New Patient Intake Information

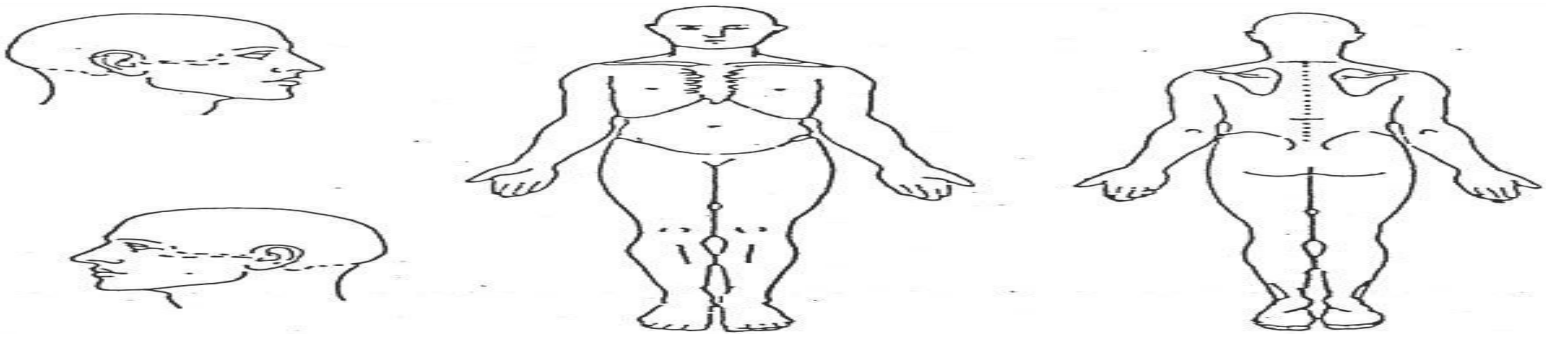
How were you referred to Dr. Black ? _____ Today's Date: _____ / ____ / _____

First Name: _____ Last Name:_____
DOB: ___ / ___ /_____ Sex: □ Male □ Female Preferred Method of Contact: □ Phone □ Text □ E-Mail
Home Address _____APT# ___ City: _____ State:____ Zip Code: ____
Cell Phone: _____ E-Mail: _____
Marital Status: □ Single □ Married Number of Children: __ Your Occupation:_____
Emergency Contact Name: _____ Relationship to Patient: _____
Emergency Contact Info: Cell Phone: _____ E-Mail:_____

What's the number one complaint you'd like help with?_____
When did the issue FIRST begin? _____
How would you describe the pain or discomfort? Dull, Numb, Sharp, Other: _____

Do the Symptoms travel, radiate, move around, OR stay in one place? Describe:_____
On a scale of 1-10, (10 = Severe) where is your pain/ discomfort level today? # _____ In the past week: #_____
Is your complaint constant, or does it come and go? _____ What time of day is it the worst: _____

Mark (X) on the picture below where you have any discomfort, pain, or other symptoms:



Have you had any Imaging for these complaints? □U/S □X-Ray □CT □MRI Date(s): ____ / ____/ ____

Have you consulted another Provider, Hospital, or Urgent Care for help? □No □Yes Date: ____ / ___ / _____

IF YES: Diagnosis and Recommendations for Treatment? :_____

IF Injury/Accident: □Motor Vehicle Accident □Work Injury □Sports Injury Date: ____ / ____ /_____

Please mark any of the following that may suffer or are more difficult/less enjoyable because of your complaints:

□ Quality Family Time □ Productivity/Focus/Work □ Sitting/Driving □ Focus/Mood □ Hobbies □ Standing

□ Sleep Quality □ Housework □Self-Care/Bathing □ Travel/Vacation/Leisure □ Exercise/Sports □ Walking

Please mark below what you have tried in the past that has NOT fixed your complaints:

□ Medications □ Acupuncture □ Homeopathy/Herbal □ Personal Training □ Exercise □ Heat/Ice

□ Injections □ Physical Therapy □ Chiropractic □ Massage Therapy □ Surgery □ Supplements □ Other_____

What prevented those treatments from resolving your problem permanently: _____

Ethos provides levels of care to meet your goals. Indicate the type of care you would like the Doctor to discuss:

□ Relief: Short-term symptom relief only, band-aid care.

□ Correction: Addressing & fixing the root causes, for lasting results.

□ Wellness & Prevention: Maintain and improve my current health with prevention.

□ All of these are important to me.

Rate where do you feel your overall Quality of Life is *today* on a scale of 1-10?

Energy: ____ Focus: _____ Productivity: _____ Mood: ___ Sleep Quality: ____

Digestion: ____ Immune System: ____ Motivation to be healthy: ____ Family & Relationships: ____

Based on the above how would you rate your current Level of OVERALL HEALTH (1-10): #_____

Where do you want your OVERALL HEALTH &WELLNESS: (rate: 1-10)# _____

Rate your commitment to reaching that goal: (rate: 1 -10) # ____

Chiropractic Experience**:**
Have you seen a Chiropractor in the past? □ Yes □ No Was there an Exam, X-Rays & Clear Diagnosis □Yes □No
What CONDITION/ Complaint were you treated for: _____
What Year(s): _____. How frequent did you go: _____ How long did you receive care: _____
Rate your experience, 1-10 #_____ What would you have changed: _____
Doctor/Clinic Name: _____

Medications & Health History:

Any Broken/Dislocated Joints or Bones? □No □Yes *If Yes,* List the Areas and Dates below:

_____

Surgeries (including cosmetic, aesthetic, weight loss, etc)? □ No □Yes Procedures & Dates:

_____

List ALL Medications that you take regularly *(prescribed, OTC):* _____

_____

How long have you been taking these: _____ Are you happy with the results of taking these? □ Yes □ No
Would you like to discuss the possibility of getting off of these if that were possible? □Yes □ No
IF Yes, what concerns do you have about your medications: _____

List all Supplements/ Herbs that you are taking: _____.
How long have you been taking them: ____ Are these helpful? □ Yes □ No What is the number one Goal/ Benefit you want: _____ What brand do you take? _____
If NOT taking currently, are you opposed to Diet & Supplements if indicated for your best results? □ Yes □ No

FEMALE PATIENTS**:** *(Patient Initials*: __) Are you pregnant? □No □Yes Date of Last Menstrual cycle: _____
HRT Therapy □ Yes □No Birth Control: □No □ Yes: Type, Dose, How long: _____

PRIVACY AUTHORIZATION HIPAA AND PHI

Our goal is to make your experience with us exceptional. Your signature below verifies that you have been given the option to review and understand our notice of HIPAA/PHI patient privacy practices. You agree that we may contact you via email, phone, or mail regarding your care and to keep you up to date on events taking place within the office. We will not share your information.
We use audio, video, and photos for training, research studies, testimonials, and/or social media sharing.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- 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 does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will then cease.
- You agree to opt-in to TEXT/ SMS messages for scheduling, events, and special promotions we share.

I authorize Ethos Medical to discuss my condition with the following individuals: *(name, relationship)*

_____

ASSIGNMENT OF INSURANCE BENEFITS

Your Insurance Company: _____. We will verify your insurance before your exam. We will discuss any insurance coverage, along with any expected contributions towards our Providers' recommendations for the Testing, Exam required to get a diagnosis, along with any prescribed treatment. As a courtesy, we will file directly to your insurance company for your exam and any recommended treatment. All fees for today's exam, scans, and any x-rays will be due in full today. All fees will be discussed with you *prior to any services being performed* today.

The undersigned patient and or responsible party, in addition to continuing personal responsibility and consideration of treatments rendered, assigns to Ethos Medical the following rights:

RELEASE OF INFORMATION

You are authorized to release information concerning my condition and treatment to my insurance company or insurance adjuster, for purposes of processing/appealing my claim for benefits and payment of services.

ALL PAYMENTS FOR SERVICES WILL BE MADE PAYABLE TO: ETHOS REGENERATIVE MEDICAL GROUP

I hereby grant Ethos Regenerative Medical Group, PLLC, the power to endorse my name upon any checks, drafts, or other negotiable instruments representing payment from any insurance group, company representing payment for treatment, consultations, and all health care rendered.

_____

Printed Name *Signature of the Patient, Parent or Guardian* *Date*