Ala Moana Chiropractic – Dr. Jeffrey F. Lee, D.C
1314 S. King Street, Suite 1550
Honolulu, HI 96814

New Patient Intake Form

Welcome to Dr. Jeffrey F. Lee, D.C.'s office. If your visit is due to a work related injury, a traffic accident, or if you have any serious health problems, please tell our receptionist now.

Patient Information **Date:** _____

First Name: _____ **Middle Initial:** ____ **Last Name:** _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____

Cell Phone: (_____) _____-_____ **Email:** _____

Date of Birth: _____/_____/_____ **Sex:** ☐ Male ☐ Female

Social Security Number: _____-_____-_____ **Marital Status:** ☐ Single ☐ Married ☐ Other

Spouse Data: _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Home Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other_____

Employer Data: _____

Name: _____ **Your Occupation:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact: _____

Contact Name: _____ **Relationship to Patient:** _____

Contact Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

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How did you hear about our office? _____

Have you ever been treated by a chiropractor? Yes No
If so, when? _____ Who treated you? _____

Have you had spinal x-rays taken in the last year? Yes No May we request them?

Medical Conditions: (Check all that apply to you)
Arthritis Cancer Diabetes Heart Disease Hypertension
Psychiatric Illness Skin Disorder Stroke Other _____

Surgeries: (Check all that apply to you)
Appendectomy Cardiovascular procedure Cervical spine Hysterectomy Joint Replacement
Prostate Lumbar spine Gall Bladder Brain Shoulder Thoracic spine
Knee Carpal Tunnel Gastro-intestinal Uro-genital Hernia Other _____

Family History: (Check all that apply)
Arthritis: Parent Sibling
Cancer: Parent Sibling
Diabetes: Parent Sibling
Heart Disease: Parent Sibling
Hypertension: Parent Sibling
Stroke: Parent Sibling
Thyroid: Parent Sibling
Other: _____

Occupational Activities: (Check one that best describes your job description)
Administration Business Owner Clerical/Secretary Computer User
Heavy Equipment operator Daycare/Childcare Construction Health Care
Food Service Industry Medium Manual Labor Manufacturing Home Services
Heavy Manual Labor Light Manual Labor Executive/Legal Housekeeper
Other _____

What activities do you do at work? (Circle one that best describes your daily job activities)
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 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

What activities do you do outside of work?
_____

Have you ever been hospitalized? No Yes

If yes, why: _____

Major accidents or falls:
_____

Do you have an implant? (Hip, Pace Maker, IUD, Other)
_____

Are you pregnant? Yes_____ No _____ N/A_____

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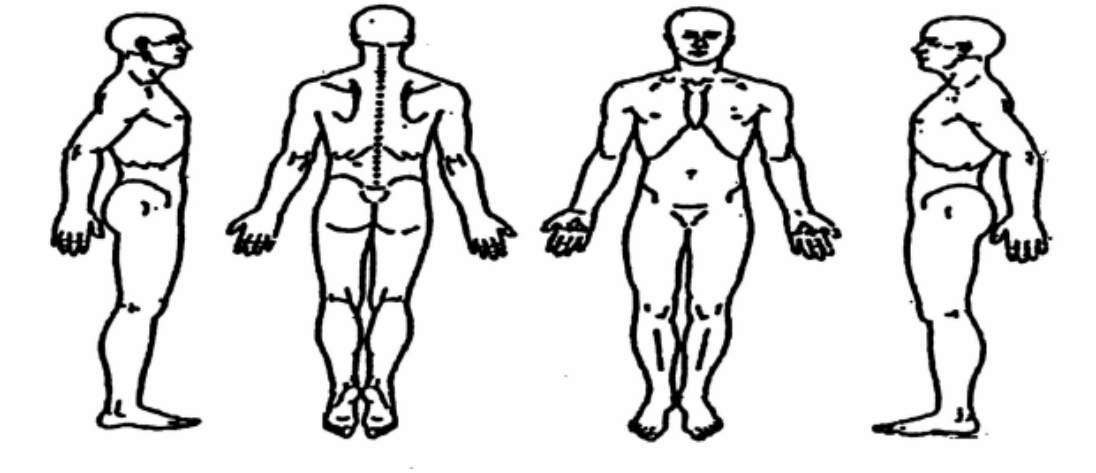
Patient Name: _____ **Date:**_____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

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



3. How often do you experience your symptoms?

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

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

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

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

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

_____

15. What is your: Height_____ **Weight** _____ **Age** _____
Occupation _____

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16. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. 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			High Blood Pressure			Diabetes		
Neck Pain			Heart Attack			Excessive Thirst		
Upper Back Pain			Chest Pains			Frequent Urination		
Mid Back Pain			Stroke			Smoking/Tobacco Use		
Low Back Pain			Angina			Drug/Alcohol Dependance		
Shoulder Pain			Kidney Stones			Allergies		
Elbow/Upper Arm Pain			Kidney Disorders			Depression		
Wrist Pain			Bladder Infection			Systemic Lupus		
Hand Pain			Painful Urination			Epilepsy		
Hip Pain			Loss of Bladder Control					
Upper Leg Pain			Prostate Problems					
Knee Pain			Abnormal Weight Gain/Loss					
Ankle/Foot Pain			Loss of Appetite			**For Females Only**		
Jaw Pain			Abdominal Pain			Birth Control Pills		
Joint Pain/Stiffness			Ulcer			Hormonal Replacement		
Arthritis			Hepatitis			Pregnancy		
Rheumatoid Arthritis			Liver/Gall Bladder Disorder					
Cancer			General Fatigue					
Tumor			Muscular Incoordination					
Asthma			Visual Disturbances					
Chronic Sinusitis			Dizziness					

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

Sit:	□ Most of the day	□ Half the day	□ A little of the day
Stand:	□ Most of the day	□ Half the day	□ A little of the day
Computer work:	□ Most of the day	□ Half the day	□ A little of the day
On the phone:	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature: _____ **Date:**_____

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Payment/Insurance Information:

Who is responsible for your bill? ☐ Self ☐ Health Insurance ☐ Spouse ☐ Worker's Comp ☐ Auto Insur. ☐ Medicare ☐ Medicaid ☐ Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Date of Birth: _____ / _____ / _____ Primary Care Physician: _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? ☐Yes ☐No Date: ____/____/____ Time: _____am / pm

If this is a result of a vehicular injury, do you have an attorney? Yes No

If yes, who? _____
Contact information: _____

Is this a result of a vehicular accident? Yes No Date: ____/____/____ Time: _____am / pm

If this is a result of a vehicular injury, do you have an attorney? Yes No

If yes, who? _____
Contact information: _____

Our office is set up to utilize direct payment from insurance companies. However, it is important that you understand that health and accident insurance benefits are an arrangement between you and your insurance company. You are personally responsible for all charges incurred in our office. We expect payment for your portion of the services not covered by insurance at the time of your visit. In an effort to keep costs down, we do not send monthly statements.

Should your account become delinquent, interest at 18% will accumulate. Past due accounts are automatically transferred to an accounts receivable company for processing with an additional service charge of $20.00 added to the balance.

All nutritional supplements and or any other additional supplies are to be paid at the time of service.

I understand and agree that any amount paid directly to this office will be endorsed and credited to my account; that all services rendered to me are charged directly to me and that I am personally responsible for the entire payment at the time of the visit, unless I make arrangements, approved by our credit manager, after today's visit.

The information above is accurate to the best of my knowledge. I understand that if accepted as a patient, I will be receiving accepted chiropractic treatment and give my permission for this treatment.

Date: _____
Print Patient's Name: _____
Patient's Signature: _____
Guardian / Spouse's Signature Authorizing Care: _____

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HIPAA Privacy Practices:

I understand that under the Health Insurance Portability & Accountability Act of 1996, 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 multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician services

Date:_____
Print Patient's Name: _____
Patient's Signature: _____
Guardian / Spouse's Signature Authorizing Care: _____

Patient Authorization Regarding Chiropractic Care being Provided in an "Open Adjusting" Environment:

It is the practice of this office to provide chiropractic care in an open adjusting environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient's history, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law within respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us, we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive, as well as enhance your access to quality health care and health information. If you choose not to be adjusted in an "open adjusting" environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Jeffrey F. Lee, D.C. or your relationship with our staff.

Your signature indicates your authorization of this activity.

Date:_____
Print Patient's Name: _____
Patient's Signature: _____
Guardian / Spouse's Signature Authorizing Care: _____

SIGNATURE OF PHYSICIAN: _____ Date: _____