Old Mill Chiropractic
New Patient Intake Form

Initial Exam Date _____

Patient Information

Full Name _____ **Nickname** _____ **DOB**
First MI Last

Address _____ **City** _____ **State** _____ **Zip**

SS # _____ **Sex:** ☐ Male ☐ Female

Marital Status ☐ Single Married Divorced Widowed Other **Spouse's Name**

Race _____ **Primary Language Spoken** _____ **Ethnicity** _____ **Age** _____

Employer _____ **Occupation** _____

Contact Information

Home Phone _____ **Cell Phone** _____ **Work Phone** _____ **Ext.**

I prefer to receive calls at: ☐ Home ☐ Work ☐Cell

Email _____ **Preferred Method of Contact** Phone Email

Emergency Contact _____ **Relationship** _____ **Contact Phone** _____

How did you hear about us?
☐_____

Payment and Insurance Information

Person Responsible for Payment _____ **Date of Birth** _____ **Phone** _____

SS# _____ **Do you have health insurance?** ☐ Yes ☐ No **Are you the Policy Holder?** ☐ Yes ☐ No
Do you have secondary insurance? Yes No

Primary Insurance	**Secondary Insurance (If Applicable)**
Insurance Company	Insurance Company
Policy Holder's Name	Policy Holder's Name
Relationship to Patient	Relationship to Patient
Policy Holder's Birth Date	Policy Holder's Birth Date
Group Number	Group Number
Policy ID Number	Policy ID Number

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release- By signing below, I authorize Old Mill Chiropractic to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Old Mill Chiropractic and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment and health care operations. By signing below, I give my consent for examination and the performances any tests, treatments or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Patient/Guardian Signature _____ **Date** _____

Health Questionnaire

Patient Information

Full Name _____ Date of Birth _____ Height _____ Weight _____

Medical History

Describe the reason for your visit _____

When did your symptoms begin? _____ How did your symptoms begin? _____

How often do you experience your symptoms? □ Constantly □ Frequently □ Occasionally □ Intermittently
(76-100% of the day) (51-75% of the day) (26-50% of the day) (0-25% of the day)

Describe your symptoms? □ Sharp □ Dull Ache □ Numb □ Shooting □ Burning □Tingling □ Stabbing

How are your symptoms changing? □ Getting better □ Staying the same □ Getting worse

Are your symptoms affecting your daily activities? □ Severe (Unable to Perform) □ Moderate (Painful/Limited) □ Mild (Painful/Can Do) □ No Effect (Discomfort)

On a scale of one to ten how intense are your symptoms? (Not intense) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

History of Treatment

Primary Care Physician _____ Facility _____ Phone _____

Have you seen a Chiropractor before? □ Yes □ No **If yes, when was your last visit?**

Have you seen another doctor for these symptoms? If yes, who? _____

List all prescription and non prescription medications, as well as supplements you take. Include associated condition.

_____

List any surgeries or hospitalizations you have had. Include month and year for each.

_____

List any allergies.

Family History (list all major diseases such as cancer, diabetes, heart problems, etc and the relation to you and the individual)

_____

_____

Do you smoke? □ Yes □ No **If yes, how many packs per day? _____ Are you pregnant?** □ Yes □ No

Description of Condition

Using the key below, mark on the body diagram where you are experiencing the following symptoms:

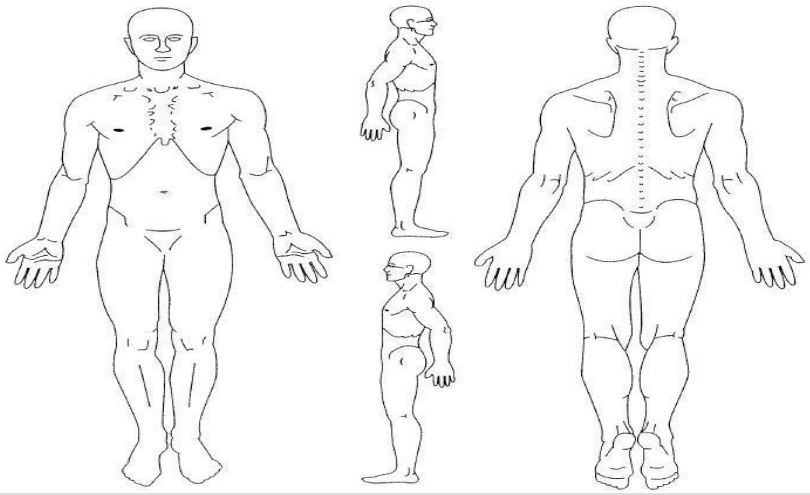
N=Numbness

B=Burning

S=Stabbing

T=Tingling

A=Dull Ache



Review of Systems

(Indicate if you have had conditions in the past or presently have the conditions)

Cardiovascular	Past	Present		**Respiratory**	Past	Present		**Allergic/Immunologic**	Past	Present
Poor Circulation				Asthma				Hives		
Hypertension				Tuberculosis				Immune Disorder		
Aortic Aneurysm				Short Breath				HIV/AIDS		
Heart Disease				Emphysema				Allergy Shots		
Heart Attack				Cold/Flu				Cortisone Use		
Chest Pain				Cough						
High Cholesterol				Wheezing						
Pace Maker								**Ear, Nose and Throat**	Past	Present
Jaw Pain /TMJ				**Eyes**	Past	Present		Difficulty Swallowing		
Irregular Heartbeat				Glaucoma				Dizziness		
Swelling of legs				Double Vision				Hearing Loss		
				Blurred Vision				Sore Throat		
Genitourinary	Past	Present						Nosebleeds		
Kidney Disease				**Psychiatric**	Past	Present		Bleeding Gums		
Burning Urination				Depression				Sinus Infections		
Frequent Urination				Anxiety						
Blood in Urine				Stress				**Gastrointestinal**	Past	Present
Kidney Stones								Gall Bladder Problems		
Lower Side Pain				**Endocrine**	Past	Present		Bowel Problems		
				Thyroid				Constipation		
Neurologic	Past	Present		Diabetes				Liver Problems		
Stroke				Hair Loss				Ulcers		
Seizures				Menopausal				Diarrhea		
Head Injury				Menstrual				Nausea/Vomiting		
Brain Aneurysm								Bloody Stools		
Numbness				**Hematologic**	Past	Present		Poor Appetite		
Severe Headaches				Hepatitis						
Pinched Nerves				Blood Clots				**Musculoskeletal**	Past	Present
Parkinson's				Cancer				Gout		
Carpal Tunnel				Bruising				Arthritis		
Vertigo				Bleeding				Joint Stiffness		
				Fever, Chills				Muscle Weakness		
Constitutional	Past	Present		Sweating				Osteoporosis		
Difficulty Sleeping								Broken Bones		
Weight Loss/Gain								Joints Replaced		

Old Mill Chiropractic, LLC
711 East Main Street, Suite L2
Lexington, South Carolina 29072

ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I, _____*(patient name)*, hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices ("Privacy Notice to Patients"). I understand that any questions or concerns that I may have about this notice can be addressed to Dr. Nazarenko or the Office Manager at any time.

_____ _____

Patient Signature or Legal Representative Date

_____

Relationship to Patient

For Office Staff Only: _____ Initial if patient declined

Notice of Privacy Practices given to the individual on _____ (Date)

Reason for Decline: _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than one attempt must have been made.

Face to face presentation(s)_____
Telephone contact(s)_____
Other

Dr. Eric Nazarenko, DC
Old Mill Chiropractic, LLC
711 East Main Street, Suite L2
Lexington, SC 29072
803-808-0711

CONSENT FOR TEXT AND EMAIL MESSAGES

I hereby give my consent for Old Mill Chiropractic, LLC to send text message reminders to my mobile telephone (as per the number listed below). These messages will be a reminder of my previously booked appointment date and time, or a notification that I need to schedule an appointment. I understand that appointment cancellations should be done by phone.

I additionally hereby consent for Old Mill Chiropractic, LLC to send me email notifications and newsletters to the email address listed below.

I understand that any correspondence regarding my care will continued to be made via direct contact on the phone or in person.

I understand that I have the right to change my mind at any time. I will let the office know in person, writing or by phone if I wish to have this service stopped.

Patient Name(s): _____ DOB: _____

Cell Phone Number: _____ Cell Phone Provider: _____

Email Address: _____

Signature: _____ Date: _____

Please be sure to let the office know of any changes!

Authorization For Use Or Disclosure Of Media Photographs and Video Images

Authorization: I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Old Mill Chiropractic LLC and/or their representatives or affiliates. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations. Media content may disclose the fact that I am or have been a patient of Old Mill Chiropractic LLC and may contain other information about me, including patient-disclosed health information, what I say in the interview, and facts that can be inferred from the photograph or film.

Purpose: The photographic/video images, and/or testimonial will be used for publicity, educational, marketing, advertising and fundraising purposes through internal publication, external publication, radio, television, video or internet [I have crossed out any purposes or media format I do not wish included.]

Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions: I understand that the practice cannot condition treatment on whether or not I sign this authorization.

If desired, copy provided:

- "Yes, I would like a copy of this form."
  (initialed by team member _____, copy provided date_____)

Name of Patient/Subject _____

Street Address _____

City, State, Zip _____ Telephone: _____

Signature of patient/subject: _____ Date:_____

If patient or subject is under the age of 18 or otherwise incapable of signing:

Signature of parent/legal guardian/personal representative _____

If personal representative, please print name and relationship to patient

_____