Health Luminosity

Chiropractic Intake

Name ____
Address ____
City ___________________________________ Zip Code _______________ Email ______________________________________
Preferred phone _____________________________________ ☐ Male ☐ Female Age _________ Birth Date _____________
How did you hear about Dr. Ray?____

Employment Information

Patient employed by _______________________________________ Occupation ____
Business address ____
Business phone ____

Emergency Information

Notify in case of emergency ____________________________________ Emergency phone _________________________________

Reason For Visit

Is today's visit due to: ☐ Illness ☐ Accident ☐ Injury ☐ Other ____
Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? __________________________________
Your reason for this visit: ____
Please describe your current pain and its location: ____
____
When did symptoms begin (date)? _________________________ Have you had similar conditions in the past? ______________
Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Sporadic How often do you have this pain? _______________________
Have you been treated by anyone else for this condition? ____
If so, when and where? ____
Activities/movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other ____
Is pain interfering with : ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Health History

Who is your primary care provider?____
Please list any medication (including pain killers, vitamins, herbal supplements) you are taking: ___________________________
____
Please list any serious injuries, injections or surgeries you have had in the last 10 years: __________________________________
____

Falls ____ Date __________________
Head injuries ____ Date __________________
Broken bones ____ Date __________________
Dislocations ____ Date __________________
Surgeries/Injections ____ Date __________________
Sprains/Strains ____ Date __________________

What are you doing for exercise and nutrition?
____
____

PLEASE *CIRCLE* THE FOLLOWING SYMPTOMS WHICH YOU HAVE NOW AND A *CHECK* NEXT TO CONDITIONS YOU PREVIOUSLY HAD.

General
Convulsions
Dizziness or fainting
Environmental allergies
Fatigue easily
Headaches
Loss of balance
Nerve pain
Nervousness or anxiety
Night sweats

Eyes-Ears-Nose-Throat
Deafness or hearing loss
Ear Discharge
Ear noises
Earache or ear pain
Eye infections
Eye pain
Frequent colds
Frequent sore throats
Nasal discharge
Nosebleeds
Sinus infections

Gastrointestinal
Abdominal distention
Constipation
Diarrhea
Food eruptions/reflux
Gallbladder trouble
Hemorrhoids
Irritable bowel syndrome
Liver problems
Spastic colons
Stomach pain
Ulcer disease

Genitourinary
Bedwetting
Blood in urine
Difficulty urinating
Frequent urination
Incontinence
Kidney infection/stones
Painful urination
Pus in urine
Sexual transmitted disease
____
____

Muscle/Joint
Arthritis/rheumatism
Bursitis
Foot trouble
Low back pain
Neck pain/stiffness
Pain between shoulders
Pain/numb/tingle in:
☐ elbows ☐ hands
☐ shoulders ☐ arms
☐ hip ☐ legs
☐ knees ☐ feet
Sciatica
Scoliosis
Swollen joints _____________
Tremors
Weakness

Heart
Chest pain/angina
Hardening of the arteries
Heart attack
High blood pressure
Low blood pressure
Palpitations
Phlebitis
Poor circulation
Rapid heart beat
Rheumatic heart disease
Skipped heart beats
Slow heart beats
Swelling of ankles/legs

Respiratory
Asthma
Chronic cough
Difficulty breathing
Pain when breathing
Shortness of breath
Spitting up blood
Spitting up phlegm
Wheezing

***Women* only**
Breast lumps or pain
Excessive menstrual flow
Menopausal symptoms
Hot flashes
Irregular menstrual cycle
Menstrual cramps
Vaginal discharge

Skin
Acne
Easy bruising
Eczema
Hives
Rashes
Skin dryness
Skin oiliness
Varicose veins

***Men* only**
Impotence
Prostate

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

How Can We Best Serve Your Needs?

☐ Symptomatic (pain relief) care only
☐ Stretching techniques as pertaining to my condition
☐ Nutritional consultation
☐ Structural care (correct and stabilize as much as possible)
☐ Strengthening exercises as pertaining to my condition
☐ Acupuncture

Authorization & Consent For Treatment

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate chiropractic treatment.

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures.

I understand that I am financially responsible for all charges.

Signature of patient ____ Current Date _________________

Signature of parent/guardian if patient is a minor ____________________________________ Current Date _________________

Dr. Jane Ray

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1997 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple Healthcare providers – directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments.

I have been informed by the practice of Dr. Jane Ray of your Notice Of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice Of Privacy Practices (NPP) prior to signing this consent. I understand that the office of Dr. Jane Ray has the right to change its NPP from time to time and that I may contact them at any time at the address listed below to receive an updated copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME ____

SIGNATURE ____

DATE ____

Dr. Jane A. Ray, D.C.
75 Manhattan Dr., Suite 100, Boulder, CO 80303
303-449-2130

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, and research and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

The effective date of this Notice of Information Practices is **January 1, 2020.**

X____
Patient Signature, if Patient is a Minor, Signature of Guardian or Responsible Party

X____
Office Manager

Health Luminosity

Financial Policy

Please read and initial the following:

____ I understand that payment is required in full for all services rendered at the time of my office visit, unless other arrangements have been made. If my account balance has not been paid within 30 days from the date of service and no financial arrangements have been made, I will be responsible for any expenses incurred in the collection of my account. Collection fees for delinquent accounts include any court costs and reasonable attorney fees, plus interest of 18% per month on all amounts outstanding.

____ Any nutritional supplements, supplies, equipment, or educational materials I purchase must be paid for in full. These items will not be charged to my account and there is no refund on opened or used products. Unopened or unused products may be returned for a credit.

____ I understand and agree that health and accident insurance are an arrangement between my insurance carrier and me. I know it is my responsibility to familiarize myself with the rules and covered benefits of my insurance policy. I authorize Dr. Jane Ray to release any information required to process insurance claims. I understand that I am financially responsible for all charges.

____ If your check is returned for insufficient or uncollected funds, there will be a $30 returned check fee in addition to any other bank fees accrued by this office in the collection of funds.

Cancellation Policy

____ 24 hour notice is required if you have to cancel your appointment. Otherwise, the full treatment price will be charged. Thank you.

Medicare (If Medicare patient)

____ We participate with Medicare but do not accept assignment. You pay your doctor at the time of the visit, then we bill Medicare for you and Medicare pays you back, usually within 6-8 weeks.

____ ______________________________

Signature of Patient Date

____ ______________________________

Signature of Patient's Representative (if minor or physically incapacitated) Date

Jane A. Ray, D.C. 75 Manhattan Dr., Suite 100, Boulder, CO 80303 303-449-2130