North Shore Chiropractic

Dr Gregory Smith D.C.
530-546-8252

Please Print and fill out our Patient Intake Form, Please use blue or black ink and print clearly.

Patient Information:

State Law requires this information
Title 16 of the California Code of Regulations, Division 4, Section 318, Chiropractic Patient Records

Full Name: _____**Social Security #** ___ _____

Address: _____ City: _____ State: _____ Zip Code: _____

Gender: ❑ Female ❑ Male _____ **Birthdate:** _____ **Height**:_____ **Weight** _____

Home Phone: (____)_____ Cell Phone: (____)_____ **E-mail:** _____

Do you consent to receiving calls,texts or e-mail for appointments and office communications: ❑Yes I consent ~ ❑ NO

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (_____)__ _____

Patient Condition/Symptoms:

Reason for visit: _____ When did you first notice the symptoms? _____

Is the condition getting progressively worse? ❑Yes ❑No

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ❑Sitting ❑Standing ❑Walking ❑Bending ❑Lying down ❑Other

Does the pain interfere with your- ❑Work ❑Sleep ❑Daily Routine ❑Recreation

***Type of pain**: ❑Sharp ❑ Dull ❑Throbbing ❑ Numbness ❑Aching ❑ Shooting
❑Burning ❑Tingling ❑Cramping/Spasm ❑ Stiffness ❑Swelling ❑ Other _____

What makes your condition feel better: _____

∗**Circle the severity of your pain 1 thru 10**. (1 = mild pain or discomfort, to 10 = excruciating pain)

1 2 3 4 5 6 7 8 9 10 Range _____

Is the pain present what % of the awake time? ❑ (0-25%) ❑ (26-49%) ❑ (50-75%) ❑ (76-90%) ❑ (100%)

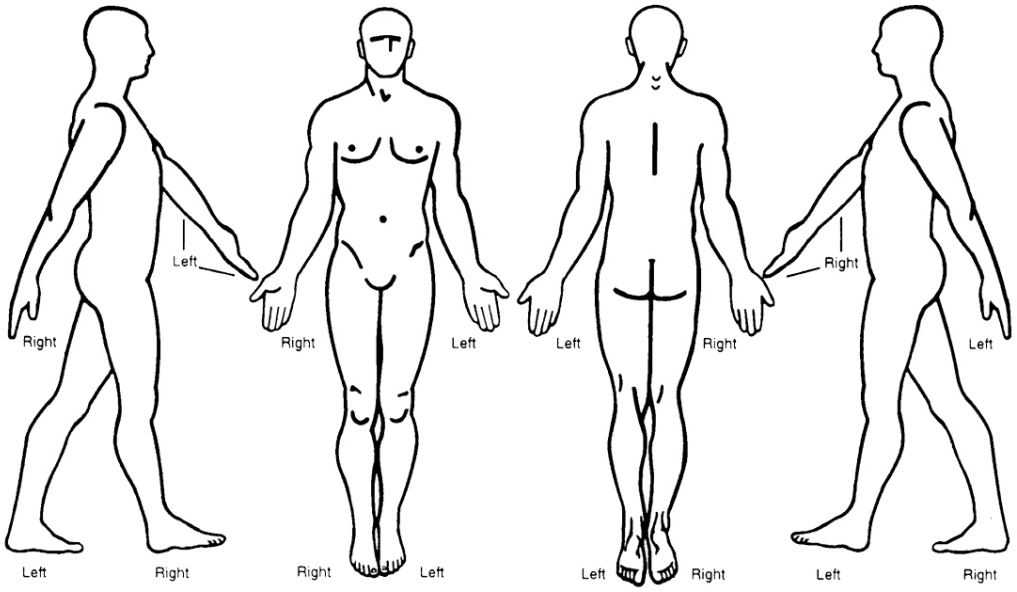
What treatment have you received for your condition?
❑Medication ❑Surgery ❑Physical Therapy ❑Chiropractic ❑ Other _____

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Please indicate on the figures below, your areas of pain and label the type of pain

(eg. aching, burning, spasm)



Health History

*Check all conditions that you have:*_____

- ❑ Anemia
- ❑ Arthritis
- ❑ Bone Weakness
- ❑ Cancer
- ❑ Concussions
- ❑ Elbow Pain
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Herniated disk
- ❑ Irritable Bowl Disease
- ❑ Knee Pain
- ❑ Low Back Pain
- ❑ Migraine Headaches
- ❑ Neurological Disorder
- ❑ Pinched Nerve
- ❑ Rheumatoid Arthritis
- ❑ Sleep Apnea
- ❑ Stroke (Heart or Brain)
- ❑ Ulcers
- ❑ Ankle Pain
- ❑ Asthma
- ❑ Breast Lump
- ❑ Chest Pain
- ❑ Depression
- ❑ Emphysema
- ❑ Fatigue
- ❑ Gluten Sensitivity
- ❑ Hearing Problems
- ❑ High Blood Pressure
- ❑ Jaw Pain
- ❑ Leaky Gut Syndrome
- ❑ Lyme's Disease
- ❑ Minor Heart Trouble
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Shingles
- ❑ Spinal Cord Injury
- ❑ Thyroid Problems
- ❑ Ulcerative Colitis
- ❑ Appendicitis
- ❑ Autoimmune Disease
- ❑ Broken Bones
- ❑ Congestive Heart Failure
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Foot Pain
- ❑ Gout
- ❑ Heart (Mitral Valve)
- ❑ High cholesterol
- ❑ Joint Stiffness
- ❑ Leg Pain
- ❑ Menstrual Problems
- ❑ Multiple Sclerosis
- ❑ Pacemaker
- ❑ Polio
- ❑ Shoulder Pain
- ❑ Sprain/Strain Injuries
- ❑ Tuberculosis
- ❑ Wrist Pain
- ❑ Arm Pain
- ❑ Back Pain
- ❑ Bronchitis
- ❑ Chicken Pox
- ❑ Dizziness
- ❑ Eye/Vision Problems
- ❑ Genetic Spinal Disorder
- ❑ Hand Pain
- ❑ Hepatitis
- ❑ Hip Pain
- ❑ Kidney disease
- ❑ Liver Disease
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Parkinsons Disease
- ❑ Prostate Problems
- ❑ Significant Weight Change
- ❑ Stomach Problems
- ❑ Tumor (s)
- ❑ No Problems Reported

History Continued:

Dates of last exams:_____

(Woman) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control Pills? ❑ Yes ❑ No

Do you have breast implants? ❑ Yes ❑ No Surgical Prosthesis? ❑ Yes ❑ No

History Continued:

List any types of injuries or surgeries which you have had and the dates which they occurred: _____

_____

Please list all medications you are currently taking: _____

Is your present condition due to an accident? ❑Yes ❑ No (If Yes, please ask for the Personal Injury Forms)

If Yes – Type of Accident ❑ Auto ❑ Work ❑ Home ❑ Other Date of Accident: _____

Allergies(prescriptions or foods): _____

Daily Habits:

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑Heavy

What do your daily work habits include? _____

What vitamins do you currently take? _____

Nutritional supplements (if any)? _____

Do you smoke? ❑ **Yes** ❑ **No** How much per day? _____

How much liquor do you consume weekly? _____ How many caffeinated beverages do you consume daily?_____

Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports ❑Custom Orthotics

FINANCIAL ARRANGEMENTS:

Payment is required at the time the treatment is rendered. Fee schedule is based on face-to-face time with Dr. Gregory Smith DC in 20-minute increments. A standard New Patient office visit (40 to 50 minutes) is $100.00 to $195.00 and subsequent intermediate office visits (20 minutes) are $70.00, this fee schedule is subject to additional charges incurred in the performance of additional procedures for a specific treatment time 10 minutes at $45 and 20 minutes at $70. Personal Injury and other complex issues require a more complete (60 minute) physical exam and treatment that are billed accordingly. Payment is required at the time for all nutritional supplements received. If you are covered by insurance for chiropractic care, we will provide you with a superbill for you to submit to your insurance, we do not bill insurance. We are considered out of network with all providers, we do not guarantee payment by insurance companies. Medicare **does not** cover initial or follow up exam(s). **You are responsible financially for all services rendered.**

Appointments: On your 1st Visit you should plan to arrive early to complete your intake forms.

Please be on time for your appointment, we strive to start at your scheduled time.

Certification and Assignment:

To the best of my knowledge, the above information is complete and correct. I have read, understand and agree to the policy of this office. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____

Print Name **Signature** **Date**

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE AT NORTH SHORE CHIROPRACTIC

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including examination and testing, various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Gregory Smith DC and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Gregory Smith DC, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with Dr. Gregory Smith DC the nature and purpose of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I understand and am informed that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications/risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, strain/or sprains, cervical myelopathy(spinal-cord), costovertebral (ribs) strains and separations. Some types of manipulation (adjustment) of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complication including stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have had the material risk of care explaned verbally and in writing [ ], including the above explanation of the Chiropractic adjustment and related treatment or exams. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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.

North Shore Chiropractic 8611 N. Lake Blvd #200, Kings Beach, CA
Dr. Gregory Smith D.C.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

To be Completed by Patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date

To be completed by patient's representative, if necessary,
e.g., **if patient is a minor or physically or legally incapacitated:**

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

_____
As: Relationship or Aurthority of Patient's Representative

Witness to Patient's Signature: Dr. Gregory Smith DC. 8611 N. Lake Blvd, Kings Beach, CA 96143

_____ _____
Gregory Smith DC Date:

North Shore Chiropractic
www.DocTahoe.com

Dr. Gregory Smith D.C.
P.O. Box 967
Kings Beach, CA 96143-0967
530-546-8252
530-546-3906 (Fax)

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____ have received a copy of this office's Notice of Privacy Practices. The privacy policy is also available on the office web site. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____
Patient

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____
Staff signature **Date**