SCOTT FAMILY HEALTH
Chiropractic | Massage | Acupuncture | Physical Therapy

Auto intake

Name:_____ □ Male □ Female **Date of Birth**: ___/____/____ **Age**: _____

Height:_____ **Weight**:_____ **Do You Currently Smoke**: □Yes □No **Marital Status**: □ Married □ Single □ Divorced □ Widowed

Race: □American Indian or Alaska Native □Asian □Black □Caucasian □Pacific Islander □Other

Ethnicity: □Hispanic □Non-Hispanic **Preferred Language:** _____

Home Address: _____
Street / P.O. Box City State Zip Code

Home Phone: _____ **Work Phone**:_____ **Cell Phone**: _____

Employment Status: □ Full Time □ Part Time □ Student **E-Mail:** _____
By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

MEDICINES: Please list all currently used medicines. Include prescription and non prescription drugs, vitamins, and herbs.

_____

_____

ALLERGIES: Please list all known allergies to medicines. _____

_____

FAMILY HISTORY: Do you or **any member of your family** have any of the following conditions?

□ Cancer_____ □ Epilepsy_____ □ Multiple Sclerosis_____
□ Diabetes_____ □ Heart Problems_____ □ Arthritis_____
□ Headaches_____ □ High blood pressure_____ □ Psychological Problems_____
□ Stroke_____ □ Spine or back disorder_____ □ Other _____

ANY OTHER SERIOUS ILLNESSES: _____

_____

Accident information:

Date of accident: _____ _____T- Boned _____ Rear-ended _____ Head- on
How many cars were involved: _____ Did the air bags deploy? _____ Yes _____ No
Speed of Accident: _____ Did you ride in an Ambulance? _____ Yes _____ No
Did you wear your seatbelt? ____ yes _____ No Did you go to the ER? _____ Yes _____ No

What is your **major** complaint?_____

When did your condition develop?_____

How did your condition develop?_____

Has your condition been getting better, worse or staying the same?_____

What makes your condition better?_____What makes it worse?_____

Do you currently have or have you had:
(Please mark all that apply)

NEUROLOGICAL	Current	Past	
Seizures			
Tremor			
Speech Problems			
Trouble Concentrating			
Headaches			
Muscle Weakness or paralysis			
Memory Loss			
Direct Head Trauma			
Loss of Consciousness			
Poor Coordination			
Numbness in groin			

MUSCULOSKELETAL	Current	Past
Hernia		
Arthritis or Gout		
Bursitis		
Fractured Bones		
Pain fails to improve with rest		
Pain greater than 4 weeks		
History of Osteoporosis		

CARDIOVASCULAR	Current	Past
Passing Out		
High Cholesterol/ Triglycerides		
Chest pain		
Heart Disease or Murmur		

ENDOCRINE	Current	Past
Diabetes		
Thyroid Trouble		
Liver Trouble		

INTEGUMENTARY/ALLERGIC	Current	Past
Skin Conditions		
Hay Fever		

HEMATOLOGIC	Current	Past
Anemia		
Bleeding or Bruising Tendency		

ENT	Current	Past
Sinus Problems		
Difficulty Swallowing		

CONSTITUTIONAL	Current	Past
History of Trauma		
Infection		
Unexplained Weight Loss		
Unusual Fatigue		
Dizziness/Poor Balance		
Change in Appetite		
Fevers/Night Sweats		
Low or High Blood Pressure		
History of Cancer		
Abdominal Pain		
Use of Corticosteroids		
Use of Anticoagulants		
Blood Clots		
Use of Birth Control		
Intravenous Drug Use		
Stroke		

RESPIRATORY	Current	Past
Asthma		
Shortness of Breath		
Chronic Cough		
Difficulty Breathing		

URINARY	Current	Past
More Frequent Urination		
Pain or Blood in Urination		
Kidney or Bladder infection		
Kidney Stones		

GASTROINTESTINAL	Current	Past
Recurrent Abdominal Pain		
Nausea		
Ulcers		
Heartburn		
Diarrhea or Constipation		
Hemorrhoids		
Loss of Bowel		
Loss of Bladder Control		
Vomited Blood		
Bloody or Black Stools		

HIPAA Privacy

Authorization Form/ Notice of Privacy Practices

Authorization of use or disclosure or protected health information

(Required by the Health Insurance Portability and Accountability Act -45 CFR Parts 160 and 164)

Please read and initial the following:

_____ I hereby authorize Scott Family Health to view radiology studies that are necessary for my treatment and/ or evaluation through the PAC system provided by Banner Health System, Poudre Valley Hospital, and related affiliates. Requests for other studies and medical information will require a separate request form and my signature. *I understand that these studies may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Hum Immunodeficiency Virus (HIV) and other communicable diseases. Behavioral Health Care/ Psychiatric Care, Treatment of alcohol and/or drug abuse and genetic testing; my signature authorizes the release of any such information.*

_____ This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, and/ or other purposes as I may direct.

_____ This authorization shall be in force and in effect until I sign a written request to terminate this agreement. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____ I understand that my treatment, payment, enrollment or eligibility for benefits will not conditioned on whether I sign this authorization.

_____ I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re- disclosed by the person or organization that received the information.

_____ I release Scott Family Health, its employees, staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

If you would like us to disclose your medical records, upon request, to any addition parties (ie; spouse, parent, providers) please provide Name, Date of Birth and Relationship:

_____

_____

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

_____

Witness Signature DATE