Flohr Chiropractic Clinic
1910 N. 22nd Ave
Bozeman, MT 59718
(406) 624-0022

New Patient Information Intake Form

Name (first, middle, last): _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Cell Phone: _____

Home Phone: _____ Email: _____

Date of Birth (mm/dd/yyyy): _____ Gender: M F

Marital Status (circle one): *single married separated divorced widowed other*

Social Security Number: _____ *(for insurance purposes only)*

How were you referred to Our office *(friend, newspaper, other)*? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Physician

Primary Physician: _____ Phone: _____

Date of last physical: _____

Financial Responsibility

Please indicate how you wish to handle your account with us:

_____ *Cash* _____ *Insurance* _____*Medicare* _____ *Auto Accident* _____ *Worker's Compensation*

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand that fees are due and payable at time of service unless other arrangements have been made in advance, or insurance is being billed first. Delinquent balances more than 90 days may be sent to collections and are subject to collection fees being added to the total amount due.

Signature: _____ Date: _____

Flohr Chiropractic Clinic
1910 N. 22nd Ave
Bozeman, MT 59718
(406) 624-0022

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Cell Phone provider (for text appointment reminders/AT&T, Verizon, etc.): _____

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. When did your symptoms start: _____ **Describe your symptoms and how they began:**

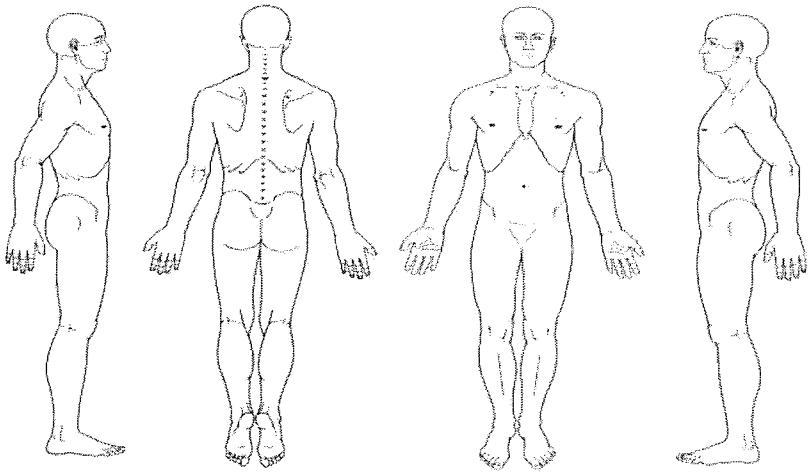
_____

_____

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

☐ No One ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
☐ MRI *date:* _____ ☐ Other *date:* _____

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ This Office ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

11. What is your occupation?

_____

☐ Professional/Executive ☐ Laborer ☐ Retired
☐ White Collar/Secretarial ☐ Homemaker ☐ Other
☐ Tradesperson ☐ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Self-employed ☐ Off work
☐ Part-time ☐ Unemployed ☐ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*

☐ Reduce symptoms ☐ Explanation of condition/treatment ☐ How to prevent this from occurring again
☐ Resume/increase activity ☐ Learn how to take care of this on my own ☐

13. Have you previously received chiropractic care: Yes No

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

Do you consume alcohol: [ ] Daily [ ] Weekly [ ] Occasionally [ ] Never

Do you consume caffeine: [ ] Daily [ ] Weekly [ ] Occasionally [ ] Never

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke			
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking/Use Tobacco Products
						☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones			
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Systemic Lupus
			☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Knee/Lower Leg Pain				☐	☐	HIV/AIDS
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Gain/Loss			
			☐	☐	Loss of Appetite	***Females Only***		
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Birth Control Pills
			☐	☐	Ulcer	☐	☐	Hormonal Replacement
☐	☐	Joint Swelling/Stiffness	☐	☐	Hepatitis	☐	☐	Pregnancy
☐	☐	Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	
☐	☐	Rheumatoid Arthritis						
			☐	☐	Cancer	***Other Health Problems/Issues***		
☐	☐	General Fatigue	☐	☐	Tumor	☐	☐	
☐	☐	Muscular Incoordination				☐	☐	
☐	☐	Visual Disturbances	☐	☐	Asthma	☐	☐	
☐	☐	Dizziness	☐	☐	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ Auto Immune

Other: _____

Please list any nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

Doctors Signature _____ ***Date*** _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

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 (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 upon the facts known, is my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

I hereby authorize the treatment of my minor son/daughter and have read the above consent information.

_____
(Parent/Guardian Signature)

To be completed by doctor or staff:

Flohr Chiropractic Clinic:

Doctor treating this patient: Josh Flohr, D.C.

Flohr Chiropractic
1910 N. 22nd Ave. Suite 1
Bozeman, MT 59718

Flohr Chiropractic Clinic
1910 N. 22nd Ave
Bozeman, MT 59718
(406) 624-0022

HIPAA Patient Privacy Policy

I understand that under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, both directly and indirectly.
2. Obtain payment from third-party payors.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

You may revoke or terminate this authorization by submitting a written revocation to this office. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand that this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure. The full-length Patient Privacy Policy is available to all patients. If you understand and agree with all of the above policies, please initial below to confirm your receipt of the privacy policy and sign your name below.

_____ I received and read the Patient Privacy Policy from Flohr Chiropractic.

_____ I was offered, but declined, a copy of the Patient Privacy Policy from Flohr Chiropractic.

Signature: _____ Date: _____

FLOHR CHIROPRACTIC

CANCELLATION POLICY/NO SHOW POLICY

STARTING NOVEMBER 1, 2018

If an appointment is not cancelled at least 3 hours in advance you will be charged a twenty dollar ($20) fee; this will not be covered by insurance. Your first 3 missed appointments will be charged the $20, after 3 missed appointments you will be charged the FULL appointment fee of $49.

Cancellation/No Show Policy

When you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. .

_____

Print Patient Name

_____ _____

Signature Patient/Guardian Date