Attention Mobile Users: This form cannot be completed on a mobile device. Please complete digitally on a laptop or desktop device, or print, complete by hand and scan & email to Admin@DukeChiroCenter.com.

DUKE CENTER for Chiropractic Sports & Spine C.A.R.E

561-571-0044

DukeChiroCenter.com

Upon completion, please email intake forms to: Admin@DukeChiroCenter.com

PATIENT INTAKE FORM

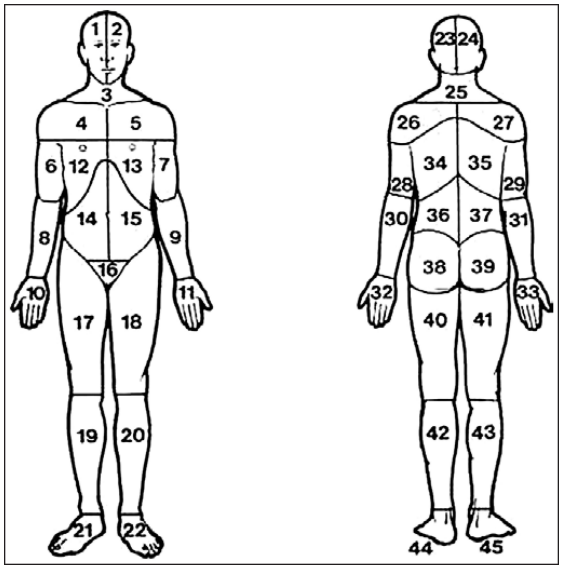
Patient Name:_____ Birth Date (M/D/Y):____/___/_____ Age: _____
Gender: ◯ Female ◯ Male ◯ Custom_____
Email:_____ Marital Status: ◯ S ◯ M ◯ D ◯ W
Address:_____ City, State:_____ Zip:_____
Phone (Home):_____ Phone(Cell):_____
Occupation:_____ Family Doctor:_____
How did you hear about our office? _____ Referred By:_____

Current Condition

Date of injury: _____
Mechanism of injury: _____
Describe your chief complaint / concern: _____
_____
Identify any position / activity that eases your symptoms: _____
_____
_____
Identify any position / activity that aggravates your symptoms: _____
_____
Do your symptoms worsen or wake you at night? ◯ Yes ◯ No

Medications	Dosage	Frequency

Please indicate your complaint area(s) below by telling us which numbered area(s) are troubling you. For Example: Low Back Pain on the left side would be #36. If there are any complaint areas unable to be identified with a number, simply write out the name of the area(s) in the spaces below.



Current Complaint (how you feel today)

◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable pain

CURRENT SYMPTOMS / CONDITION

(check all that apply)

☐ Cancer / infection	☐ Recent falls	☐ Abdominal pain / pulsating
☐ Fever, chills, night sweats	☐ Balance / dizziness	☐ Blood in urine
☐ Nausea / vomiting	☐ Weakness / joint pain	☐ Changes in bowel / bladder
☐ Unexplained weight gain	☐ Numbness / tingling	☐ Difficulty swallowing

☐ Pregnancy? # of weeks:____	☐ Shortness of breath	☐ Difficulty Starting/Stopping Urine
☐ Smoker Pack(s)/Day: _____	☐ Excessive cough	☐ Diabetes
☐ Confusion / memory loss	☐ Severe pain in calf	☐ Excessive thirst
☐ Pacemaker	☐ High blood pressure	☐ Insulin dependent

During the past month, have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

PAST MEDICAL HISTORY

List any medical condition you have been diagnosed with or hospitalized for, any history of X-rays, MRI, & CT scans as well as Epidurals, Cortisone Injections, Etc.

Patient / guardian signature: _____ Date: _____

Doctor's Use Only

(notes for follow-up questions)

OPQRST _____ THISMD _____ OCCUP _____ ADDITIONAL _____

INFORMED CONSENT

I hereby request and consent to the performance of Chiropractic adjustments and other procedures including various modes of Physio therapies, manual muscle therapies, therapeutic exercises & other Chiropractic procedures performed by the doctor of Chiropractic named below and or other licensed doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as a backup for the doctor of Chiropractic named below, including those working at the clinic or office listed below.

I have had an opportunity to discuss with the Doctor of Chiropractic named below or other office clinical personnel, my diagnosis, the nature and purpose of my Chiropractic adjustments and procedures, the risks and benefits of my Chiropractic treatment, alternatives to my Chiropractic treatment, and the risks and benefits of alternative treatment, including receiving no treatment at all.

I further understand and I am informed that in the practice of Chiropractic, there are some risk to treatment including but not limited to; post treatment soreness, stiffness & bruising. In rare cases, treatment may include risks of fractures, (broken bones), increased symptoms and pain, disc injuries, stroke, dislocations and sprains/strains.

I understand that results are not guaranteed and no promises have been made to me concerning the results expected from treatment.

I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the treatment/procedure which the doctor feels at the time, based upon the fact then known, and is in my best interest.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. 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.

_____ _____ ____/____/_____

Printed name of patient or representative Signature Date

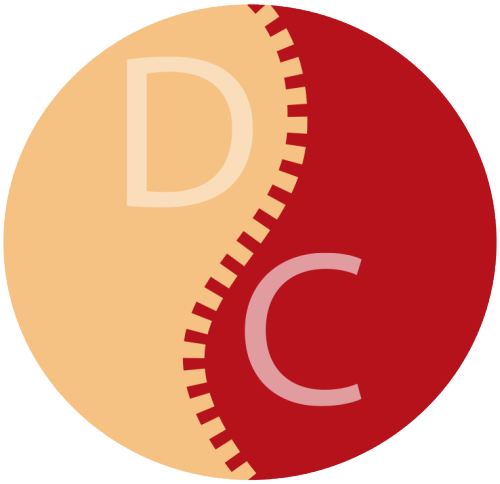
Relationship to patient (if other than patient):

_____

Dr. Scott Duke at Duke Center for Chiropractic Sports & Spine C.A.R.E.

_____ ____/____/_____

Doctor's Signature Date



WE ARE REQUIRED BY LAW TO PROVIDE YOU (OUR PATIENT) WITH A NOTICE OF PRIVACY PRACTICES.

PLEASE READ THE FOLLOWING **5** PAGES AND WHEN YOU ARE DONE WE ASK THAT YOU SIGN THE TOP OF THE PAGE TITLED:
"ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES"

THANK YOU.

Judicial and Administrative Proceedings — We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

Disclosures for Law Enforcement Purposes — We may disclose your PHI to law enforcement officials for these purposes:
• As required by law
• In response to a court, grand jury or administrative order, warrant or subpoena
• To identify or locate a suspect, fugitive, material witness or missing person
• About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement
• To alert a potential victim or victims or intending harm ("duty to warn")
• To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
• About crimes that occur at our facilities
• To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances
To Avert Serious Threat to Health or Safety — We will use and disclose your PHI when we have a duty to report under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

Coroners, Medical Examiners and Funeral Directors — We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

Organ, Eye or Tissue Donation — To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

Workers Compensation — We may disclose your PHI to the extent necessary to comply with worker's compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Special Government Functions — If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Research — We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that information that identifies who you are, we will ask for your permission.

Fundraising — We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

AUTHORIZATION

The following uses and/or disclosures specifically require your express written permission:

Marketing Purposes — We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

Sale of Health Information — We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the

information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

YOUR RIGHTS

Right to Revoke Authorization — You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Right to Request Restrictions — You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

Right to Receive Confidential Communications — You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

Right to Inspect and Copy — You have the right to inspect and request copies of your information. To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If you request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

Right to Amend — If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend th information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

Right to an Accounting of Disclosures — You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

Right to a Paper Copy of this Notice — You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint — You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: Penny Duke
Address: 5550 Glades Road, Suite 500 #1088, Boca Raton, FL 33431
Email: Admin@DukeChiroCenter.com
Phone: 561-571-0044

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, , acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Duke Center for Chiropractic Sports & Spine C.A.R.E., which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Signature: Date:

Print Name: