Harbor Bay
CLINIC OF
CHIROPRACTIC

Stacey Dent, D.C., B.C.A.O.
23620 Three Notch Rd. Unit 104
Hollywood, MD 20636
P: 301-373-3731 F: 301-373-3970
HarborBayChiropractic.com

ADULT INTAKE FORM

Discover Your True Health Potential.

Welcome to Harbor Bay Clinic of Chiropractic!
(For any question that does not apply to you, simply respond "N/A" for Not Applicable.)

Today's Date: _____

Have you ever received chiropractic care? No ☐ Yes, ☐ (Name of Doctor): _____

PERSONAL INFORMATION

Full Name: _____ ☐ Male ☐ Female
Preferred Name: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D
Date of Birth: _____ Age: _____ Full Name of Spouse: _____
Address: _____ List The Name(s) & Age(s) of Your Children:
City: _____ State: _____ _____
Zip: _____ _____
Home Phone: _____ Name of Emergency Contact: _____
Work Phone: _____ Emergency Contact's Phone #: _____
Cell Phone: _____ **Family Member(s) Responsible For Finances:**
Email: _____ ☐ Myself ☐ My Spouse ☐ Both Myself & My Spouse
Occupation: _____ ☐ My Parent(s)/Guardian(s) ☐ Other: _____
Employer: _____ Other's Phone #: _____

I wish to be called at home ☐ work ☐ cell ☐ other ☐ (check all that apply) reguarding my care and follow-up.
I do ☐, I do not ☐ give permission to leave relevant medical information on my answering machine or voice mail.
I do ☐, I do not ☐ want relevant medical information shared with the person who may answer the telephone.
The name(s) of the individual(s) with whom you may leave pertinent information are:
_____

INSURANCE INFORMATION

Method of Payment: ☐ Cash ☐ Check ☐ Credit Card (V, MC, Disc, AmEx) Do you have Medicare? ☐ Y ☐ N

Insurance. Primary: _____ Secondary: _____

HEALTH GOALS

Check all of your current health and lifestyle goals:

☐ Relieve Pain/Discomfort
☐ Relieve Muscle Tension
☐ Restore Proper Function
☐ Increase Energy
☐ Improve Posture
☐ Improve Mobility
☐ Improve Flexibility
☐ Drink More Water
☐ Get Adequate Sleep
☐ Pregnancy Care
☐ Fertility Support
☐ Spiritual Renewal
☐ Reduce Medication(s)
☐ Improve Diet/Nutrition
☐ Improve Work & Life Balance
☐ Improve Focus/Concentration
☐ Increase Self Confidence
☐ Restore Emotional Health
☐ Strengthen Immune System
☐ Maintain Healthy Body Weight
☐ Improve Athletic Performance
☐ Increase Time With Family/Friends
☐ Treat Injury: _____
☐ Treat Illness: _____
☐ Quit Unhealthy Habit: _____
_____
☐ Other: _____

CASE HISTORY

How often do you smoke? ☐ Never ☐ In The Past ☐ Occasionally ☐ Daily ☐ Other: _____
How often do you drink alcohol? ☐ Never ☐ In The Past ☐ Occasionally ☐ Daily ☐ Other: _____
How often do you exercise? ☐ Never ☐ In The Past ☐ Occasionally ☐ Daily ☐ Other: _____
What is your typical work activity? (Check all that apply): ☐ Light Lifting ☐ Heavy Lifting ☐ Physical Repetition ☐ Excessive Sitting ☐ Excessive Standing ☐ Low Stress ☐ High Stress ☐ Other: _____
Have you ever had an operation? ☐ No ☐ Yes, (List all operation(s) including the year):
_____
Have you ever had a serious illness or health emergency? ☐ No ☐ Yes, (List condition(s) including the year):
_____
Do you have any genetic disorders or disabilities? ☐ No ☐ Yes, (Explain): _____
_____
Do you have any allergies? ☐ No ☐ Yes, (Explain): _____
Have you ever been in an auto accident? ☐ No ☐ Yes, (Include the year): _____
Have you ever been unconscious? ☐ No ☐ Yes, (Explain): _____
_____
Have you ever fractured a bone? ☐ No ☐ Yes, (Explain): _____
_____
Have you ever taken an antibiotic drug? ☐ No ☐ Yes, (Include times per lifetime): _____
Are you currently taking any over-the-counter or prescription drug, vitamin/supplement, or natural remedy?
☐ No ☐ Yes, (Please list the name & reason for taking): _____
_____

Primary Care Dr./Pediatrician & Clinic: _____

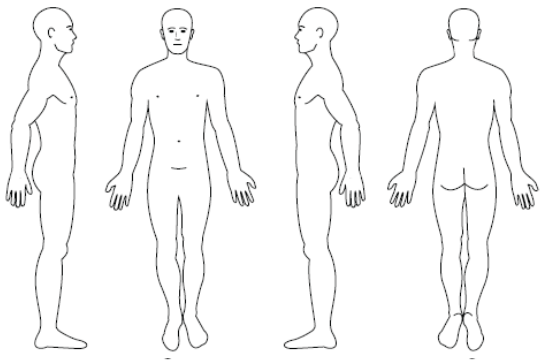
CURRENT SYMPTOMS

Select which is true for you:
☐ I **DO NOT** have symptoms. I am seeking chiropractic care to maintain wellness.
(If checked, move ahead to the "INITIAL ASSESSMENT" section.)
☐ I **DO** have symptoms for which I am seeking chiropractic care. **(List all of your symptoms below):**
_____
_____

In the diagram to the right, mark the figures in relation to where you experience symptoms on your body. Use the symbols below to show what you are experiencing.

SYMBOLS

A	=	Aching	P	=	Pressure
B	=	Burning	R	=	Radiating
F	=	Stiff & Tight	S	=	Sharp & Stabbing
N	=	Numbness	T	=	Tingling



When did your symptom(s) begin? ☐ Today ☐ Days Ago ☐ Weeks Ago ☐ Months Ago ☐ Years Ago
Did your symptom(s) begin as a result of an injury? ☐ No ☐ Yes, (Explain): _____
_____
When do your symptom(s) occur? ☐ Morning ☐ Afternoon ☐ Constant All Day ☐ Night ☐ During Sleep
☐ Increases During The Day ☐ Decreases During The Day ☐ Comes & Goes During The Day
☐ Only During Specific Activities, (Explain): _____
☐ Other: _____
Does your symptom(s) move or travel to anywhere else on your body? ☐ No ☐ Yes, (Explain): _____
_____
What have you already tried that **HAS NOT** helped to relieve your symptom(s)? _____
_____
What have you already tried that **HAS** helped to relieve your symptom(s)? _____
_____

INITIAL ASSESSMENT

NAME:_____ DATE:_____

Select which is true for you.

☐ I **DO NOT** have symptoms. (If checked, move ahead to the "STRESS ASSESSMENT" section.)
☐ I **DO** have symptoms. (If checked, use the "EFFECT SCALE" to answer the "SELF RATING" questions below.)

EFFECT SCALE





0	1 2 3	4 5 6	7 8 9	10
NO EFFECT	**MILD EFFECT**	**MODERATE EFFECT**	**LIMITING EFFECT**	**SEVERE EFFECT**
I am free from any symptom. I can do all of my daily activities. My quality of life is good. I am grateful for my good health.	I barely notice the symptom. I can do most of my daily activities. I don't think much about the symptom, but it does cause me some discomfort.	I notice the symptom and it causes me distress. I can do some of my daily activities. I can only ignore the symptom for a short period of time.	I experience constant distress from the symptom. I am unable to do many of my daily activities. I can not ignore the symptom, it disrupts my ability to think clearly, hold a job, and maintain social relationships.	I am in distress and excruciating pain from the symptom. I am unable to do any of my daily activities. I am weak, delirious and bedridden. (Very few people ever experience this level of pain. Suicide is often considered.)

SELF RATING

What is your main symptom for seeking chiropractic care? **Write it here:**_____

For each statement below, place an "X" in the "RATING" box to best show how the symptom effects you.	**RATING**										
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											

If you have a second symptom for seeking chiropractic care, **write it here:**_____

For each statement below, place an "X" in the "RATING" box to best show how the symptom effects you.	**RATING**										
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											

*** If you have more then 2 symptoms, simply ask a team member for another form.**

STRESS ASSESSMENT

Check all of the stresses you have experienced in the past 3 months:

☐ Slip / Falls
☐ Car Accident
☐ Sports Injury
☐ Depression
☐ Anxiety
☐ Poor Diet / Nutrition
☐ Excessive Sitting
☐ Excessive Standing
☐ Lack of Exercise
☐ Increase of Exercise
☐ Lack of Sleep
☐ Death of A Loved One
☐ Hospitalization
☐ Surgery / Operation
☐ Change In Medication
☐ Emotional Stress
☐ Occupational Stress
☐ Financial Stress
☐ Other: _____
_____

ACTIVITIES OF DAILY LIVING

Based on the "EFFECT SCALE" from the previous page, rate how each activity effects you.
Place an "X" in the box to mark your rating. Use "N/A" for any activity Not Applicable to you (or your child).

PERSONAL HYGIENE & DAILY CARE

ACTIVITY	RATING												ADDITIONAL NOTES:
	N/A	0	1	2	3	4	5	6	7	8	9	10	
Bathing / Showering													
Grooming Hair													
Brushing Teeth													
Using The Toilet													
Dressing The Upper Body													
Dressing The Lower Body													

DAILY PHYSICAL ACTIVITIES

ACTIVITY	RATING												ADDITIONAL NOTES:
	N/A	0	1	2	3	4	5	6	7	8	9	10	
Standing													
Sitting													
Squatting													
Kneeling													
Reaching Overhead													
Bending Forward													
Turning Left													
Turning Right													
Move From Lying to Sitting													
Move From Sitting to Standing													
Move From Standing to Sitting													

FUNCTIONAL ACTIVITIES

ACTIVITY	RATING												ADDITIONAL NOTES:
	N/A	0	1	2	3	4	5	6	7	8	9	10	
Sleeping													
Eating													
Going Up & Down Stairs													
Getting In & Out of Car													
Driving													
Using A Computer													
Focusing/ Concentrating													
Preparing Food													
Household Chores													
Lifting Children													
Carrying Bag / Purse													

SOCIAL, RECREATIONAL, & OTHER ACTIVITIES

ACTIVITY	RATING												ADDITIONAL NOTES:
	N/A	0	1	2	3	4	5	6	7	8	9	10	
Competitive Sports													
Running / Jogging / Hiking													
Other Recreation Activities													
Hobbies													
Sexual Activity													

FAMILY HEALTH HISTORY

Place an "X" in the box below to show if you or your family members have ever had the following conditions.

- If there is more than one family member per category, use an "X" to represent each individual.
- If you are helping someone fill out this form, use "SELF" to represent his or her conditions.

CONDITION	SELF	SPOUSE	SON(S)	DAUGHTER(S)	FATHER	MOTHER	SIBLING(S)
Acid Reflux/GERD							
ADD/ADHD							
Anxiety							
Arthritis/Joint Pain							
Asthma/Allergies							
Autoimmune Disease							
Bed Wetting							
Birth Defect							
Cancer							
Colic							
Convulsions/Epilepsy							
Deceased							
Depression/Mood Changes							
Diabetes							
Digestive Problems							
Ear Problems/Hearing Loss							
Fibromyalgia/Muscle Pain							
Frequent Cold/Flu							
Gall Bladder Problems							
High/Low Blood Pressure							
HIV/AIDS							
Impotence/Sexual Dysfunction							
Kidney Problems							
Learning Disability							
Liver Problems							
Menstrual Dysfunction							
Migraines							
Neck Pain/Back Pain/Disc Problems							
Prostate Problems							
Sciatica							
Scoliosis							
Sinus/Drainage Problems							
Skin Problems							
Sleep Problems							
TMJ Dysfunction							
Tongue or Lip Tie							
Thyroid Problems							
Tremors							
Vertigo/Dizziness							
Vision Problems							
Other:							

TERMS OF ACCEPTANCE

At Harbor Bay Clinic of Chiropractic the term Practice Member is used for those that have suffered either an injury or are seeking wellness rather than symptom management. A Practice Member is an active participant in his or her chiropractic care, and is therefore, invited to ask any questions or express any concerns that he or she may have. Practice members can expect quality service and leadership as they regain control of their health. First, a complete analysis of your spine will be administered to detect the presence of vertebral subluxations and to monitor your progress. Please read and sign this form stating that you understand the items explained below. If there is anything that is unclear please ask questions before you sign. If you refuse to sign this form the doctor reserves the right to refuse care.

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby consent to give the doctor of chiropractic, and anyone working in the Harbor Bay Clinic of Chiropractic office, authorized by the chiropractor, permission and authority to care for me. Chiropractic tests, diagnosis, analysis and adjustments are very safe and beneficial. However, in rare cases, underlying physical defects, deformities or pathologies may make an individual more prone to injury. It is the responsibility of the Practice Member to make it known, or to learn through health care procedures if he or she is suffering from latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the chiropractor. The doctor of chiropractic will not give any treatment or care if she or he is aware that such care should not be used for a particular condition or circumstance. Your doctor of chiropractic is a licensed primary care provider, and is able to work with all other types of providers. I understand that if I am accepted as a Practice Member at Harbor Bay Clinic of Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. I understand that following the doctor's recommended care plan is essential to maximizing my healing and reaching optimal health through chiropractic. Furthermore, any questions that I have regarding chiropractic care, will be explained to me upon my request.

AUTHORIZATION FOR X-RAYS

Specific postural x-rays may be necessary for the identification of the location, type, and severity of any vertebral subluxations, as well as for the diagnosis and identification of latent or dangerous conditions requiring medical attention. X-rays may also be used to show progress after a period of recommended chiropractic care. **At your request, you can receive a copy of your x-rays to a disc for the mandated fee of $5.00.**

By signing below, I authorize Harbor Bay Clinic of Chiropractic to perform diagnostic x-rays of me.

Females, select which is true for you:

☐ To the best of my knowledge, there is no chance that I am pregnant at this time.

☐ I know or believe that I may be pregnant at this time and therefore **I DO NOT** authorize Harbor Bay Clinic of Chiropractic to perform diagnostic x-rays of me.

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFIT

By signing below, I recognize that I am financially responsible for all services rendered to me regardless of insurance or benefits. I further understand that any health insurance policy is an arrangement between me and my insurance carrier and that I may be required to pay for some or all of the fees charged to my account. I hereby authorize Harbor Bay Clinic of Chiropractic LLC to release all necessary information concerning my health condition to any billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition I authorize Harbor Bay Clinic of Chiropractic LLC to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Harbor Bay Clinic of Chiropractic LLC to proceed with Chiropractic tests, diagnosis, analysis and adjustments.

Signature of Practice Member Date

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to your health information and records.

Harbor Bay Clinic of Chiropractic LLC, understand the importance of privacy and we are commited to maintaining the confidentiality of your protected health information (PHI) in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have developed office policies and procedures that protect your personal and health information when used within our office and any devices used to copy or transfer this data. We assure you that your information will only be shared as required and only for the purpose of administering your case and obtaining payment for services. Be assured that without your permission, your health information will not be used for any other purpose.

The following ways are how your PHI may be used within our office to provide you the best care and services possible:
- To provide treatment, obtain payment, and conduct health care operations.
- To schedule appointments and send reminders.
- To communicate with your family, friends, emergency contact, and/or caregivers with your authorization.
- As permitted or required by the law.

The following describes your rights regarding your PHI. You may:
- Request to inspect any copy of your records.
- Request to amend incomplete or inaccurate information in your records.
- Receive an accounting of certain disclosures of your health information.
- Ask for additional privacy protections (although your request may be declined).
- Receive a paper copy of this notice.

Harbor Bay Clinic of Chiropractic LLC, reserves the right to change this privacy policy as allowed by law and to make the new notice apply to health information already received as well as any information received in the future. A copy of our current notice is available upon request. The notice will display the effective date.

If you believe that we have not properly respected the privacy of your PHI, you may notify our office by calling (301) 373-3731, sending a letter to our office address or by emailing info@harborbaychiropractic.com.

I confirm that I have received and reviewed this notice and understand how health information about me may be used and disclosed and how I can get access to my health information and records.

Signature of Practice Member _____ Date _____

SOCIAL MEDIA CONSENT

Select an option below.

☐ I **DO** authorize Harbor Bay Clinic of Chiropractic to display testimonials, photographs and videos of me in the office or on social media outlets. I understand that the purpose of sharing this information is to provide others with chiropractic education and give hope to those seeking answers to their health concerns. My consent remains in effect until revoked by me in writing.

☐ I **DO NOT** authorize Harbor Bay Clinic of Chiropractic to display testimonials, photographs and videos of me in the office or on social media outlets at this time.