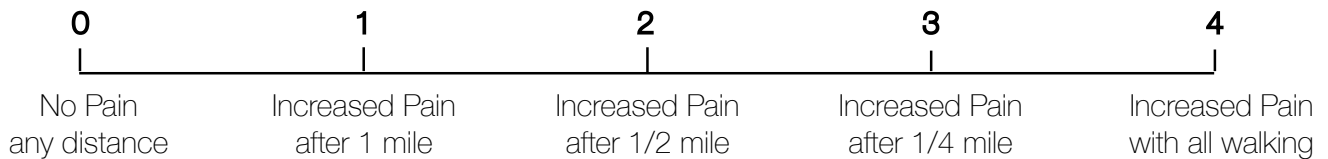
7. Frequency of Pain



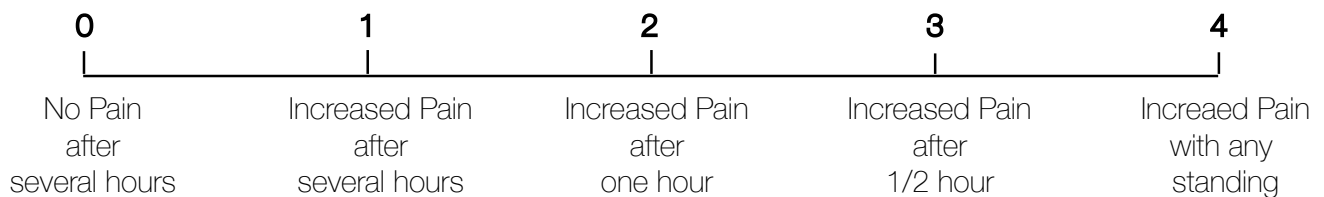
8. Lifting



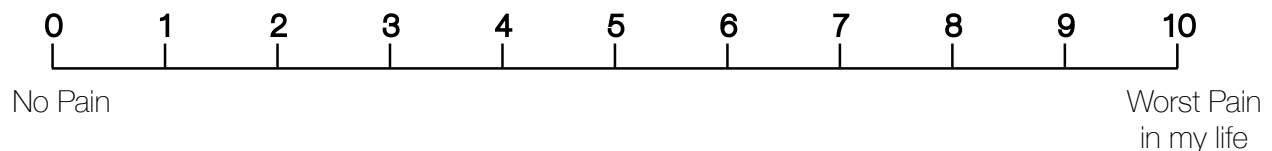
9. Walking



10. Standing



VAS: Rate your pain for today



Patient Signature _____ Date _____

Office Guidelines & Fee Policy

Patient Name:

Date

Please initial EACH line in this section.

I understand and agree to the following:

_____ As per my health insurance contract and the Office Fee Policy, **my personal payment is due at the time of service for any Self-pay, Co-pay, Co-Insurance, and/or Deductible amounts** (except for No Fault or Worker's Compensations cases).

If full payment is not an option, please speak to the Office Manager **prior to your treatment to request a payment plan or discount due to a financial hardship. You will be required to provide documentation such as income statements or proof of Medicaid insurance in order for a discount to be considered. If a payment plan is not arranged prior to receiving your treatment, you may be ineligible for a payment plan for that day's treatment.*

_____ If my personal account becomes 90 days delinquent, **Greater Rochester Chiropractic** has the right to deem it a collection item and it will be turned over to a collection agency.

_____ A \$20.00 fee will be added to my account for any check that is returned by the bank for "Insufficient Funds."

_____ I may be charged a **\$50.00 Missed Appointment Fee**, if I fail to give 24 hours notice when canceling an appointment, or if I fail to show up for a scheduled appointment.

_____ If I do not follow this agreement, Greater Rochester Chiropractic reserves the right to cancel or not schedule future appointments.

continued on next page >

Office Guidelines & Fee Policy continued

GREATER ROCHESTER CHIROPRACTIC
30 ALLENS CREEK RD, ROCHESTER, NY 14618
WWW.GRCHEALTH.COM
(585) 442-3220

Please initial ONE line in this section.

I understand and agree to the following:

_____ **I have health insurance:** I am ultimately responsible for determining my health insurance policy's chiropractic coverage, including but not limited to the following: co-payments, co-insurances, deductible amounts, limits on number of visits, referral requirements, maximum reimbursements available for chiropractic services, and verifying that my doctor participates with my insurance plan. I am responsible for paying any charges that are NOT covered or are DENIED by my health insurance plan.

** Please contact your insurance company at the Customer Service phone number printed on your insurance card if you have questions pertaining to your coverage and benefits and/or questions about how your insurance company processed your claim.*

** Please be aware that health insurance companies provide quotes, but will not guarantee your coverage and benefits based on a quote. Your insurance company will process the claims we submit and make a final determination of your coverage.*

_____ **I have Medicaid:** Medicaid does not provide any coverage for chiropractic treatment. I will provide proof of continued Medicaid coverage each month and I will Self-pay.

_____ **My doctor does not participate with my insurance company or my specific insurance plan: I will Self-pay for my treatment.**

** We submit claims to the insurance companies and plans with which our doctors participate. If your doctor does not participate with your insurance company or your insurance plan, we will provide a detailed receipt for you to submit for possible reimbursement. As previously stated, your payment to Greater Rochester Chiropractic will be due at the time of service.*

_____ **My insurance does not cover chiropractic treatment: I will Self-pay for my treatment.**

_____ **I do not have health insurance: I will Self-pay for my treatment.**

_____ **My injury occurred at work (Workers' Compensation):** Choose ONE of the following options:

_____ I am being treated by Mitchell J. Long, DC, MS, E. Daniel Quatro, DC, or Megan A. Stavalone, DC, who participate with the NYS Workers' Compensation Board. I am responsible for filing an injury report with my employer and will provide Greater Rochester Chiropractic with all necessary information related to the case. Claims will be billed to my employer's Workers' Compensation insurance carrier and payment will be made directly to Greater Rochester Chiropractic.

_____ I am being treated by a doctor who does not participate with the NYS Workers' Compensation Board and I will Self-pay. My personal health insurance company is not responsible for and cannot be billed for any treatment of injuries that occurred at work, regardless of whether I file a Workers' Compensation claim through my employer or not.

_____ **I was involved in a Motor Vehicle Accident/No-Fault (NF):** I am responsible for filing an accident report with the automobile insurance carrier and providing this office with all necessary information related to the case. Claims will be billed to the insurance carrier and payment will be made directly to the doctor. If my NF or PI carrier denies payment for my case, I will owe payment for the services rendered.

** Please be aware that some auto policies have a Medical Deductible that must be paid by you before payments will be made by the insurance company. You must complete any paperwork your insurance carrier requests and attend any examinations they require. If you do not follow the insurance company's guidelines they could deny payment, making you fully responsible for payment.*

Printed Name of Patient or that of Legal Representative

Patient's Signature or that of Legal Representative

Witness Signature (GRC office staff)

If Legal Representative, indicate relationship

Today's Date

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

— NOTICE TO PATIENT —

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient's Name:

Date of Birth:

I acknowledge that I **have received and had the opportunity to review the Notice of Privacy Practices** on the date below on behalf of Greater Rochester Chiropractic.

I understand that the Notice describes the uses and disclosures of my protected health information by Greater Rochester Chiropractic and informs me of my rights with respect to my protected health information.

Printed Name of Patient or that of Legal Representative

Patient's Signature or that of Legal Representative

Today's Date

If Legal Representative, indicate relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- Communications barriers prohibited obtaining the acknowledgement.

Other (please specify): _____

Employee Name

Today's Date