OMNE CHIROPRACTIC

NEW PATIENT INTAKE FORMS

Your completed intake paperwork helps us better serve you as we get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call 402-522-6663 if you have any questions or are unsure how to complete any section of this form.

Today's Date _____

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ Height: _____ Weight: _____

City/State/Zip: _____ Gender: ☐ Male ☐ Female

Preferred Phone: _____ ☐ Home ☐ Mobile ☐ Work

Email: _____ ***We E-mail quality content / No Spam***

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Referral

How did you hear about the clinic? ☐ Another Physician ☐ Google ☐ Family ☐ Friend ☐ Social Media

❑ Creighton Athletics Other: _____ Referring Physician: _____

Primary Care Physician: _____ Date of Last Visit: _____

***May we contact these providers to keep them informed of your progress** ☐ Yes ☐ No

Insurance Plan

Please provide insurance information at your first appointment for all <u>primary</u> and <u>secondary</u> insurance coverage. We will request cards for photocopy and add them to your patient file.

This includes any information related to <u>WORKERS COMPENSATION</u> or <u>PERSONAL INJURY</u> claims, which are expected to be declared on initial presentation to the clinic.

OFFICE USE ONLY:

FOA: ❑ *NDI* ❑ *Revised Oswestry* ❑ *UEFS* ❑ *LEFS*

MC: IMPORTED ❑ *OPTUM AUTH. REQUIRED:* ❑ YES ❑ NO ❑ N/A

Initials_____

Onset and Mechanism of Injury

Approximately when did this pain begin? _____ What caused your current problem _____

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

Since your pain began, how has it changed? ☐ Increased ☐ Decreased ☐ No Change

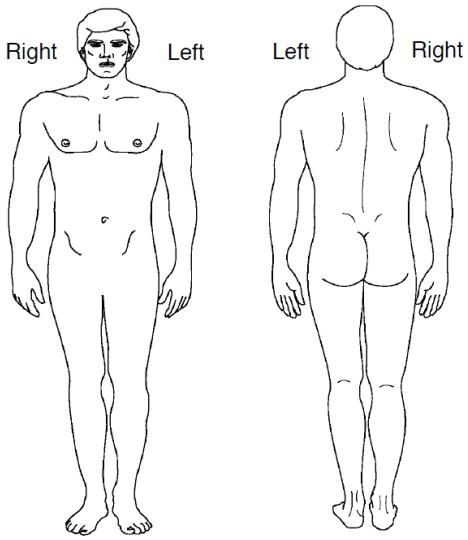
Pain Location / Intensity / Frequency

_____ What number on the pain scale (0-10) best describes your pain **right now**?

What percentage of your day do you experience this pain? _____

_____ What number on the pain scale (0-10) best describes your **worst** pain?

What percentage of your day do you experience this pain? _____



Please mark the location of your pain and if it travels to other areas.

Pain Description / Activity Limitations

Describe your pain: _____

What makes your pain worse? ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down ☐ Work Other_____

What makes your pain better? _____

List 2 important activities you are unable to perform or having difficulty due to your problem and rate your current level of difficulty for each: **0: Unable to perform** **10: able to perform at prior level**

ACTIVITY	Current Level of Difficulty [0 – 10]

Initials_____

Prior Pain Treatments

Mark all of the following treatments you have had prior to today's visit for your current pain complaints:

☐ Chiropractic ☐ Physical Therapy ☐ Psychological Therapy ☐ Acupuncture ☐ Dry Needling

☐ Epidural Steroid Injection(s) ☐ Trigger Point Injections ☐ Joint Injection(s) ☐ Nerve Blocks

☐ Medication: _____

☐ Other: _____

☐ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

☐ MRI of the _____ Date: _____ Facility: _____

☐ X-ray of the _____ Date: _____ Facility: _____

☐ CT scan of the _____ Date: _____ Facility: _____

☐ Other diagnostic testing: _____

☐ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Past Medical History

Mark the following conditions/diseases that you are being or have been treated for:

☐ Anemia	☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Back Problem	☐ BPH	☐ Breast CA	☐ CAD
☐ Cancer	☐ CHF	☐ High Cholesterol	☐ COPD
☐ Dementia	☐ Depression	☐ Dermatitis	☐ Diabetes
☐ Epilepsy	☐ GERD	☐ Glaucoma	☐ Gout
☐ Headache	☐ Hepatitis	☐ HIV	☐ Hypertension
☐ MI	☐ Migraine	☐ Pneumonia	☐ Kidney Stone
☐ Stroke	☐ TB	☐ Thyroid Disease	☐ Other: _____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Spine / Back Surgery

☐ Discectomy (levels)_____

☐ Laminectomy (levels)_____

☐ Spinal fusion (levels) _____

☐ I HAVE NEVER HAD ANY SURGICAL PROCEDURES

Other Surgeries (please list)

_____

_____

Attestation, HIPPA, and Financial Policy

I certify that the information I have supplied is accurate, complete and true.

I authorize OMNE Chiropractic and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for OMNE Chiropractic to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review OMNE Chiropractic's Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize OMNE Chiropractic to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize OMNE Chiropractic to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that OMNE Chiropractic will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

I understand given my provider's contract with Secure Care and other third-party payors, this office CAN NOT back bill insurance once a TIME OF SERVICE DISCOUNT (cash payment) has been chosen. If you choose to have us bill your insurance we can do that from the date that decision is made. We CAN NOT, however, bill any services provider prior to that decision.

Any additional questions can be addressed in our Financial Policy

Initial:_____

Testimonials and social media policy: Occasionally we ask patients to provide OMNE Chiropractic with video testimonials or have their photograph taken to be used on the website and other social media platforms. If you are asked and agree to this please initial here. Your full name will not be used and no personal information will be given to anyone.

Printed Name: _____

Signature: _____ Date: _____

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physiotherapy, exercises, nutritional supplementation, or acupuncture may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty I will achieve these benefits.

I realize that the practice of medicine, along with chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, resricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to the authorization for treatment.

Signature of Patient_____ Date_____

Signature of Parent
or Guardian (if a minor)_____ Date_____