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# Profile Information — Step 1 of 4

You are completing the following intake forms: Intake Form

## You are filling out an intake form for Patient Name

Please take a moment to fill out our online intake form before your visit. This is essential information for us to properly handle your care, and should take less than twenty minutes to complete. Thank you for your time!

Only staff members can edit this information on an intake form.

**First Name** – Required

**Last Name** – Required

**Email** – Required

**Preferred Name (if different)**

**Prefix / Title**

Select an option...

Please provide at least one phone number. Your mobile number can be used to look up your Account.

**Mobile Phone** – Required

US

A mobile phone is required if you would like to receive SMS appointment reminders.

**Street Address** – Required

Suite Number (i.e. Suite #100)

**City** – Required

**State** – Required

**Country** – Required

**Zip Code** – Required

**Date of Birth** – Required

**Month**

**Day**

**Year**

**Gender** 

**Sex** – Required 

**Occupation**

**Employer**

**Guardian**

**Emergency Contact**

**Emergency Contact Phone**

**Emergency Contact Relationship**

**How Did You Hear About Us?**

# Insurance Information — Step 2 of 4

*You are completing the following intake forms: Intake Form*

## Your insurance policy

Insurer

# Questionnaires — Step 3 of 4

*You are completing the following intake forms: Intake Form*

## Intake Form

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### ACCIDENT INFORMATION

Is your condition due to one of the following accidents?

- Auto    Work    Other    None

To whom have you made a report of your accident?

- Auto Insurance    Employer    Worker Comp.    Other    N/A

Case No.

Adjuster's Name (if applicable)

**Attorney Name (if applicable)**

**Attorney Contact (if applicable):**

Phone:

Email:

## PATIENT HEALTH QUESTIONNAIRE

*Please fill out this questionnaire to the best of your abilities. This will help Dr. Branco assess your situation and determine the best treatment option available.*

### Current Condition

**What is the reason for your visit?\***

**When did you notice your symptoms start appearing?**

**Is your pain getting progressively worse?**

Yes    No    Unsure

**Please rate the severity of your pain:**

0 - no pain at all    1    2    3    4    5    6    7    8    9     10 - debilitating pain

Please describe the type of pain you're experiencing:

- Numbness
- Stiffness
- Shooting
- Aching
- Cramping
- Burning
- Dull
- Tingling
- Swelling
- Throbbing
- Sharp
- Other

Is the pain constant, or does it come and go?

- Constant
- Comes and Goes

Does this pain interfere with your:

- Work/School
- Sleep
- Daily Routine
- Recreation
- Other

and/or your ability to:

- Sit
- Stand
- Walk
- Bend
- Lay Down

Is there anything else about your pain you would like to share?

## Health History

What treatment have you already received for your condition?

- Medications
- Surgery
- Physical Therapy
- Chiropractic Services
- Other
- None

Please list the dates of your last:

Physical Exam:

Spinal Exam:

Spinal X-Ray:

MRI, CT Scan, Bone Scan:

Please briefly describe any of the following you have experienced, including dates, if possible:

Falls:  
 Head Injuries:  
 Broken Bones:  
 Dislocations:  
 Surgeries:

Please indicate if you have ever experienced or been diagnosed with the following:

**Autoimmune**

- Diabetes     Multiple Sclerosis     Mononucleosis     Rheumatoid Arthritis

**Blood & Urine**

- Anemia     Kidney Disease     Other bleeding disorders

**Musculoskeletal**

- Arthritis     Bone Fractures     Herniated Disk     Osteoporosis

**Cardiovascular**

- Heart Disease     High Blood Pressure     High Cholesterol     Pacemaker

**Mental Health**

- Alcoholism     Substance Use Disorder     Depression     Disordered Eating  
 Psychiatric Care     Other mental illness

**Neurological/Nervous System**

- Epilepsy     Migraine Headaches     Parkinson's Disease     Pinched Nerve     Stroke

**Other**

- Athsma     Emphysema     Cancer     Non-Cancerous Tumor/Growth     Hernia  
 HIV/AIDS     Prosthesis     Thyroid Problems

## Current Health

Are you currently pregnant?

Yes  No

If yes, when is your due date?

Do you smoke or vape?

Yes  No

If yes, how much per day?

Do you drink alcohol?

Yes  No

If yes, how many drinks do you consume in a typical week?

Are you currently taking any prescription or over-the-counter medications?

Yes  No

If yes, please list the medication below:

Please list anything else below you believe we should know about your current or previous health history before seeing you:

# Back Pain Index

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box that closely describes your problem. If you do not suffer from back pain, you may skip these questions.

## Section 1 - Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

## Section 2 - Personal Care

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of waking or dressing even though it causes pain.
- Washing and dressing increase the pain but I manage not to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing or dressing without help.

## Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off of the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

**Section 4 - Walking**

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one km. without increasing pain.
- I cannot walk more that 1/2 km. without increasing pain.
- I cannot walk more than 1/4 km. without increasing pain.
- I cannot walk at wall without increasing pain.

**Section 5 - Sitting**

- I can sit in any chair as long as I like.
- I can only sit in my favourite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more that 1/2 hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increase pain straight away.

**Section 6 - Standing**

- I can stand as long as I want without pain.
- I have some pain on stand but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer that 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without pain.
- I avoid standing because it increases pain straight away.

**Section 7 - Sleeping**

- I have no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal night's sleep is reduced by less than 1/4.
- Because of pain my normal night's sleep is reduced by less than 1/2.
- Because of pain my normal night's sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

### Section 8 - Social Life

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.)
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of pain.

### Section 9 - Traveling

- I get no pain while travelling.
- I get some pain while travelling but none of my usual forms of travel make it any worse.
- I get extra pain while travelling but it does not compel me to seek alternative modes of travel.
- I get extra pain while travelling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except which is done lying down.

### Section 10 - Changing Degree of Pain

- My back pain is rapidly getting better.
- My back pain fluctuates but overall is definitely getting better.
- My back pain seems to be getting better but improvement is slow at present.
- My back pain is neither getting worse or better.
- My back pain is gradually getting worse.
- My back pain is rapidly getting worse.

## Neck Pain Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box that closely describes your problem. If you do not suffer from neck pain, you may skip these questions.

**Section 1: Pain Intensity**

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

**Section 2: Personal Care (Washing, Dressing, etc.)**

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self care
- I do not get dressed, I wash with difficulty and stay in bed

**Section 3: Lifting**

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

**Section 4: Reading**

- I cannot lift or carry anything
- I can read as much as I want to with no pain in my neck
- I can read as much as I want to with slight pain in my neck
- I can read as much as I want with moderate pain in my neck
- I can't read as much as I want because of moderate pain in my neck

- I can hardly read at all because of severe pain in my neck
- I cannot read at all

**Section 5: Headaches**

- I have no headaches at all
- I have slight headaches, which come infrequently
- I have moderate headaches, which come infrequently
- I have moderate headaches, which come frequently
- I have severe headaches, which come frequently
- I have headaches almost all the time

**Section 6: Concentration**

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

**Section 7: Work**

- I can do as much work as I want to
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I can't do any work at all

**Section 8: Driving**

- I can drive my car without any neck pain
- I can drive my car as long as I want with slight pain in my neck
- I can drive my car as long as I want with moderate pain in my neck

- I can't drive my car as long as I want because of moderate pain in my neck
- I can hardly drive at all because of severe pain in my neck
- I can't drive my car at all

#### Section 9: Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr sleepless)
- My sleep is mildly disturbed (1-2 hrs sleepless)
- My sleep is moderately disturbed (2-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (5-7 hrs sleepless)

#### Section 10: Recreation

- I am able to engage in all my recreation activities with no neck pain at all
- I am able to engage in all my recreation activities, with some pain in my neck
- I am able to engage in most, but not all of my usual recreation activities because of
- pain in my neck
- I am able to engage in a few of my usual recreation activities because of pain in
- my neck
- I can hardly do any recreation activities because of pain in my neck
- I can't do any recreation activities at all

## Consents — Step 4 of 4

*You are completing the following intake forms: Intake Form*

### Communication

#### Appointment Notifications and Reminders

##### Email

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

I would like email notifications of new, cancelled, and rescheduled appointments

Email 2 days before appointment

### Text Message (SMS)

Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

Text Message (SMS) 2 hours before appointment

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## Intake Form – Consents

### Accuracy of Information – Required

I certify that the above medical information is correct to my knowledge.

### Privacy and Sharing of Information – Required

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I agree

### Office Payment Policy – Required

We want to deliver the best, most effective and cost efficient chiropractic health care available.

On your first visit, we will obtain a history from you and perform an examination, which may include x-rays if necessary. If you are in a great deal of pain, we will begin therapy to help give you relief.

On your second visit, the doctor will discuss with you the plan of treatment and your options for care so that you can make an educated decision about how you would like to proceed.

Payment for your initial and future visits is due at the time of service. We will file your insurance for you, but you are responsible for your deductible, co-pay, and any services not covered by your insurance. We try to verify your insurance as soon as you give us the information so that you will know which portions of your treatment you, and your insurance, will be responsible for.

For worker's compensation and automobile accident cases, we require all of the necessary information; namely, your insurance, the at-fault party's insurance, your claim number, your adjuster's name, and your attorney's information, within two weeks. Otherwise, we will expect you to pay out of pocket until that information is delivered. We require that you allow us to file all insurance for your case out of our office including major medical, medpay, and liability insurance. This is to your advantage, in that any overpay is refunded to you. Please contact our office for additional information regarding injury cases, if necessary.

I am aware of, and agree to, the office's payment policy.

## Informed Consent for Care – Required

I hereby request and/or consent to the performance of chiropractic adjustments and/or other chiropractic procedures on me (or on the patient for whom I am legally responsible) by Dr. Christopher Branco and/or his assigned staff who now and/or in the future may care for me in this office.

I understand and am now informed that, as in the practice of medicine, there are some risks in the practice of chiropractic care, including but not limited to sprain and strain, fractures, dislocations, CVA, stroke, and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor or staff the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor will perform an examination in order to minimize any risk of care; however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise judgement during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is within my best interest.

I have read, or have read to me, the above consent. I have also had an opportunity to ask questions about its content, and I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

initials  
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## Notice of Privacy Practices – Required

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. **Please review it carefully.**

### **YOUR RIGHTS**

#### **Get an electronic or paper copy of your medical record**

You can ask to see or receive an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct your medical record**

You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.

#### **Request confidential communications**

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say yes to all reasonable requests.

#### **Ask us to limit what we use or share.**

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

**ONLY** if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.

#### **Get a list of those with whom we've shared information**

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cash-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take action.

### **File a complaint if you feel your rights are violated**

You complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201, calling 1-877-696-6775, or visiting <https://www.hhs.gov/hipaa/filing-a-complaint/index.html> (<https://www.hhs.gov/hipaa/filing-a-complaint/index.html>). We will not retaliate against you for filing a complaint.

## YOUR CHOICES

### **For certain health information, you can tell us your choices about what we share**

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want to do, and we will follow your instructions.

#### **In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

#### **In these cases we *never* share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information

**In the case of fundraising:** We may contact you for fundraising efforts, but you can tell us to never contact you again.

## OUR USES AND DISCLOSURES

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

- **Treat you** - We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization** - We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and*

services.

- **Bill for your services** - We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?** We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

#### **Help with public health and safety issues**

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.

#### **Do research**

We can use or share your information for health research.

#### **Comply with the law**

We will share information about you if state or federal law requires it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

#### **Reply to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

#### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

#### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions, such as military, national security, and presidential protective services.

#### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### **OUR RESPONSIBILITIES**

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy and safety of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, visit

[https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/consumers/consumer\\_summary.pdf](https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/consumers/consumer_summary.pdf)  
([https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/consumers/consumer\\_summary.pdf](https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/consumers/consumer_summary.pdf)).

#### **Changes to the Terms of This Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

*Effective September 21, 2015*

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**Signature** – *Required*

Draw  Type

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Submit Intake Form

(<https://jane.app>)

[Terms of Use \(https://jane.app/terms\)](https://jane.app/terms)

[Privacy Policy \(https://jane.app/privacy\)](https://jane.app/privacy)