Dr. Donald G. Ajlouni, D.C. (Patient Intake Form)

Patient Name:_____ **Date:**_____

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

Date of Birth:_____ **SS#**_____ **Spouse/ Partner Name:**_____

Home Number:_____ **Cell Phone Number:**_____

Email Address:_____ **Occupation:**_____

Employer's Name:_____ **Work Number:**_____

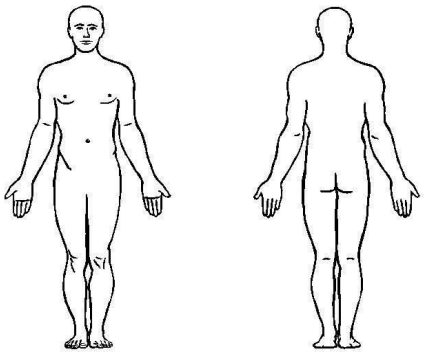
How do you prefer we contact you? □ **Home Phone** □ **Work Phone** □ **Cell Phone** □ **Text** □ **Email**

In case of emergency please contact:_____ **Phone Number:**_____

How did you hear about us? (ie. yelp, google, friend/coworker's name,doctor): _____

1. Is today's problem caused by: □ **Auto Accident** □ **Workman's Compensation** □ **Not caused by accident**

2. Indicate on the drawings below where you have pain/symptoms:



If you marked more than one area on the drawing to the left, list problems you want addressed in order of concern below:

1. _____
2. _____
3. _____
4. _____

3. Using a scale from 0-10 how would you rate your problem, 10 being the worst pain?

(Please circle) 0 1 2 3 4 5 6 7 8 9 10 *(worst)*

4.How often do you experience your symptoms?

□ Constantly (76- 100% of the time) □ Frequently (51- 75% of the time) □ Occasionally (26-50%) □ Intermittently (1- 25%)

5. How would you describe the type of pain? (mark all that apply)

□ Sharp □ Numb □ Achy □ Sharp with Motion □ Shooting □ Stiff
□ Dull □ Tingly □ Burning □ Other _____

6. How are you symptoms changing with time? □ Getting worse □ Staying the same □ Getting Better

7. How much has the problem interfered with work? □ Not at all □ Little bit □ Moderately □ Quite a bit □ Extremely

8. How much has it interfered with social activities? □ Not at all □ Little bit □ Moderately □ Quite a bit □ Extremely

9. Who else have you seen for your problem? □ No one

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician
□ Orthopedist □ Physical Therapist □ Massage Therapist □ Other _____

10. How long have you had this problem? _____

11. How do you think your problem began? _____ □ Unknown

12. What aggravates your problems?_____

What makes it better? _____

13. What concerns you the most about your problem, what does it prevent you from doing?

_____

14. What is your: Height_____ **Weight**_____ **Average Blood Pressure**_____/_____ **□ Don't Know**

15. Indicate if you have any immediate family members with the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Problems □ Cancer □ ALS

16. 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	□	□ Heart Attack	□	□ Diabetes
□	□ Neck Pain	□	□ High Blood Pressure	□	□ Frequent Urination
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Smoking/Tobacco Use
□	□ Mid Back Pain	□	□ Stroke	□	□ Drug/Alcohol Dependence
□	□ Low Back Pain	□	□ Angina	□	□ Allergies
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Depression
□	□ Elbow/Upper Arm Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Wrist Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hand Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Hip Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ Asthma
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Other_____
□	□ Jaw Pain	□	□ Abdominal Pain		
□	□ Joint Pain/Stiffness	□	□ Cancer	**For Females Only:**	
□	□ Rheumatoid Arthritis	□	□ Tumor	□	□ Pregnancy
□	□ Dizziness				

17. List all surgical procedures/hospitalizations you have had:_____

_____

18. List all prescription and over the counter medications you are currently taking (use back if necessary):

_____

19. What activities do you do at work?

□ **Sit:**	□ Most of the day	□Half of the day	□ A little of the day
□ **Stand:**	□ Most of the day	□Half of the day	□ A little of the day
□ **Computer at Work:**	□ Most of the day	□Half of the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□Half of the day	□ A little of the day

20. Primary Care Doctor Name_____ **Okay to contact if needed?** □ Yes □ No

21. List any abnormal test findings (Blood, Xray, MRI): _____

22. Do you take any supplements (Vitamins, Minerals, etc.), if so, which ones? _____

24. Anything else pertinent to your visit today?_____

Signature_____ □ Patient □ Guardian ***Date:***_____

Acknowledgement of Receipt of Notice of Privacy Practices and Patient Bill of Rights and Responsibilities

1. I have had the opportunity to receive, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information and *Patient Bill of Rights and Responsibilities*. I understand that this practice has the right to change its *Notice of Privacy Practices* and *Patient Bill of Rights and Responsibilities* from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the *Notice of Privacy Practices* and *Patient Bill of Rights and Responsibilities.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Assignment of Benefits (If you are using Insurance)

2. I, the undersigned, do hereby authorize payment directly to the office above, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. If these payments are made out to me I grant unto the office above as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

Treatment/Communication Consent

3. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Donald Ajlouni and/or other licensed doctors of chiropractic (contracted or non-contracted, in-network or out-of-network) who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, 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.

It may become useful during the course of treatment to communicate by email (e.g. Gmail), text message (e.g. “SMS”) or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Dr. Donald Ajlouni there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages.

***1. Check [ ] to acknowledge privacy practice and patient bill of rights.**
***2. Check [ ] to authorize direct insurance billing as described above.**
***3. Check [ ] to allow email or text communication by the means stated above, mostly appointment reminders.**

Patient/Guardian Signature _____ Date _____