Patient Intake Form

Patient Name: _____ Date: _____
Preferred Name: _____ Social Security #: _____
Mailing Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Date of Birth: _____/_____/_____ Age: _____ Sex: M F
Please circle your preferred method of contact: Email Telephone
Is the patient a minor? Yes No
Please circle one: Single Married Divorced Widowed
Spouse Name: _____
Employment Status: Full Time Part Time Retired Unemployed Student Other
Your Employer: _____ Work Phone: _____
Occupation: _____
Emergency Contact: _____

Responsible Party

Financially Responsible Party: Self Spouse Parent Other
Name of Person Responsible for this account: _____
Relationship to Patient: _____ Phone #: _____
Address: _____ City: _____
State: _____ Zip Code: _____

Referral Source

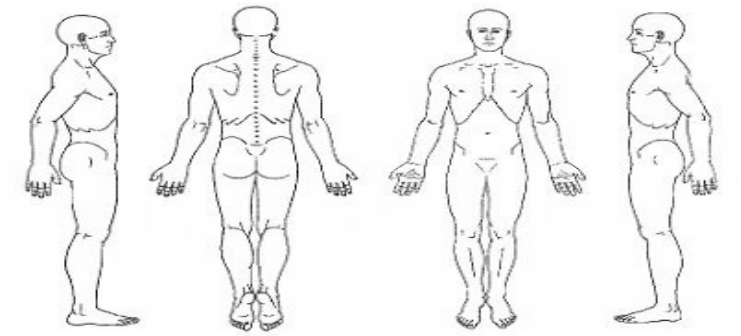
Were you referred by a patient of ours? Yes No
Patient's Name: _____
Were you referred by the Internet? Yes No
If so, what specific directory or site? (Ex. Facebook, Google, Instagram, Tik Tok, etc.)
_____
Were you referred by: Doctor Referral Lecture/Screening MAC
Other: _____

Insurance Information

We will help you in any way we can for you to file your Insurance claim, however we do not accept insurance reimbursements for Sports Chiropractic Services. In the past, we have seen patients get back an average of 60-80% from their insurance carriers, depending on what their out-of-network deductible is. *For more info on why we do not take insurance please refer to our website.*

Name on the Insurance: _____
Insurance Company: _____ Group #: _____
Insurance Phone #: _____ PPO / HMO / Other

1. Reason for visit: _____
2. When did you first notice the symptoms? _____
3. Is today's problem caused by: ☐ Injury ☐ Auto Accident
4. Indicate on the drawings below where you have pain/symptoms:



5. How often do you experience symptoms?
☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

6. How would you describe the type of pain?

☐ Sharp	☐ Numb
☐ Dull	☐ Tingly
☐ Diffuse	☐ Sharp with motion
☐ Achy	☐ Shooting with motion
☐ Burning	☐ Stabbing with motion
☐ Shooting	☐ Electric like with motion
☐ Stiff	☐ Other: _____

7. How are your symptoms changing with time?
☐ Getting worse ☐ Staying the same ☐ Getting better

8. Using a scale from 0-10 (10 being the worst) how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (please circle number)

9. How much has the problem interfered with your work?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

10. How much has the problem interfered with your social activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

11. Who else have you seen for your problem?
☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER Physician ☐Orthopedist ☐ Other _____
☐ Massage Therapist ☐ Physical Therapist ☐ No One

12. How do you think your problem began? _____
13. Do you consider this problem to be severe? ☐ Yes ☐ No ☐ Sometimes
14. What aggravates your problem? _____
15. What alleviates your problem? _____
16. What concerns you most about your problem? _____

17. What does it prevent you from doing? _____
18. What is your: Height _____ Weight _____

19. How would you rate your overall health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

20. What type of exercise do you do?
☐ Strenuous ☐ Moderate ☐ Light ☐ None

21. Please indicate if you have any immediate family members with any of the following:
☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ Heart Problems ☐ Cancer ☐ ALS

22. Date of last exams: _____
23. Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

24. List any types of surgeries which you have had and the dates that they occurred: _____
_____
_____

25. Please list all medications (prescription and over the counter) you are currently taking: _____
_____
_____

26. Please list all supplements you are currently taking: _____
_____
_____

27. Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____

28. How much liquor do you consume on a weekly basis? _____

29. How much coffee or caffeinated beverages do you consume on a daily basis? _____

30. What activities do you do at work?

Sit	☐ Most of the day	☐ Half of the day	☐ Little to none
Stand	☐ Most of the day	☐ Half of the day	☐ Little to none
Computer Work	☐ Most of the day	☐ Half of the day	☐ Little to none
On the phone	☐ Most of the day	☐ Half of the day	☐ Little to none

31. What activities do you do outside of work? _____
_____
_____

32. Have you ever been hospitalized? ☐ Yes ☐ No

33. Have you had significant past trauma? ☐ Yes ☐ No

34. Anything else pertinent to your visit today? _____
_____

35. For each of the conditions listed below, place a check in the "past" column if you have had the condition is the past. If you presently have a condition listed below, place a check in the "present" column:

Past	Present
☐	☐ Headaches
☐	☐ Neck Pain
☐	☐ Upper Back Pain
☐	☐ Mid Back Pain
☐	☐ Low Back Pain
☐	☐ Shoulder Pain
☐	☐ Elbow/Upper Arm Pain
☐	☐ Wrist Pain
☐	☐ Hand Pain
☐	☐ Hip Pain
☐	☐ Upper Leg Pain
☐	☐ Knee Pain
☐	☐ Lower Leg Pain
☐	☐ Ankle/Foot Pain
☐	☐ Jaw Pain
☐	☐ Joint Pain & Stiffness
☐	☐ Arthritis
☐	☐ Rheumatoid Arthritis
☐	☐ Cancer
☐	☐ Tumor
☐	☐ Asthma
☐	☐ Chronic Sinusitis
☐	☐ High Blood Pressure
☐	☐ Heart Attack
☐	☐ Chest Pains
☐	☐ Stroke
☐	☐ Angina
☐	☐ Kidney Disorders
☐	☐ Kidney Stones
☐	☐ Bladder Infection
☐	☐ Painful Urination
☐	☐ Loss of Bladder Control
☐	☐ Prostate Problems

Past	Present
☐	☐ Abn. Weight Gain/Loss
☐	☐ Loss of Appetite
☐	☐ Abdominal Pain
☐	☐ Ulcer
☐	☐ Hepatitis
☐	☐ Liver/Gall Bladder Disease
☐	☐ General Fatigue
☐	☐ Muscular Incoordination
☐	☐ Visual Disturbances
☐	☐ Dizziness
☐	☐ Diabetes
☐	☐ Excessive Thirst
☐	☐ Frequent Urination
☐	☐ Smoking/Tobacco Use
☐	☐ Drug/Alcohol Dependency
☐	☐ Allergies
☐	☐ Depression
☐	☐ Systemic Lupus
☐	☐ Epilepsy
☐	☐ Dermatitis/Eczema
☐	☐ HIV/AIDS
☐	☐Other _____

For Females Only

☐	☐ Birth Control Pills
☐	☐ Hormone Replacement
☐	☐ Pregnancy

Sports History

Were you active in sports? Yes No
Which one(s)? _____
Are you currently active in sports? Yes No
Which one(s)? _____
Have you been hurt in any of these Sports? Yes No
When/ How? _____

Chiropractic History

Have you ever received any form of Chiropractic Care? Yes No
If yes, who was your Chiropractor Practitioner? _____ State: _____
If yes, for how long did you receive care? _____
If yes, how often did you go? _____ If yes, when was your last visit? _____
If you stopped, why did you stop? _____
Does anyone in your immediate family receive chiropractic care? Yes No

Diagnostic History

If possible, bring your old diagnostic images and report with you when you come in for your appointment.

Has anyone ever taken imaging of your injured area? Yes No When? _____
Who has the images now? _____
What is that office's phone#: _____
Have you had, or do you receive any of the following:
(Include……. When, How Often, Last Session)
Exercise Training: Yes No _____ Massage: Yes No _____
Yoga: Yes No _____ Acupuncture: Yes No _____
Other Modalities: Yes No _____

Authorization Consent

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during or after the period of chiropractic care, to any third-party payers and/or health practitioners. I agree to be responsible for payment of all services rendered at the time of treatment on my behalf or my dependents behalf. I give permission to Dr. Bart Kennedy, D.C., C.C.S.P. to administer chiropractic treatment at Rock Sports and Spine therapy as explained to me, including the benefits and risks involved with the application of chiropractic manipulative therapy and the physical modalities used at this office. I also, agree that the Practice's Privacy Notice has been provided to me prior to my signing this consent and that I read and fully understand it. I understand my photograph made on behalf of Rock Sports & Spine may be used in connection with publicizing and promoting Rock Sports & Spine Therapy. I authorize Rock Sports & Spine Therapy to use my name, brief biographical information, and the photograph as defined on this form. I hereby irrevocably authorize Rock Sports & Spine Therapy to copy, exhibit, publish or distribute the photograph for purposes of publicizing Rock Sports & Spine Therapy services or for any other lawful purpose. These pictures may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I agree that I will make no monetary or other claim against Rock Sports & Spine Therapy for the use of the picture. In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my photograph appears. I hereby hold harmless and release Rock Sports & Spine Therapy from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization. I have read the authorization and release information and give my consent for the use of my photograph as indicated above.

Patient Signature _____ **Date** _____

14690 Memorial Dr. Houston, TX, 77079
Phone: 281.531.7465
Fax: 281.531.7657

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1. Some patients may experience some stiffness or soreness following the first few days of treatment.
2. Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3. We will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4. Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).
I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.
I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature **Patient Name (Please Print)**

_____ _____

Witness Signature **Date**

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.

(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.

(c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -
• (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

• (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e)Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f)Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h)Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i)Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j)Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k)Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l)Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m)Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n)Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o)Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Appointment Reminders

•Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
•You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

Sign-in Log

This Practice maintains a sign-in log for individuals seeking care and treatment in the office. This sign-in sheet are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

Family/Friends

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

• (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

• (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions

You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment

You Have a Right to

Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Practice

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

PRACTICE'S REQUIREMENTS

1.The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

Patient Signature: _____ Date: _____

Cancelled/Missed Appointments
Office Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding missed and/or cancelled appointments. **Please remember that we have reserved appointment times especially for you. Therefore, we kindly ask that if you need to change your appointment, you provide us 24 hours' notice.** This courtesy makes it possible to give your reserved time to another patient on our waiting list.

There will be a $75 fee charged for all missed appointments, or appointments not canceled 24 hours prior.
There will be a $150 fee charged for all "No Call, No Show" appointments.

Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Name: _____ Date: _____

Signature: _____