Patient Intake Form

General Information: (Please Print Clearly)

Name:_____ DOB:_____ Age:_____ Sex: M F

Address:_____

Phone- Cell:_____ Home: _____ Work:_____

(Please Indicate Preferred Method of Contact)

Email:_____ Referred by:_____

(Your email will NOT be shared with any 3rd parties and is only used for general office communication)

Emergency Contact & Phone #: _____ , _____

Drivers Lic.#:_____ SSN:_____ Marital Status: S M D W DP

Name of Spouse/Parent _____ Spouse/Parent Contact #_____

Chief Complaint(s): _____

Insurance & Payment Information:

Reason for this visit is a result of (please circle): **Auto Chronic Fall Sports Work Other**

Has your accident or Injury been reported: **Yes No** To Whom:_____

Party Responsible for Payment: **Insurance Self Work Comp Other:**_____

Employer Name: _____ Occupation: _____

Do you have Insurance? **Yes No**

Special consideration may be given if you qualify for a certain plan. Please indicate if you feel this may apply to you:

Athletic Organization:_____ Member since_____

Dance Organization:_____ Member since_____

I understand and agree that health and accident insurance are an arrangement between an insurance carrier and me. I clearly understand and agree that all money from my insurance carrier goes directly to this office to pay for the services rendered. I also clearly understand and agree that I am personally responsible for payments of all services rendered to me: Co-payments, co-insurance fees, deductibles and any and all fees that are not paid by my insurance. I understand that if I suspend or terminate my care and treatment all fees for professional services rendered to me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patients Signature:_____ Date:_____

Guardian's Signature: _____ Date: _____

Current Complaints

Chief complaint(s): _____

Date of Injury: _____ Date Symptoms Began: _____ ___

How did your pain begin? ☐Immediately after a specific event ☐After multiple events
☐Gradually developed ☐ No apparent reason

Are your pain or symptoms: ☐ Improving ☐ Worsening ☐ Not changing

Are your pain or symptoms: ☐Constant (75-100% of time) ☐Frequent (51-75%)
☐Occasional (25-50%) ☐ Intermittent (25% or less)

Have you ever had a similar problem before? **Yes** or **No** If so, When? _____

Does anything decrease your pain or symptoms? _____

What makes your pain worse? _____

Is this interfering with your (please circle) **Work Sleep Daily Routine Sports Recreation**
Other? If so, please explain: _____

Have you been treated for any of these conditions in the past year? **Yes** or **No**
If **YES**, please check: ☐ Surgery ☐Injections ☐ Physical Therapy ☐ Supportive devices
☐Medications _____ Other _____

Did they help? **Yes** or **No**

Prior tests, results and dates: (X-ray, MRI, CT, ultrasound, lab, other): _____

Have you ever been treated by a chiropractor before: **Yes** or **No** If yes, date of last visit: _____ Name of previous chiropractor: _____

How would you rate your general stress levels? **None Minimal Moderate Great**

Are your complaints affecting your ability to work or otherwise be active?

☐Some restrictions (able to perform light duty work & household tasks)
☐ Need limited assistance with common everyday tasks
☐ Significant inability to function without assistance
☐ No effect
☐ Need assistance often
☐ I am totally disabled (impaired and cannot care for self)

How much time do you spend? (please circle)

Sitting	Most of the day	Half of the day	A little of the day	None
Standing	Most of the day	Half of the day	A little of the day	None
Computer work	Most of the day	Half of the day	A little of the day	None
Strenuous manual labor	Most of the day	Half of the day	A little of the day	None
Moderate manual labor	Most of the day	Half of the day	A little of the day	None
On the Phone	Most of the day	Half of the day	A little of the day	None
Driving	Most of the day	Half of the day	A little of the day	None

Patient Initials: _____

Please List each area of your symptoms in order of severity. Then at the scale below, mark (**X**) at a point along the that demonstrates the level of severity.

Areas of Symptom

1. _____
2. _____
3. _____
4. _____

Severity

No Pain or Symptoms — Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

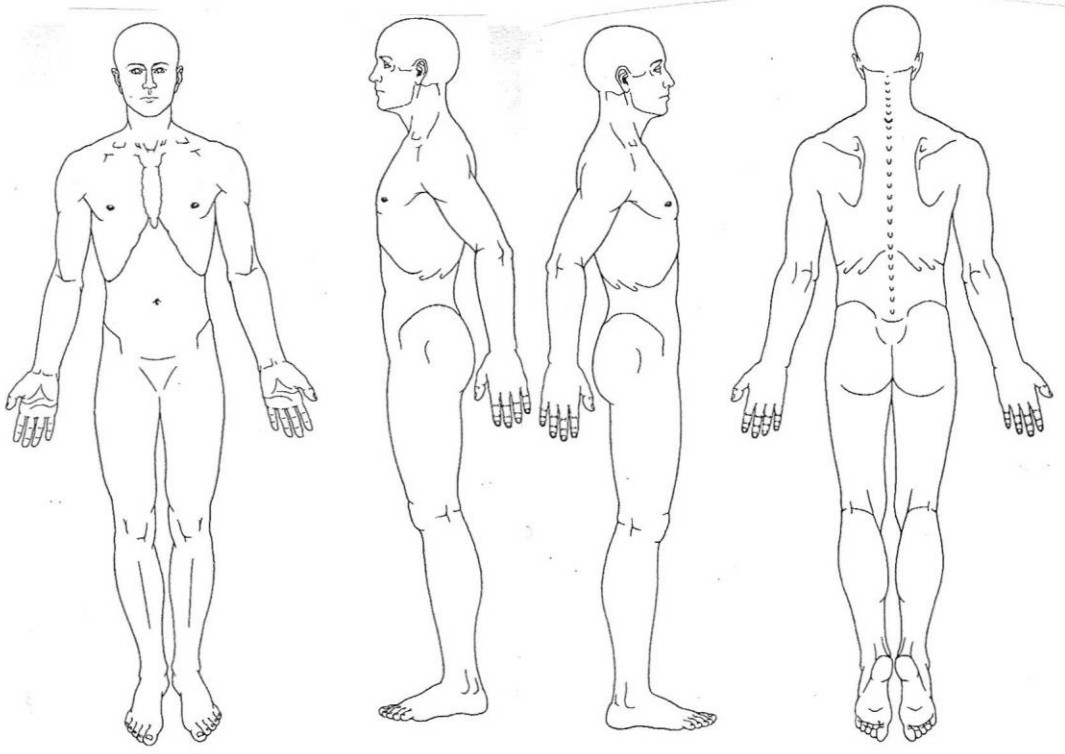
0 1 2 3 4 5 6 7 8 9 10

0 1 2 3 4 5 6 7 8 9 10

0 1 2 3 4 5 6 7 8 9 10

In the area to the right please indicate where you are experiencing pain or symptoms by drawing in the letter abbreviations on the diagrams

Sharp Pain = P Stiffness = S Tingling = T Dull Pain = D Numbness = N Burning = B



Medical History

Have you been treated for any other conditions in the last year? Yes No
If yes, please describe:_____

Date of Last physical exam:_____ Findings?_____

Have you had any dental care or minor surgery in the last 4 weeks? **Yes** or **No**

Are you, or do you think that you may be pregnant? **Yes** or **No** If yes, # of weeks:_____

Patient Initials: _____

Do you ever experience night sweats? Yes or No
Do you wear orthotics? Yes or No
Does weather affect your symptoms? Yes or No
Do you experience muscle spasm? Yes or No

Please List Any:	Date:	Please describe:
Motor Vehicle Accident		
Recent Work Injury		
Sports/Recreational Injury		
Falls or Other Traumas		
Surgeries		
Hospitalizations		
Other Medical Conditions		

Medication/Supplement	Dosage	Reason for taking	Taking since (date)

Family Heath History

Family Members	Medical Conditions: Past and Present (IE: Heart Disease, Cancer, Diabetes, ect.)
Mother	
Father	
Sister	
Brother	

Patient Initials: _____

General Habits	None	Light	Moderate	Heavy
Coffee/Tea				
Tobacco				
Recreational Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweeteners				
Alcohol				

Do you have any difficulty with the following?
-Please place "**N**" in the space if the condition is Now
-Please place "**P**" if the condition was in the Past

___Abdominal Pain
___Alcoholism
___Allergy
___Anemia
___Arthritis
___Asthma
___Cancer
___Chest Pain
___Colds/Infections
___Colon Trouble
___Constipation
___Depression
___Diabetes
___Dizziness
___Epilepsy
___Fatigue
___Gall Bladder
___Gout
___Gynecological Problems
___Hardening of Arteries
___Hearing Problems
___Heart Disease
___Headaches
___Hemorrhoids
___Hepatitis
___High Blood Pressure
___HIV / AIDS
___Indigestion
___Kidney Trouble
___Knocked Unconscious
___Liver Trouble
___Lung Problems
___Mental Disorders
___Nausea
___Nervousness
___Pneumonia
___Poor Appetite
___Prostate Problems
___Sciatica
___Short of Breath
___Sinus Trouble
___Sleeplessness
___Stress
___Stroke
___Thyroid Trouble
___Ulcers
___Varicose Veins
___Vision Problems
___Weight Gain

Patients Signature:_____ Date:_____

Guardian's Signature: _____ Date: _____

Dr Saby Szajowitz DC CCSP
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dr Saby Szajowitz DC CCSP is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. If payment if not made as arranged, our office may utilize an outside collections agency, credit reporting agency or other means of collecting outstanding debt. Your file, containing protected health care information, may be reviewed by the designated collection agency or authority.

Worker's Compensation
If applicable, we may disclose your health information as necessary to comply with state Worker's Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing and Other Communications
We may contact you for marketing purposes, as described below: (example)
"As a courtesy to our patients, it is our policy to call your home on the evening prior to your appointment to remind you of your appointment time. If you are not home, we leave a reminder message on you answering machine or with a person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and request to call our office if you need to cancel or reschedule your appointment"

Change of Ownership
In the event that Dr Saby's practice is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights
You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Dr Saby Szajowitz DC CCSP is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through and alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have the right to request that Dr Saby Szajowitz DC CCSP amend your protected health information. Please be advised, however, that Dr Saby Szajowitz DC CCSP is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have the right to receive an accounting of disclosures of your protected health information made by Dr Saby Szajowitz DC CCSP.

You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Dr Saby Szajowitz DC CCSP reserves the right to amend this Notice of Privacy Practices at anytime in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Dr Saby Szajowitz DC CCSP is required by law to comply with this Notice.

Dr Saby Szajowitz DC CCSP is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Dr Saby Szajowitz DC CCSP by calling (858) 356-2808. If Dr Saby Szajowitz DC CCSP is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints
Complaints about your privacy rights or how Dr Saby Szajowitz DC CCSP has handled your health information should be directed to Dr Saby by calling this office (858) 356-2808. If Dr Saby is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights 200
Independence Ave, S.W.
Room 509F HHH Building
Washington, DC 20201 The

notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my right contained in the notice.

By way of my signature, I provide Dr Saby Szajowitz DC CCSP with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

_____ Patient's Name
(Print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

Informed Consent for Chiropractic Treatment and Care for Dr Saby Szajowitz DC CCSP

I hereby request consent to the performance of chiropractic adjustments and other chiropractic procedures, including various models of physiotherapy and massage/tissue work (or on the patient named below, for whom I am legally responsible for) by Dr Saby Szajowitz DC CCSP or a chiropractic intern, affiliated with Dr Saby Szajowitz DC CCSP. I also consent to another licensed chiropractor who may be providing coverage for Dr SabySzajowitz DC CCSP to perform such treatments as well.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to the above treatments/procedures, including but not limited to fractures, disc injuries, strokes, dislocations, and sprain/strains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise his judgment during the course of the procedure/treatment, which the doctor feels at the time and based on the facts known, is to be in my best interest.

I have read, or have had this read to me, the above consent. By signing below I agree to the above and allow Dr Saby Szajowitz DC CCSP or chiropractic intern, affiliated with Dr Saby Szajowitz DC CCSP or a licensed chiropractor providing coverage to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for my future condition and for any future condition(s) for which I seek treatment.

Dr Saby Szajowitz DC CCSP consists of Dr Saby Szajowitz DC CCSP. Acupuncturists, massage therapists, and other practitioners in the office are independent care providers and are not part of Dr Saby Szajowitz DC CCSP.

_____ _____

Patient's Printed Name Date

_____ _____

Patient's Signature Guardian's Signature

Dr Saby Szajowitz DC CCSP 7220 Avenida Encinas Suite 110-B Carlsbad, CA 92011
(858) 422-9027 (phone)
(760) 268-1076 (fax)

Financial Policy: No Insurance Accepted ($150 Initial Visit - $115 Regular Visit)

You agree to pay by cash, check or credit card on the day that treatment is rendered. Unless we approve other arrangements in writing, the balance on your account is due and payable when the services are rendered. **_____(Initials)**

Missed Appointment Fees:
Patients who do not show up for an appointment or cancel with less than 24 hours notice will be charged a fee of **$100** per Chiropractic Visit. This fee must be paid before a new appointment is scheduled, or will be billed to your current account. Providing updates to any and all contact information is the sole responsibility of the patient. **_____(Initials)**

Credit History:
We will report your account status to any credit-reporting agency such as a credit bureau for delinquent accounts. If your accounts become past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of balance to a lawyer, you agree to pay all legal fees which we incur.

Returned Checks:
There is a fee **$35** for any checks returned by the bank.

Waiver of Confidentiality:
You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you have received treatment at our office may be a matter of public record.

Transfer of Records:
You will need to request in writing, and pay a reasonable copying fee (currently **$35**) if you want to have copies of your records sent to another doctor or organization.

Effective Date:
Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

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

Responsible Party: _____ **Signature: _____**

(If not Patient)

Date:_____