Patient Name: _____ Date: _____

WELCOME TO PANGEMANAN CHIRO! PLEASE FILL OUT COMPLETELY + LEGIBLY - PATIENT INFORMATION / INTAKE FORM

*WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

How did you FIND our PHONE NUMBER? ___Friend told me ___Business Card ___Internet ___Phone Book:.....

Last Name .....First Name ..... Nick Name..... Middle Initial..... **Sex**: M / F

Date of Birth (DOB) ...../...../..... **SSN #** .....-.....-..... **Status**: Married / Partnered / Single / Widowed / Divorced

Address .....City .....State..... Zip .....

Home Phone:_____
Cell Phone: _____
Work Phone: _____
Preferred Method of Contact:
__Home __Cell __Work

E-mail address: ..... (for appointment reminder + health newsletter)

Occupation ..... Since ...../..... Employer .....

Spouse's Name ..... Phone#.....

Emergency Contact: ..... Relationship:..... Phone: .....

Previous Chiropractor..... Last Treatment ...../..... to ...../.....

City .....State..... For the same problems? YES / NO If yes, did it help? Yes / No

Family Medical Doctor..... City .....State ..... May we contact your doctor(s) ? YES / NO.

(WOMEN Initial ____) I realize X-ray may be hazardous to an unborn child and I certify that I am not pregnant. Date last period:...../...../.....

The following person(s) have my PERMISSION TO ACCESS / RECEIVE my health information: (PLEASE PRINT CLEARLY)

Name..... Relationship..... Name..... Relationship.....

Name..... Relationship..... Name..... Relationship.....

PAYMENT FOR SERVICES WILL BE BY: ❑Cash/Credit Card ❑Health Ins. (enter below) ❑Automobile Ins. Claim#.....

Primary Insurance Company .....Plan Type ..... ID # .....

Who carries this policy? __Self __Spouse __Parent Insured's First, Last Name..... DOB...../...../.....

Supplement/Secondary Insurance Company .....Plan Type ..... ID # .....

CREDIT GUARANTEE Patients who are uninsured or whose insurance does not cover chiropractic care because of high deductibles or other limitations are personally responsible for payment. Your (patient's) insurance policy is an agreement between you and your insurance company. As a courtesy to the patient, we will bill your health insurance carrier on your behalf and wait up to 30 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment. Any payments made on these claims thereafter will be refunded to you. By signing below you, the patient, agree to these terms and authorize Pangemanan Chiropractic to charge this card below for any payment due.

CREDIT CARD: ❑ VISA ❑ MASTERCARD ❑ DISCOVER ❑ AMEX

CARDHOLDER NAME: _____ CARD # _____EXP. DATE_____

ACKNOWLEDGEMENTS: (1) All of the health and personal information I entered on all forms from this office is complete and truthful and I understand that it is my responsibility to inform Pangemanan Chiropractic LLC (PC) of any changes in my medical status or personal information. If there is anyone I do not want access to my records or health information, I will inform PCin writing. (2) I authorize PC to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I authorize payment of benefits directly to PC. (3) I acknowledge that any insurance I may have is an agreement between the insurance company and me, and that I am responsible for the payment of any covered or non-covered services I receive. (4) I grant permission to PC to be contacted by phone, email or text to confirm or reschedule appointments and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office. (5) I understand that there are no warranties, express or implied. I may choose not to follow the doctors' advice and/or terminate my care at any time and take full responsibility of the consequences, such as relapse and/or worsening of my symptoms. (6) I understand my evaluation and treatment will be conducted in a room and in an open space where others may see and/or hear my conversation and medical records, so therefore I release PC from any liabilities related to HIPAA or privacy laws infringement or violations. (7) I have read, understood, accepted, and hereby consent to the terms on PC's Care Agreement, the Consent for Chiropractic Care, Financial Policy, Notice of Privacy Practices Pursuant To HIPAA and Consent for Use or Disclosure of Protected Health Information for the Purposes of Treatment, Payment and Healthcare Operations (HIPAA 2013). (8) I have had plenty of opportunity to ask questions regarding anything that I do not understand. I hereby request chiropractic care and adjunctive services by PC.

Patient's Legal Signature: **X**_____ Guardian's Signature Authorizing Care _____ Date:_____

(Signature must match Signature on Driver's License or Passport)

FAMILY / MEDICAL HISTORY Please mark **S (self), or M (Mother), F (Father), B (Brother), S (Sister)** on any of these conditions:

___AIDS/HIV positive	___Bladder Trouble	___Depression	___Insomnia	___Neck Pain
___Anemia	___Cancer	___Dislocated Joints	___Kidney Disorders	___Poor Circulation
___Arthritis	___Chest Pain	___Epilepsy	___Bowel Control Loss	___Polio
___Asthma/Hay Fever	___Concussions	___Headache/Migraine	___Mental Illness	___Reproductive Disorders
___Back Pain	___Convulsions	___Heart Trouble	___Muscular Dystrophy	___Scoliosis
___Bone Fracture	___Diabetes	___Hepatitis	___Multiple Sclerosis	___Sinus Trouble
___Bursitis	___Emphysema	___High Blood Pressure	___Neuritis/Neuralgia	___Spinal Surgery

REVIEW OF SYSTEMS Have you had, or do you now have any of the following symptoms/conditions? **Mark N = Now P=Past**

CONSTITUTIONAL:	___Fainting	___Fast weight gain/loss	___Poor appetite	___Low libido	___Weakness
MUSCULOSKELETAL:	___Osteoporosis	___Scoliosis	___Neck Pain	___Back Problems	___Poor Posture
	___TMJ Issues	___Feet/ankle/knee pain	___Elbow/wrist pain	___Shoulder Problems	
NEUROLOGICAL:	___Dizziness	___Depression/Anxiety	___Headache	___Pins/Needles	___Numbness
CARDIOVASCULAR:	___Heart attack	___High / Low BP	___Stroke	___High Cholesterol	___Easy bruising
RESPIRATORY:	___Asthma	___Apnea	___Emphysema	___Difficult breathing	___Pneumonia
DIGESTIVE:	___Ulcer	___Diarrhea recurrent	___Food Allergy	___Heartburn	___Constipation
SENSORY:	___Blurred vision	___Ringing in ears	___Hearing Loss	___Loss of Smell	___Loss of Taste
INTEGUMENTARY:	___Skin cancer	___Psoriasis	___Eczema/ Rash	___Acne	___Hair Loss
ENDOCRINE:	___Hypoglycemia	___Thyroid disorder	___Immune disorder	___Swollen glands	___Low energy
GENITOURINARY:	___Infertility	___ Erectile dysfunction	___Bedwetting	___ Kidney stones	___PMS symptoms

Any congenital / hereditary / genetic health issues you know about? .....

Any health condition you've been treated by a physician in the last year: .....

MEDICATIONS / SUPPLEMENTS *(name, what for)* .....

SURGICAL HISTORY*:(What kind, month/year)*.....

*For women, please include information on *childbirth(s)* + dates: .....

SOCIAL HISTORY Tell us about your **health habits** and **stress levels**:

Alcohol use:	__Daily	__Weekly	How much? _____	Prayer / Meditation:	❑Yes / ❑No
Coffee use:	__Daily	__Weekly	How much? _____	Job Pressure / Stress:	❑Yes / ❑No
Tobacco use:	__Daily	__Weekly	How much? _____	Financial Peace:	❑Yes / ❑No
Exercising:	__Daily	__Weekly	How much? _____	Breakfast:	❑Yes / ❑No
Painkillers:	__Daily	__Weekly	How much? _____	Recreational drugs:	❑Yes / ❑No

ADL. Rate ZERO (0=no effect) to FIVE (5=severe) on how your symptoms interfere with your life and ability to function:

__*Sitting*	__*Standing*	__*Computer Use*	__*Grocery Shopping*	__*Household Chores*
__*Driving*	__*Shower/Bath*	__*Dressing yourself*	__*Exercising*	__*Sleeping*
__*Lifting*	__*Yard Work*	__*Reaching overhead*	__*Love life*	__*Caring for Family*

ACCIDENT / INJURY HISTORY*: (Month/year)* ❑Job ❑Auto ❑Other .....

__Bone(s) fractured:..... __Spine/Nerve Disorder __Knocked Unconscious __Used crutch/ neck/back brace

Any **additional symptoms** you have been experiencing:

❍ Blurred Vision	❍ Constipation	❍ Dizziness	❍ Head Seems Heavy	❍ Loss of Balance
❍ Buzzing/Ringing in Ears	❍ Confusion	❍ Fainting	❍ Headaches	❍ Loss of Smell / Taste
❍ Cold Feet/Hands	❍ Depression	❍ Fatigue	❍ Insomnia / Toss+Turn	❍ Muscle Jerking ……..
❍ Cold Sweats	❍ Diarrhea	❍ Fever	❍ Light Bothers Eyes	❍ Shortness of Breath
❍ Pins + Needles in Arms	❍ Pins + Needles in Legs		❍ Numbness in Fingers	❍ Numbness in Toes

IN REGARDS TO YOUR PRESENT CHIEF COMPLAINTS:

Have you ever had the same or a similar condition in the past?❑ Yes ❑ No If yes, when and describe……

Doctors Recently / Previously Seen for these condition(s):……

Have you had any X-rays, CT or MRI or any tests taken for this problem(s) in the last 2 years? ❑Yes / ❑No

(If yes, ask to have the written radiology reports faxed to us) **#Days lost from work** .....

What is the major **stressor** in your life? ..... How much **sleep** do you average per night? ___ Hours

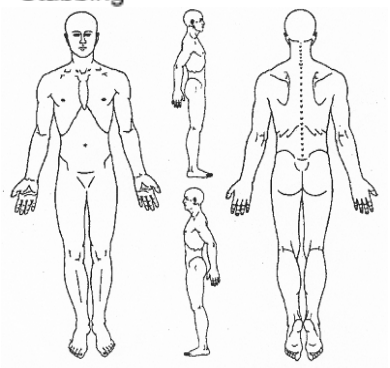
In addition to the main reason(s)/complaints for your visit today, what additional health goals do you have?

.....

PANGEMANAN Chiropractic, 1004 Dewey Dr, Ste C, Lawrenceburg K$ 40342. Ph. 502-839-7171. Web: www.839-7171.com

Please mark accordingly:

Numbness - - - - -
Tingling O O O
Burning ^ ^ ^ ^
Aching X X X
Stabbing



Box Reserved for Doctor's Notes

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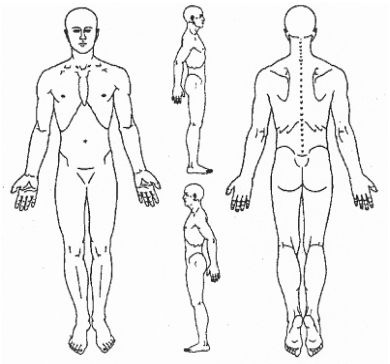

1. What is your **MAJOR COMPLAINT (#1)**? Where?.....

a. This is the result of: ☐Unknown ☐ Auto accident ...../...../.....

☐Gradual onset ☐Job related ..../...../.... .....

b. *ONSET*. When did you first notice your current symptoms:
___days # ___weeks # ___months #___years ago

c. What makes it WORSE? __Stand __Sit __Twist __Bend __Lift
.....

d. What makes it BETTER? __Stand __Sit __Sleep __Morning __Evening
__Medicine/Drug.....

e. *QUALITY*. What does it feel like? __Achy __Sharp stabbing __Numb __Tingling
__Stiff / Cramps __Burning __Throbbing

f. *RADICULAR*. Does the pain shoot/travel/radiate to other body parts? Where? .....

g. *SEVERITY*. Rate your symptoms intensity from zero (absent) to ten (excruciating):
0 1 2 3 4 5 6 7 8 9 10

h. *TIMING*. How often do you feel it? ☐*Come+Go* ☐*Frequent* ☐*Constant*
☐*Getting Worse* ☐*Getting Better* ☐*Stay the same*

i. Past interventions to relieve symptoms: __ Chiropractic __ Physical Therapy __Massage

Additional Info: .....

2. What is your **SECONDARY COMPLAINT (#2)**? Where?.....

a. This is the result of: ☐Unknown ☐ Auto accident ...../...../.....

☐Gradual onset ☐Job related ..../...../..... .....

b. *ONSET*. When did you first notice your current symptoms:
___days # ___weeks # ___months #___years ago

c. What makes it WORSE? __Stand __Sit __Twist __Bend __Lift
.....

d. What makes it BETTER? __Stand __Sit __Sleep __Morning __Evening
__Medicine/Drug.....

e. *QUALITY*. What does it feel like? __Achy __Sharp stabbing __Numb __Tingling
__Stiff / Cramps __Burning __Throbbing

f. *RADICULAR*. Does the pain shoot/travel/radiate to other body parts? Where? .....

g. *SEVERITY*. Rate your symptoms intensity from zero (absent) to ten (excruciating):
0 1 2 3 4 5 6 7 8 9 10

h. *TIMING*. How often do you feel it? ☐*Come+Go* ☐*Frequent* ☐*Constant*
☐*Getting Worse* ☐*Getting Better* ☐*Stay the same*

i. Past interventions to relieve symptoms: __ Chiropractic __ Physical Therapy __Massage

Additional Info: .....

.....

.....

PANGEMANAN Chiropractic, 1004 Dewey Dr, Ste C, Lawrenceburg K$ 40342. Ph. 502-839-7171. Web: www.839-7171.com

CARE AGREEMENT & CONSENT FOR CARE - Pangemanan CHIROPRACTIC

The patient (hereinafter referred to as "Patient(s)" or "I"/"my"/"me") identified above authorizes PANGEMANAN Chiropractic (hereinafter referred to as "PC") to use and disclose protected health information and has agreed to the following. By my signature below, I acknowledge and accept the terms and conditions stated here:

1. I authorize the release of necessary medical information to PC for purposes of processing this or any related insurance claims. I also give PC the authority to make available any requested documents contained in my file to myself and/or other health care provides involved in the treatment of my condition. I have the right to revoke this authorization, in writing, at anytime. However, my written request to revoke this authorization is effective to the extent that PC has provided services or taken action in reliance on my authorization. I may revoke this authorization by mailing or hand delivering a written notice to PC that must contain the following information: My name, SS#, and Date of Birth, a clear statement of my intent to revoke this authorization, the date of my request and my signature. The revocation is not in effect until received by PC requests this authorization for its own use/disclosure of PHI. I have the right to refuse to sign this authorization; PC reserves the right to refuse to provide treatment. I have the right to inspect a copy of the PHI to be used/disclosed. I have the right to rescind within 72 hours any obligation to pay for services performed in addition to free or discounted service.
2. PAYMENT & INSURANCE. I acknowledge that I am fully responsible for all the charges incurred at PC for the services or products I received including my insurance deductible, co-payment, and any services or products rejected by my insurance company. I understand that health insurance is a contract between me and the company and that insurance have limits to what they will pay. I authorize PC to release any information needed for this claim to the necessary carriers or their intermediates. I request that payment under the medical insurance program be made to PC for any services or equipment furnished to me. I request that a copy of this authorization be used in place of the original. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that if PC submits a claim for billed charges to my health plan(s) on my behalf, I am not relieved of my financial responsibility for payment. In the event that the health plan or any third party payor does not pay the entire billed amount, I agree to pay any remaining balance within 90 days since services performed except as restricted by specific Medicare and Medicaid reimbursement policies. I understand that PC has a Zero Balance Policy, and PC reserves the right to refuse care to patients with outstanding balance at anytime and the right to collect using various collection methods. I understand and agree that PC is not responsible to send bills or charges to patients.
3. PERMISSION. I give permission to PC to be called or texted to confirm or reschedule an appointment, including leaving a voicemail message, on the phone numbers given, and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office. I give PC permission to treat me in an open room where other patients are also being treated without sound or visual barriers. I am aware that other persons in the office may see or overhear some of my protected health information during the course of care. Should I need to speak with the doctor in private, the doctor will provide a room for private conversation with a staff in the room. I agree to be responsible for charges for texts or voicemails and can revoke this permission in writing to PC. I give PC full permission to use photographs or videos taken of me or my minor children for the purpose of educating the public about the benefits of chiropractic care.
4. RISKS I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me by the doctors and staff of PC who now or in the future treat me while employed by, working or associated with, or serving as a backup for PC's doctors. I have had the opportunity to discuss my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. The doctor will use a mechanical instrument or hands upon my body in such a way as to move my joints. In rare cases, may cause an audible "pop" or "click" much as I have experienced when I "crack" my knuckles and I may feel or sense movement. With the instrument, the pressure exerted on the joint is somewhat comparable to the pressure exerted when testing the ripeness of a fruit such as avocado or pear. I understand that there are some risks to exam and treatment within chiropractic including, but not limited to, bruising, musculoskeletal discomfort, soreness, inflammation, dizziness, burns, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. The incidences of stroke are rare and are estimated may occur in 1 in 5.8 million cervical adjustments. The best evidence indicates that the incidence of artery injuries associated with high-velocity, upper-neck manipulation is extremely rare – about 1 case in 5.85 million manipulations. To put this risk into perspective, if a person drives more than a mile to get to my chiropractic appointment, s/he is at greater risk of serious injury from a car accident than from my chiropractic visit. For more comparison, there are about 500 deaths per 1 million neck surgery, 153 deaths per 1 million users, and less than one death in almost 6 million chiropractic treatments (ACA, Haldeman et al.). PC will make every reasonable effort during the examination to screen for contraindications to care; however, if I have a condition that would otherwise not come to our attention, it is my responsibility to inform PC. Some patients will feel some stiffness, soreness, or aggravation of original symptoms following the first few days of treatment or following activities at home or work that requires bending, lifting, pushing, pulling, prolonged sitting, prolonged standing, poor posture while sleeping, sitting, standing, etc. I hold PC and affiliated individuals or corporations not culpable or liable for problems arising from the care and services I received when I am not compliant with the treatment plan and recommendations. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.
5. CARE COMPLIANCE: For my own benefits, I agree to keep my appointments and follow the treatment schedule prescribed by the doctor(s) at PC. In rare cases where I have to cancel my appointment, I will make every effort to change my scheduled appointment(s) at least 24 hours prior to the scheduled appointment. I agree to follow the home / workplace care instructions prescribed by the chiropractic doctor(s) at PC. This includes, but not limited to, icing instructions (cryotherapy) to reduce swelling and inflammation, exercises, stretches, rest, posture, etc. Failure to keep the prescribed appointments and perform the home or workplace care instructions (ice applications, exercises, stretches, posture, etc) will likely result in a slow recovery and possible worsening or relapse of symptoms. PC reserves the right to stop my care at any time and refer me to another chiropractic doctor or medical doctor for my own benefit.
6. FEDERAL HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPAA) RELEASE AGREEMENT: I hereby consent to PC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services rendered to me or to carry out PC's healthcare operations. I also consent to PC using or disclosing my protected health information for treatment activities provided by another healthcare provider, as well as the payment activities conducted by another healthcare provider or entity. I further consent to the disclosure of my protected health information in order for another provider or healthcare entity to conduct healthcare operations including quality assessment and reviewing competence of healthcare professionals. I hereby authorize PC to perform an examination and any other medical services deemed necessary. I authorize the release of any medical information required by my insurance carrier for services furnished to me by PC. I acknowledge PC has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this Consent, as well as other rights I have regarding my protected health information. I certify that I have fully informed myself of the contents of this Consent Form by reading it or having it read to me and by asking any questions to clarify the information so that I completely understand and agree with its contents before I sign it. I understand that protected health information may be disclosed or used for treatment, payment or healthcare operations. I acknowledge I had the opportunity to review the Notice of Privacy Practices. I acknowledge and give permission to PC who may utilize my testimonials, images, personal stories from the care that I received for public education or promotional purposes. I have the right to restrict the uses of my information but PC does not have to agree to those restrictions. I may also revoke this Consent in writing at any time and all future disclosures will then cease. PC reserves the right to change the Notice of Privacy Practices, and may condition treatment upon the execution or revocation of this Consent. Information used or disclosed pursuant to this Consent may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X_____	**X**_____	**X**_____	_____
Patient Name	Patient Signature	Date	Staff Initial