Thornton Family Chiropractic LLC

870 S Woodruff Ave
Idaho Falls, ID 83401
208-529-2044

Patient Information

Full Name: _____ Date: _____
First *M.I.* *Last*

Gender: Male Female Unknown Date of Birth: ____/____/____

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Reminder Preference [ ] Phone [ ] Text [ ] Email Social Security No.: ____/____/____

Race: _____ Ethnicity: [ ] Caucasian [ ] Hispanic [ ] _____ Language: [ ] English [ ] _____

Primary Care Provider: _____ Vision Impaired? [ ] Yes [ ] No Hearing Impaired? [ ] Yes [ ] No

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

*Did anyone refer you to our office? No Yes — Who may we thank? _____

INSURANCE COVERAGE *Do you have [ ] Insurance [ ] AFLAC [ ] Colonial [ ] Combined No Yes
*Is this condition due to an injury from [ ] Work [ ] Vehicle Collision No Yes
Please provide a COPY of Insurance Card(s)

History

Please circle the numbers that best describe your pain overall:
INTENSITY: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)
FREQUENCY: Pain Present 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% of the time.

- ☐ Headaches ____/10
- ☐ Neck pain ____/10
- ☐ Midback pain ____/10
- ☐ Low back pain ____/10
- ☐ Arm pain ____/10
- ☐ Hand pain ____/10
- ☐ Shoulder pain ____/10
- ☐ Hip pain ____/10
- ☐ Leg pain ____/10
- ☐ Foot pain ____/10
- ☐ _____ ____/10

When did the symptoms begin?

How did the symptoms occur?

Have you missed any work or school? If so, how much?

What seems to help your pain?

What seems to make your pain worse?

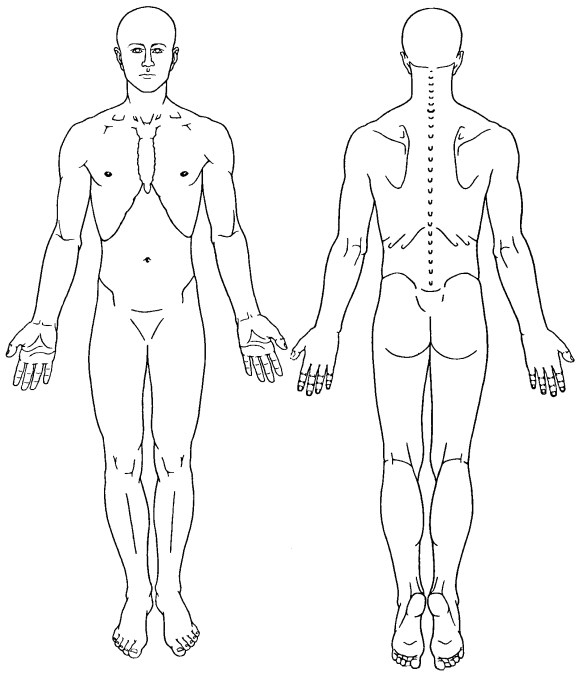
Did you have any similar pain or any other pain before this occurred? If so, where?

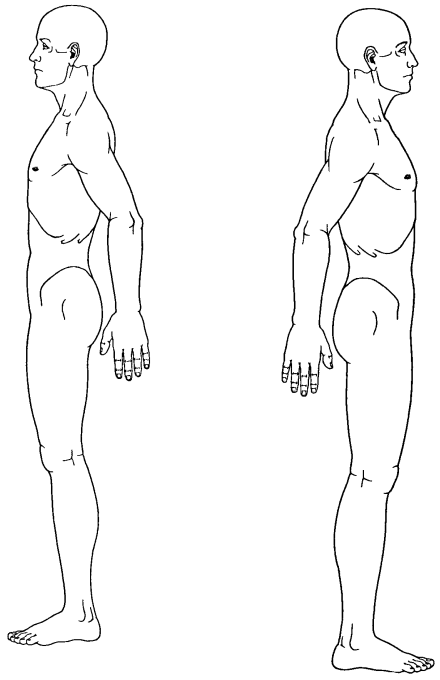
Have you seen anyone for this condition previously? If so, who?

Have there been any prior treatments? If so, what?

Did you notice relief with prior treatment? Yes No

Please mark the areas of pain and draw lines if the pain radiates.





My pain is aggravated by:

- ☐ Walking
- ☐ Sitting
- ☐ Stress
- ☐ Running
- ☐ Exercising
- ☐ Lifting Weight
- ☐ Climbing Stairs
- ☐ Bending Forward
- ☐ Standing
- ☐ Looking Up
- ☐ Looking Down
- ☐ Repetitious Movement
- ☐ Emotional Upset
- ☐ Flashing Lights
- ☐ Lifting Boxes
- ☐ Bowel movements

My pain is:

- ☐ constant
- ☐ aching
- ☐ intermittent
- ☐ radiating
- ☐ sharp
- ☐ throbbing
- ☐ numbness
- ☐ tingling
- ☐ burning
- ☐ tight
- ☐ nausea
- ☐ vomiting
- ☐ visual disturbance
- ☐ altered hearing
- ☐ ringing in ears
- ☐ loss of balance

My pain is relieved by:

- ☐ chiropractic care
- ☐ antacids
- ☐ bowel movement
- ☐ lying still
- ☐ milk
- ☐ heat &/or ice
- ☐ taking a deep breath
- ☐ taking a short nap
- ☐ painkillers
- ☐ sleep
- ☐ taking Ibuprofen or Tylenol
- ☐ exercising
- ☐ resting
- ☐ sitting

What are two important activities that you cannot do or are having trouble doing? (example: sitting, standing, walking, playing golf, etc.)

Activity #1: _____

Rated at:

0 1 2 3 4 5 6 7 8 9 10

Unable to perform — Perform at same level as before

Activity #2: _____

Rated at:

0 1 2 3 4 5 6 7 8 9 10

Unable to perform — Perform at same level as before

For Office Use Only:

98940	98941	98942	98943	97010
97012	97014	97035	97110	97112
97114	99212	99202	S8990	
Laser	KT Tape			

MEDICAL HISTORY INFORMATION

Please circle if you have had trouble with the following in the PAST or CURRENTLY.

GENERAL:
Headaches
Fatigue
Loss of sleep
Depression
Nervousness
Weight Loss / Gain
Cancer
Dizziness
Fainting
Mental Illness
Tremors

Skin:
Bruises easily
Varicose veins
Rash
Discoloration
Hives / Allergies
Itching

Cardiovascular:
Atherosclerosis
High blood pressure
Low blood pressure
Poor circulation
Swelling of ankles
Chest pain
Irregular pulse
Palpitations
Rapid heartbeat
Slow heartbeat

Respiratory:
Chronic cough
Difficulty breathing
Shortness of breath
Spitting phlegm / blood
wheezing
Asthma
Emphysema

Gastrointestinal:
Abdominal pain
Colitis / Crohn's
Diarrhea
Constipation
Hernia
Vomiting
Vomiting blood
Bloody stools
Difficult digestion
Poor appetite
Nausea

Ears / Eyes / Nose / Throat:
Cold / Flu
Sore throat
Glasses / Contacts
Hearing Loss
Ringing in ears
Tonsillitis
Ear Ache
Gum / Teeth problems
Nasal obstruction
Sinus infection
Eye pain
Hoarseness
Nose bleed

Genitourinary:
Blood in urine
Decreased flow / force
Prostate problems
Stress incontinence
Bed-wetting
Infections
Painful urination
Wake up at night to urinate

Reproductive :
Irregular Menstrual Cycle
Menopause
Breast problems
Vaginal discharge
Testicular problems

Muscle / Joint:
Arthritis
Fractures / Breaks
Lower extremity pain
Upper extremity pain
Muscle weakness
Sprain / Strain
Bursitis
Neck pain
Mid-back pain
Low back pain

DOCTOR'S NOTES ONLY:

PAST Medical History: Circle all that apply

High Cholesterol	Diabetes	Seizures
Glaucoma	Heart attack	Thyroid
Hepatitis	Pacemaker	Reflux
Blood clots	Stroke	HIV

MEDICATIONS

1._____ 4._____
2._____ 5._____
3._____ 6._____

Surgical History:

1._____ Date: _____
2._____ Date: _____
3._____ Date: _____
4._____ Date: _____

Accident History:

Job / Auto / Sport / Other _____
Job / Auto / Sport / Other _____
Job / Auto / Sport / Other _____
Job / Auto / Sport / Other _____

Allergies: seasonal / non-seasonal / medications
Explain:_____

Do You **Smoke?** YES / NO
How Much? _____

Do you **Drink?** YES / NO
How much? _____

WOMEN ONLY:

1st Day of Last Period: _____
Number of Children: _____
Last Visit to OB/GYN: _____
Birth Control Method: _____

FAMILY HISTORY: Circle all that apply & Relation to you

Obesity / Cancer / Diabetes / High blood pressure: _____
Obesity / Cancer / Diabetes / High blood pressure: _____
Obesity / Cancer / Diabetes / High blood pressure: _____
Obesity / Cancer / Diabetes / High blood pressure: _____

GROUP INSURANCE BENEFIT ASSIGNMENT

I, _____, hereby authorize Thornton Family Chiropractic, LLC, through its employees, agents and representatives (my "Doctor"), to furnish my Group Insurance Carrier (“Insurance Company”), or the designee, any medical information requested concerning the condition or treatment received by me, my spouse, or children.

I further authorize and direct the above Insurance Company to pay my Doctor and Thornton Family Chiropractic, LLC, directly and according to benefits assigned under my policy for professional services, including any treatment to myself, my spouse, or children. I further grant Thornton Family Chiropractic, LLC a specific lien on the proceeds of any Group Benefits to the extent of any sum due to Thornton Family Chiropractic, LLC. I understand that this is in no way relieves me of my personal primary responsibility to pay my Doctor at Thornton Family Chiropractic, LLC for such services. I agree that if I am paid directly by my insurance company I will promptly (within one week of receipt of payment) submit and/or forward all payments to Thornton Family Chiropractic, LLC at 870 S Woodruff Ave Idaho Falls, ID 83401. I further understand that this agreement is made for the Doctor's additional protection and in consideration of the agreement by my Doctor to furnish medical treatment for me, my spouse and/or my children, without any solicitation from Thornton Family Chiropractic, LLC or their employees.

I further authorize the Insurance Company or persons to disclose to my Doctor any claim or benefit information to include, but not limited to, coverage, status of payments, and disbursement of funds or copies of checks if requested by my Doctor for whatever purpose. My Doctor is authorized to furnish my Insurance Company any necessary documentation to process these claims for payment. I further agree and acknowledge that if the insurance coverage is not enough to cover my medical bills with Thornton Family Chiropractic, LLC it will remain my full responsibility until payment in full is received on my account.

I understand that Thornton Family Chiropractic, LLC reserves the right to bill me for charges above the usual and customary amount allowed for services as contracted by my insurance carrier.

_____ _____

PATIENT SIGNATURE DATE

_____

_____ _____

WITNESSES SIGNATURE DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB:_____

Receipt of Notice of Privacy Practices

I acknowledge I have received or I have been provided the opportunity to receive a copy of Thornton Family Chiropractic, LLC Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by Thornton Family Chiropractic, LLC. I may obtain a current copy by contacting Thornton Family Chiropractic, LLC Privacy/Security Official, or by visiting the Thornton Family Chiropractic, LLC web site at [Thornton Family Chiropractic, LLC Website Address].

HIPAA Disclosure Authorization(s)

I authorize Thornton Family Chiropractic, LLC to:

Contact me at the following number(s):_____

Leave a voice message with me at the following number(s):_____

Provide the following person(s) with my protected health information:

Print Name: _____ Relationship to Patient/Phone number: _____

Print Name: _____ Relationship to Patient/Phone number: _____

I do not authorize Thornton Family Chiropractic, LLC to disclose my protected health information to anyone other than myself, except as permitted by HIPAA and as described in Thornton Family Chiropractic, LLC Notice of Privacy Practices.

HIPAA Unencrypted Communication Authorizations

Electronic mail (email) and text messaging are common forms of communication and can be utilized to communicate with your physician and your care team. It is important for you to understand that unencrypted email and text messaging are not secure communications. This means there is a potential risk that messages containing your protected health information may be intercepted by a third party. Encryption is the process of making information unreadable unless you have the password or key to decrypt the information. Thornton Family Chiropractic, LLC does not encrypt text messages, and we cannot guarantee that all email messages will be encrypted.

By initialing below and signing this authorization, I understand and accept the conditions outlined above. I authorize Thornton Family Chiropractic, LLC to send unencrypted communications to the email address and/or phone number listed below.

I authorize Thornton Family Chiropractic, LLC to:

Initial ____ Send email to the following address: _____

Initial ____ Send text messages to the following phone number: _____

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized. I understand this authorization is valid while I continue to receive services from any Thornton Family Chiropractic, LLC provider.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name Relationship to Patient

For Practice Use Only: Complete this section if you are unable to obtain a signature.
If the Patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

Completed by:

_____ _____
Signature of Practice Representative Date

I have received my examination and the doctor explained to me what he/she found. Based on this, I give my permission to have diagnostic tests, procedures, and a chiropractic treatment plan for my condition(s).