New Patient Intake Form

Date: _____

Title: (Circle one) Mr. Mrs. Ms. Miss Dr.
Other _____

Name: First _____ MI ____Last _____

Age:_____**Date of Birth:** _____/_____/_____ **Gender:** □Male □Female

Social Security Number: _____

Street_____

City _____ State _____Zip Code _____

Communication Preferences:

Home Phone: (_____) _____

Cell Phone: (_____) _____

Email: _____@_____

Employment Status: □Employed □Unemployed □Student □Other _____

Occupation: _____Employer: _____

Marital Status: □Single □Married □Other

Spouse's Name: _____ Spouse's Phone: _____

Emergency Contact:

Emergency Contact Name:_____

Relationship to Patient: _____ Contact #: _____

Patient Signature (or Legal Guardian): _____Date _____

Please check all that apply:

Medical Conditions:	Surgeries:	Allergies:
□Arthritis	□Appendectomy	□Mold
□Cancer	□Cardiovascular procedure	□Seasonal
□Diabetes	□Cervical spine	□Milk/Lactose
□Heart Disease	□Hysterectomy	□Wheat/Glutens
□Hypertension	□Joint Replacement	□Animal
□Psychiatric Illness	□Prostate	□Chemical □Sulfites
□Skin Disorder	□Lumbar spine	□Other _____
□Stroke	□Gallbladder	
□Fibromyalgia	□Brain	***Please Any Medications:***
□Asthma	□Shoulder	_____
□Osteoporosis	□Thoracic spine	_____
□Other _____	□Knee	_____
	□Carpal Tunnel	_____
	□Gastro-intestinal	_____
	□Uro-genital	_____
	□Hernia	_____
	□Breast Augmentation	_____
	□Other _____	

Are you Pregnant? No ____ Yes ____ Due Date _____

Reason for Visit

❒ Wellness Care (routine maintenance care)

❒ Treatment For… _____

Social History

Caffeine □occasional □often □never

Alcohol □occasional □often □never

Exercise □occasional □often □never

Water □ MORE 64 oz/day □ LESS 64 oz/day □never

Cigarettes □ MORE 1 pack/day □ LESS 1 pack/day □never

Sleep □ MORE 8 hours/night □ LESS=8 hours/night □Insomnia

□Other _____

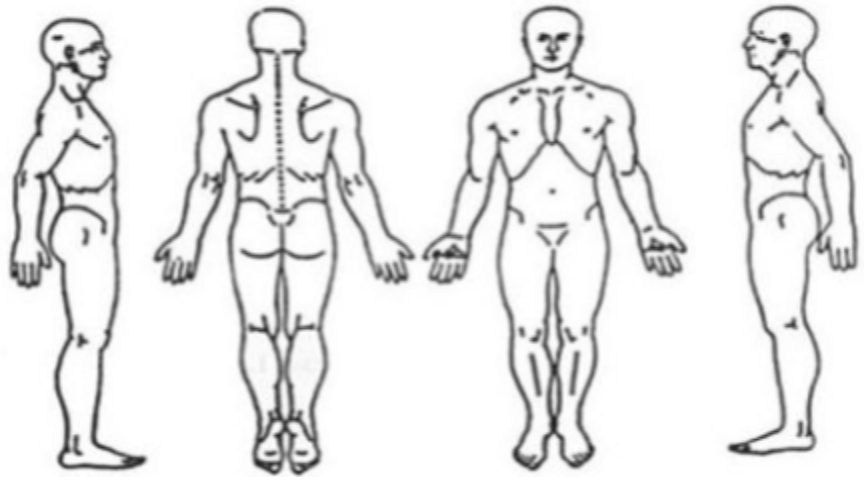
Patient Signature (or Legal Guardian): _____Date _____

Family History	Arthritis	□Parent	□Sibling
	Hypertension	□Parent	□Sibling
	Cancer	□Parent	□Sibling
	Stroke	□Parent	□Sibling
	Diabetes	□Parent	□Sibling
	Thyroid	□Parent	□Sibling
	Heart Disease	□Parent	□Sibling
	Other	_____	

Occupational Activities	□Administration	□Business Owner	□Clerical
	□Heavy Equipment Operator	□Childcare	□Computer
	□Health Care	□Medium Manual Labor	□Construction
	□Food Service Industry	□Manufacturing	□Home
	□Heavy Manual Labor	□Light Manual Labor	□Executive/Legal
	□Housekeeping	□Other: _____	

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N= Numbness B= Burning S= Sharp
A= Dull Ache T= Tingling



Patient Signature (or Legal Guardian): _____Date _____

Average Pain Intensity: (Circle one)

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No *If Yes, please explain:_____

When did your symptoms begin? _____

How did your symptoms begin? _____

Are your symptoms a result of? (Check one)
□Motor Vehicle Accident □Work-related Accident □Other_____

How often do you experience your symptoms? (Check one)

□**Constantly**	□**Frequently**	□**Occasionally**	□**Intermittently**
76-100% of the day	51-75% of the day	26-50% of the day	0-25% of the day

What describes the nature of your symptoms? □Sharp □Ache □Numb □Shooting
□Burning □Tingling □Throbbing □Other _____

Office Policy

Camilli Chiropractic is a Chiropractic Wellness clinic. This means that we provide Chiropractic Adjustments/Manipulation and manual mobilization as our primary therapy. Care is directed at improving functionality and reducing fixations that impair balance, disrupt activities of daily living and result in pain or immobility.

At **Camilli Chiropractic** our patients can access our care on a visit by visit basis, a "Patient Membership", or a "Treatment Package". The fees for these services are posted in our office and on our website. Our office hours are also posted and can be subject to change. We do not bill insurance for our services.

Camilli Chiropractic is not an acute trauma clinic. **We do not accept new patients that experience new injuries arising from, or associated with, a current automobile claim or workman's compensation claim.** We will refer those injuries to the appropriate Chiropractic or medical facility that can perform a complete post injury work-up.

Consent to Release Information

I _____ (Print) give **Camilli Chiropractic** my consent to release/obtain information from the following individuals with respect to my care by report, letter, phone, fax, email, or direct communication: _____

Patient Signature (or Legal Guardian): _____Date _____

Explanation of Chiropractic Care, Benefits and Risks

Chiropractic:

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment. Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, nutrition, electrical or thermal therapy and exercise.

Benefits:

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for more invasive care such as drugs or surgery.

Risks:

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.
The risks include:

- The temporary worsening of symptoms-- Usually, any increase in pre-existing symptoms of pain or stiffness will only last a few hours to a few days.
- Sprain or Strain-- Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- Rib fracture-- While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- Injury or aggravation of a disc-- Over a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities. Patients who already have a degenerated or damaged disc may or may not have symptoms. Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition. The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed in the most severe cases.
- Stroke-- Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke. Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and traveling up to the brain. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke, but stroke has occurred while patients have been in Chiropractic care. However, that association occurs very infrequently, and may be explained because an artery was already damaged, and the patient was progressing toward a stroke when the patient consulted the chiropractor. The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives:

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Patient Signature (or Legal Guardian): _____Date _____

Questions or Concerns:

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

I hereby acknowledge that I understand the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

Patient Name (Print)**:** _____

Patient Signature (or Legal Guardian):

_____Date _____

Medicare Eligible Patients
Advanced Beneficiary Notice of Non-Coverage (ABN) Form

Notifier: Camilli Chiropractic
4620 Dick Pond Rd. (Rt. 544) Unit D
Myrtle Beach, SC 29575

Patient Name (Print): _____

Attention: If Medicare does not pay the Chiropractic care that is described below the patient is subject to pay. Medicare does not pay for everything, even care that you and your provider have reason to believe you need. We understand that Medicare may not pay for the Chiropractic maintenance care you require.

Description of Care:

- Chiropractic Maintenance Care is a treatment rendered on a routine basis to preserve optimal function, reduced pain and sustain balance. This care is rendered to enhance activity and sustain general well-being.
- Estimated cost for this care ranges between $10.00 to $50.00 per visit.
- Reason Medicare may not pay: Spinal manipulative therapy provided for maintenance rather than restorative/corrective care is not a payable service according to Medicare.

Options: Please circle the option that you prefer below. Please note that this office does not accept third party (insurance) payments and does not bill these agencies on behalf of the patient.

Option 1	I want the maintenance chiropractic care mentioned above and will not bill Medicare. The renderer of care may asked to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
Option 2	I do not want the Maintenance care described above. I understand with this choice that I will be referred/recommended to a different provider that accepts Medicare parameters for payment. I cannot appeal to Medicare to see if they will pay for any services in this office.
Option 3	I want the maintenance care described, and I understand that I am responsible to pay for my care now. I also want Medicare billed for official decisions on payment, which is sent to me every 3 months on a "Medicare Summary Notice" (MSN). I understand that if Medicare does not pay that I am responsible, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay for these services, prior payments would be refunded less co-pays and deductibles. By selecting this option, I understand that this office does not bill for these services and I will be referred/recommended to another provider.

I understand that this notice is the opinion of this office and not an Official Medicare Decision. I am free to contact Medicare at 1-800-MEDICARE (1-800-633-4227)/TTY: 1-877-486-2048.

I also understand that If I choose Option 1. and except the terms of care that I must complete this form annually.

Patient/Legal Guardian Signature: _____Date:_____