Addasu Family Chiropractic | Dr. Kevin Powell
1585 Mallory Lane, Suite 208, Brentwood, TN 37027
P (615) 590-9618 |F (615) 5909619 |www.addasufamilychiro.com

PREGNANCY INTAKE PAPERWORK

HELLO AND WELCOME TO ADDASU FAMILY CHIROPRACTIC!

Who may we thank for referring you / how did you hear about us? ______________________________

Please fill out the following information and to the best of your ability.

PATIENT'S NAME: ______________________________ HR#: ______________ DATE: ______________

PERSONAL INFORMATION

Name: ______________________________ Birthdate: _____-_____-_____ Age: _______ ❑ Male ❑ Female
Preferred Name: ______________________________ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
E-mail: ______________________________ Do you have insurance? ❑ Yes ❑ No
Address: ______________________________ City: ______________________________ State: _____ Zip: ____________
Home Phone: ______________________ Work Phone: ______________________ Mobile Phone: ______________________
Social Security #: ______________________________ Driver's License #: ______________________________
Employer: ______________________________ Occupation: ______________________________
Spouse's Name ______________________________ Spouse's Employer ______________________________
Number of children and ages: ____
Name & Number of Emergency Contact: ______________________ ______________________Relationship: ______________________

PERSONAL HEALTH HISTORY

Height: __ ft __ in Weight: ___ lbs

What is your typical daily work activity?

❑ Sitting ❑ Standing ❑ Working at a Computer
❑ Manual Labor ❑ Light Lifting ❑ Heavy Lifting
❑ Driving ❑ Other: ______________________

Indicate if you have experienced the following:

❑ Been unconscious due to an illness or injury
❑ Serious illness, operation, or health emergency
❑ Motor vehicle accident. ❑ Fractured a bone
Explain (include year(s)):______________________

List any over-the-counter/prescription drugs and vitamins/supplements that you are currently taking: ❑ N/A ______________________
____

Do you have any genetic disorders or disabilities? ❑ No ❑ Yes *If yes, explain*: ______________________________

SOCIAL HISTORY

Do you smoke:	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
Are you exposed to second hand smoke?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
Do you drink alcohol?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
Do you use recreational drugs?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
How often do you exercise?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes,** how many times? ___________
When was the last episode? ______________________ How did the injury happen? ______________________________
Other forms of treatment tried: ❑ No ❑ Yes **If yes,** please state what type of treatment: ______________________
Who provided it? ______________________ How long ago? ___________ What were the results. ❑ Favorable ❑ Unfavorable
Please explain: ____
Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:
____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the ***Past*** **C** for ***Currently*** have **N** for ***Never*** have had

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: ______________________

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem: ❑ N/A

Injuries: ❑ No ❑ Yes Surgeries: ❑ No ❑ Yes Childhood Disease: ❑ No ❑ Yes Adult Diseases: ❑ No ❑ Yes

If yes*:* What was/is the injury, surgery or disease? ____
How long ago? ____________ What type of care did you receive? ______________________ Provided by whom? ______________________

CONCEPTION/PREGNANCY/BIRTH

Was your baby conceived using IVF? ❑ Yes ❑ No Intended location of birth: ❑ Home ❑ Hospital ❑ Other:___________________________

Have you received Hormonal medication prior to / for pregnancy? ❑ Yes ❑ No

What is your desired birth plan? ❑ Vaginal ❑ C-Section ❑ VBAC

Please check all that apply to your birth plan: ❑ Epidural ❑ Pain Medication ❑ Placenta delivery ❑ Other: ____________________________

Do you have complicating factors for pregnancy such as: ❑ PCOS ❑ Endometriosis ❑ Obesity ❑ Other: ______________________________

Is there anything else you feel the Doctor should know? ____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: ____

Secondary: ___________________________ Third: _____________________________ Fourth: ___________________________________

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? ________________________ When is the problem at its worst? ❑ AM ❑ PM ❑ mid-day ❑ late PM

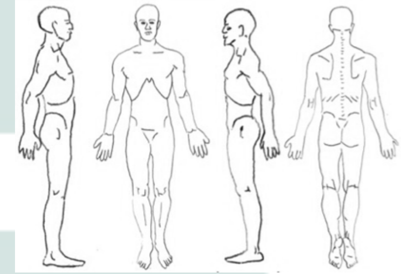
How long does it last? ❑ It is constant ❑ I experience it on and off during the day ❑ It comes and goes throughout the week

How did the injury happen? ____

Condition(s) ever been treated by anyone in the past? ❑ No ❑ Yes **If yes,** when? _______ by whom? ____________________________

How long were you under care? ____________ What were the results? ____

Name of previous chiropractor: ___________________________________ ❑ **N/A**



PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

What relieves your symptoms? ____

What makes your symptoms feel worse? ____

Is your problem the result of ANY type of accident? ❑ Yes ❑ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

____

____

FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes **If yes,** whom?

❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister(s) ❑ brother(s) ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

Any other hereditary conditions the doctor should be aware of? ❑ No ❑ Yes: ____

CHIROPRACTIC & HEALTH LIFESTYLE GOALS

What are your health and lifestyle goals you hope to achieve while under chiropractic care?

PLEASE CHECK ALL THAT APPLY:

❑ Decrease the severity & intensity of my pain/problem(s)

❑ Decrease the frequency of my pain/problem(s) (how often the pain/problem(s))

❑ By the end of my corrective chiropractic care, I hope to be able to ________________________________

I hereby authorize payment to be made directly to Addasu Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Addasu Family Chiropractic for any and all services I receive at this office.

____________________________________ ______ - ______ - ______

Patient or Authorized Person's Signature **Date Completed**

____________________________________ ______ - ______ - ______

Doctor's Signature **Date Form Reviewed**

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activity	No Effect	Minimal Pain (can do)	Significant Pain (limited activity)	Unable to Perform	N/A
Bath/Shower	❑	❑	❑	❑	❑
Groom Hair	❑	❑	❑	❑	❑
Brush Teeth	❑	❑	❑	❑	❑
Use Toilet	❑	❑	❑	❑	❑
Dress Upper Body	❑	❑	❑	❑	❑
Dress Lower Body	❑	❑	❑	❑	❑
Daily Physical Activities	❑	❑	❑	❑	❑
Stand	❑	❑	❑	❑	❑
Walk	❑	❑	❑	❑	❑
Sit	❑	❑	❑	❑	❑
Squat	❑	❑	❑	❑	❑
Kneel	❑	❑	❑	❑	❑
Reach Overhead	❑	❑	❑	❑	❑
Bend Forward	❑	❑	❑	❑	❑
Turn Left	❑	❑	❑	❑	❑
Turn Right	❑	❑	❑	❑	❑
Seat to Standing	❑	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	❑
Eat	❑	❑	❑	❑	❑
Go Up/Down Stairs	❑	❑	❑	❑	❑
Get In/Out of Car	❑	❑	❑	❑	❑
Drive	❑	❑	❑	❑	❑
Use Computer	❑	❑	❑	❑	❑
Focus/Concentrate	❑	❑	❑	❑	❑
House Hold Choirs	❑	❑	❑	❑	❑
Lift Children	❑	❑	❑	❑	❑
Carry Bag/Purse	❑	❑	❑	❑	❑
Run/Hike	❑	❑	❑	❑	❑
Sexual Activity	❑	❑	❑	❑	❑
Other: _______________	❑	❑	❑	❑	❑

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
___________________________________	___________________________________	___________________________________
___________________________________	___________________________________	___________________________________
___________________________________	___________________________________	___________________________________
___________________________________	___________________________________	___________________________________
___________________________________	___________________________________	___________________________________

____
Patient or Authorized Person's Signature

_____ - _____ - _____
Date Completed

____
Doctor's Signature

_____ - _____ - _____
Date Form Reviewed

REVIEW OF SYSTEMS & ORGAN DYSFUNCTION

DIRECTIONS: Check the box(es) that apply to conditions that you or your family members currently have or have had in the past. (Adopted? ❑ No ❑ Yes)

Condition	Current	Past	Never	**Family** (if applicable) Circle: Child/Sibling/Parent/Grandparent
Acid Reflux/Heartburn/GERD	❑	❑	❑	❑ C/S/P/G
ADHD/ADD	❑	❑	❑	❑ C/S/P/G
Allergies	❑	❑	❑	❑ C/S/P/G
Anxiety	❑	❑	❑	❑ C/S/P/G
Arthritis/Joint Pain	❑	❑	❑	❑ C/S/P/G
Asthma/Difficulty Breathing	❑	❑	❑	❑ C/S/P/G
Autism Spectrum	❑	❑	❑	❑ C/S/P/G
Bed Wetting	❑	❑	❑	❑ C/S/P/G
Cancer	❑	❑	❑	❑ C/S/P/G
Carpal Tunnel Syndrome	❑	❑	❑	❑ C/S/P/G
Chest Pain	❑	❑	❑	❑ C/S/P/G
Constipation/Diarrhea	❑	❑	❑	❑ C/S/P/G
Depression	❑	❑	❑	❑ C/S/P/G
Diabetes	❑	❑	❑	❑ C/S/P/G
Difficulty Swallowing	❑	❑	❑	❑ C/S/P/G
Disc Problems	❑	❑	❑	❑ C/S/P/G
Dizziness/Vertigo	❑	❑	❑	❑ C/S/P/G
Eating Disorder	❑	❑	❑	❑ C/S/P/G
Ear Problems/Ringing	❑	❑	❑	❑ C/S/P/G
Epilepsy/Convulsions	❑	❑	❑	❑ C/S/P/G
Fibromyalgia	❑	❑	❑	❑ C/S/P/G
Frequent Illness (Cold/Flu/ect.)	❑	❑	❑	❑ C/S/P/G
Headaches/Migraines	❑	❑	❑	❑ C/S/P/G
Hearing Loss	❑	❑	❑	❑ C/S/P/G
Hemorrhoids	❑	❑	❑	❑ C/S/P/G
High/Low Blood Pressure	❑	❑	❑	❑ C/S/P/G
Infertility	❑	❑	❑	❑ C/S/P/G
Irritable Bowel Syndrome	❑	❑	❑	❑ C/S/P/G
Learning Disability	❑	❑	❑	❑ C/S/P/G
Loss of Balance	❑	❑	❑	❑ C/S/P/G
Menstrual Dysfunction	❑	❑	❑	❑ C/S/P/G
Mid Back Pain	❑	❑	❑	❑ C/S/P/G
Mood Changes/Irritability	❑	❑	❑	❑ C/S/P/G
Numbness/Tingling	❑	❑	❑	❑ C/S/P/G
Pain Coughing or Sneezing	❑	❑	❑	❑ C/S/P/G
Pregnancy (Now)	❑	❑	❑	❑ C/S/P/G
Scoliosis	❑	❑	❑	❑ C/S/P/G
Sinus/Drainage Problems	❑	❑	❑	❑ C/S/P/G
Swelling of Legs/Feet	❑	❑	❑	❑ C/S/P/G
TMJ/Jaw Pain	❑	❑	❑	❑ C/S/P/G
Tremors	❑	❑	❑	❑ C/S/P/G
Trouble Sleeping	❑	❑	❑	❑ C/S/P/G
Vision Problems	❑	❑	❑	❑ C/S/P/G
Organic/System Problems	❑	❑	❑	❑ C/S/P/G

If checked select ALL that apply: ❑ Digestive ❑ Gallbladder ❑ Liver ❑ Stomach ❑ Pancreas ❑ Colon ❑ Reproductive ❑ Lung/Respiratory ❑ Heart ❑ Urinary ❑ Kidney ❑ Prostate ❑ Vision ❑ Thyroid ❑ Skin ❑ Sexual

❑ Other(s): ________________________ Explain: ____

__________________________________ ______ - ______ - ______

Patient or Authorized Person's Signature **Date Completed**

______________________________________ ______ - ______ - ______

Doctor's Signature **Date Form Reviewed**

QUADRUPLE VISUAL ANALOGUE SCALE

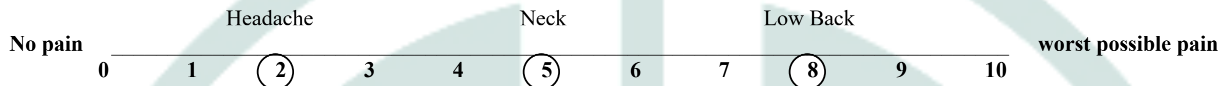
Patient Name ____ Date __________________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



1 – What is your pain RIGHT NOW?

2 – What is your TYPICAL or AVERAGE pain?

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

OTHER COMMENTS:

____

____

____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

TERMS OF ACCEPTANCE

Please read the below and if you have any questions, feel free to ask one of our staff members.

INFORMED CONSENT

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments. Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Addasu Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

___________________________________	___________________________________	____/____/____
Patient Name (print)	Patient Signature	Date
___________________________________	___________________________________	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
___________________________________	___________________________________	____/____/____
Witness Name (print)	Witness Signature	Date

AUTHORIZATION FOR X-RAYS

By signing below, I confirm that I **AM**/believe **I MAY BE** pregnant, therefore **I DO <u>NOT</u>** authorize Assasu Family Chiropractic to X-ray me at this time.

❑ The first day of my last menstrual cycle was on _____-_____-_____ (Date)

❑ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant. By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

After careful consideration, I do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case **<u>AFTER</u>** my pregnancy

___________________________________	___________________________________	____/____/____
Patient Name (print)	Patient Signature	Date
___________________________________	___________________________________	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
___________________________________	___________________________________	____/____/____
Witness Name (print)	Witness Signature	Date

HIPPA PERSONAL HEALTH INFORMATION RELEASE

I, ___________________________________, hereby authorize Addasu Family Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ❑ Spouse Name: ____
- ❑ Significant Other Name: ____
- ❑ Parent/Legal Guardian Name: ____
- ❑ Child(ren) Name(s): ____
- ❑ Any Specified Person Name: ____
- ❑ Information is not to be discussed with or released to anyone.

Restrictions:

- ❑ No Restrictions ❑ Only discuss my appointment time with the above-named individual(s).
- ❑ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ❑ Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call ❑ my home ❑ my work ❑ my cell phone Phone Number: _____ - _____ - _____

If unable to reach me:

- ❑ you may leave a detailed message ❑ please leave a message asking me to return your call
- ❑ ____

I understand I may terminate this consent at any time by giving written notice to Addasu Family Chiropractic. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: ____ Date: ______________________

ADASSU FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff.

YOUR RIGHTS:

1. To inspect or obtain a copy of your records within 15 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we've shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
9. For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

COMPLAINT: If you wish to make a complaint about how we handle your health information, please contact our Dr. Kevin G. Powell at drkpowell@addasufamilychiropractic OR call (615) 590-9618. If Dr. Powell is unavailable, you may make an appoint with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: U.S. Dept. of Health and Human Services, Office of Civil Rights |200 Independence Avenue, SW, Washington DC 20201 | 877-696-6775 | www.hhs.gov/ocr/privacy/hipaa/complaints

___________________________________ ______ - ______ - ______

Patient or Authorized Person's Signature **Date Completed**

_______________________________________ ______ - ______ - ______

Doctor's Signature **Date Form Reviewed**

ADASSU FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE *(CONTINUED)*

I hereby acknowledge I have read and received a copy of Addasu Family Chiropractic Privacy Practices Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice. I am aware an extended detail version of this "Notice" is available to me upon request. At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: ____ Date: ____________________

Print Name: ____ Telephone: _______________

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient
_____ Guardian or conservator of an incompetent patient
_____ Beneficiary or personal representative of deceased patient

Name of Patient: ____

For Office Use Only

Signed form received by: ____

Reason acknowledgment not obtained: ____

Efforts to obtain: ____

PATIENT'S NAME: __________________________________ HR#: ____________ DATE: __________