360 INTEGRATED® MEDICAL CENTER
A Team Approach to Total Health™
2504 Monroe Street, LaPorte, IN 46350
PH: (219) 326-5100 FX: (219) 326-0180

Confidential Patient Intake Form

WELCOME TO OUR OFFICE! Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent medical records and will help us get a better understanding of your overall health. Please ask if you have any questions or concerns while completing this form. THANK YOU!

PERSONAL INFORMATION

Patient Legal Name: _____ **Date:** _____/_____/_____
Date of Birth: _____/_____/_____ **Age:** _____ **Sex:** ❑ Male ❑ Female **Marital Status:** S / M / D / W
SSN: _____/_____/_____ **Home Phone:** (_____) _____-_____ **Cell Phone:** (_____) _____-_____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Email: _____ **Occupation:** _____
Employer Name/City: _____ **Work Phone:** (_____) _____-_____
Spouse or Guardian's Name: _____ **How Many Children (Ages):** _____
Spouse's Employer: _____ **Spouse's SSN:** _____/_____/_____
Emergency Contact: _____ **Phone:** (_____) _____-_____
Whom May We Thank for Referring You to Us? _____
How Else Did You Hear About Us? _____

If Patient is School Age (15+), I Authorize Treatment in My Absence esp. In Case of Medical Emergency (GUARDIAN SIGN BELOW):

Legal Guardian Signature: _____ Patient Relation: _____ Date: _____

RESPONSIBLE PARTY – Do You Currently Have Medical Insurance? ❑ No ❑ Yes (complete the following:)

Who is Responsible for Your Account: ❑Myself Only ❑Myself AND: Spouse / Work Comp / Auto Insur. / Health Insur.
Personal Health Insurance Carrier: _____ **Health ID Card #:** _____
Policy Holder's Name: _____ **Group #:** _____
Policy Holder's Social Security #: _____/_____/_____ **Primary Care Physician:** _____

ASSIGNMENT OF HEALTH BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that regardless of whatever health insurance or medical benefits I have, I am ultimately responsible to pay **360 Integrated Medical Center PC and/or Back to Health Wellness Center PC** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20_____. **Patient Signature:** X_____

Guardian Signature (if applicable): _____ Print Patient Name: _____

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Patient Name: _____ Date: _____/_____/_____

CHIEF COMPLAINT – HPI (HISTORY OF PRESENT ILLNESS)

What is Your MAIN SYMPTOM? _____

Location (Where is your main pain/problem?): _____

Quality (Describe this pain/problem): _____

Duration (When did this pain/problem start?): _____

Cause (What started this pain/problem?): _____

Severity (How severe is this pain/problem?): _____

Frequency (How often is this pain/problem?): _____

Timing (Worse in morning, night, constant?): _____

Change (Getting better, worse, same over time?): _____

Relieving Factors (What activities make it better?): _____

Aggravating Factors (What activities make it worse?): _____

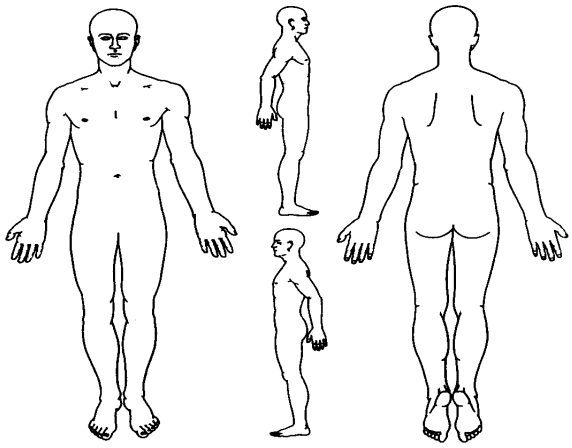
Radiation (Other body areas affected by this pain/problem?): _____

OTHER HEALTH COMPLAINTS

Please list health complaints you are having currently and mark location(s) on the diagram using the "Key". Then indicate below the severity of the symptom(s) from 1 to 10 with 10 being worst.

	No Pain ▼									Worst Pain ▼
Primary Complaint:										
1)_____	1	2	3	4	5	6	7	8	9	10
Additional Complaints										
2)_____	1	2	3	4	5	6	7	8	9	10
3)_____	1	2	3	4	5	6	7	8	9	10
4)_____	1	2	3	4	5	6	7	8	9	10
5)_____	1	2	3	4	5	6	7	8	9	10

Diagram Key: A=Ache, B=Burning, N=Numbness, P=Pin & Needles, S=Sharp



ACTIVITIES OF DAILY LIVING

Work Status: ❑Employed ❑Unemployed ❑Retired ❑Disabled ❑Student ❑Stay-at-home ❑Other: _____

Usual Daily Activities: ❑Bend ❑Reach ❑Climb ❑Sit ❑Kneel ❑Stand ❑Pull ❑Twist ❑Push ❑Walk ❑Lift

Repetitive Activities: ❑Assembly/Fine Manipulation ❑Hand Tool Use ❑Computer Use/Typing ❑Operate Machinery ❑Grasping ❑Phone Use ❑Other: _____

How Has Primary Condition Affected Job Performance? ❑No Effect ❑Limited Ability ❑Can't Perform Normal Duties

How Has Primary Condition Affected Daily Activities?

Bending:	❑No Effect	❑Mild	❑Moderate	❑Severe	Lifting:	❑No Effect	❑Mild	❑Moderate	❑Severe
Changing Positions:	❑No Effect	❑Mild	❑Moderate	❑Severe	Sleeping:	❑No Effect	❑Mild	❑Moderate	❑Severe
Climbing Stairs:	❑No Effect	❑Mild	❑Moderate	❑Severe	Sitting:	❑No Effect	❑Mild	❑Moderate	❑Severe
Driving:	❑No Effect	❑Mild	❑Moderate	❑Severe	Standing:	❑No Effect	❑Mild	❑Moderate	❑Severe
Computer Use:	❑No Effect	❑Mild	❑Moderate	❑Severe	Walking:	❑No Effect	❑Mild	❑Moderate	❑Severe
Household Chores:	❑No Effect	❑Mild	❑Moderate	❑Severe	Yard Work:	❑No Effect	❑Mild	❑Moderate	❑Severe

How Has Primary Condition Affected Recreational Activities? _____

_____

Provider APN/MD Signature: _____ Date: _____/_____/_____

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Patient Name: _____ Date: _____/_____/_____

PAST MEDICAL HISTORY

Height: _____ft. _____in. **Current Weight:** _____lbs. **Recently Lost or Gained More Than 10 lbs?** ❑Yes ❑No

Last Physical Exam Date and Results? _____

Have You Seen Other Physicians/Providers for THIS Main Primary Condition? ❑Yes ❑No

If Yes, List All Doctors or Therapist Consulted for THIS Condition (include approximate dates and diagnosis).

Provider Name: _____ Date of Visit: _____ Diagnosis: _____

Provider Name: _____ Date of Visit: _____ Diagnosis: _____

Describe Any Treatment You've Had for THIS Condition (include medications, testing, etc.): _____

_____

Have You Ever Received Chiropractic Care? ❑No ❑Yes: When? _____ Satisfied with Care? ❑Yes ❑No

MEDICATIONS & ALLERGIES

List Any Prescription & Non-Prescription Medications, Vitamins You Are Currently Taking: ❑ Not Taking Any Meds

Medication	Dosage	For What Condition?	How Long Been Taking This?

List Any Allergies, Including Sulfa, Seasonal, Food and Medicinal Allergies: ❑ No Known Allergies

Allergen	Reaction to Allergen

PAST HOPITALIZATIONS/SURGERIES

Please Indicate If You Have Had the Following Surgeries:

❑ Carpal Tunnel Surgery Date: _____ ❑ Rotator Cuff Repair Date: _____
❑ Laminectomy Date: _____ ❑ Knee Repair Date: _____
❑ Joint Reconstruction Date: _____ ❑ Spinal Fusion Date: _____
❑ Joint Replacement Date: _____ ❑ Spinal Disc Surgery Date: _____

List Any Other Past Hospitalizations and Surgeries: _____

_____

_____

PAST INJURIES

Please Indicate If You Have Had the Following Injuries:

❑ Back Injury Date: _____ ❑ Severe Fall Date: _____
❑ Joint Injury Date: _____ ❑ Auto Accident Date: _____
❑ Broken Bones Date: _____ ❑ Sprain/Strain Date: _____
❑ Head Injury Date: _____ ❑ Severe Laceration Date: _____

List Any Other Past Major Injuries: _____

_____

_____

Provider APN/MD Signature: _____ Date: _____/_____/_____

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PAST ILLNESSES/DISEASES

Please Indicate If You Have Ever Had the Following Illnesses:

❑ Measles	❑ Pneumonia	❑ Asthma	❑ Hepatitis	❑ Anemia
❑ Mumps	❑ Rheumatic Fever	❑ Eczema Hives	❑ Ulcer	❑ Bladder Infection
❑ Chicken Pox	❑ Arthritis	❑ AIDS & HIV	❑ Kidney Disease	❑ Epilepsy
❑ Whooping Cough	❑ Venereal Disease	❑ Infectious Mon	❑ Thyroid Disease	❑ Migraine Headaches
❑ Scarlet Fever	❑ Polio	❑ Bronchitis	❑ Blood Clots	❑ Blood Pressure Issue
❑ Diphtheria	❑ Tuberculosis	❑ Mitral Valve Prolapse	❑ Cancer	❑ Glaucoma
❑ Small Pox	❑ Diabetes	❑ Stroke	❑ Bleeding Tendency	❑ Hemorrhoids

List Any Other Past Serious Illnesses or Disease: _____

_____

REVIEW OF SYSTEMS

Please Indicate Any of the Following You Have Experienced in the Last 1-2 months.
Please Circle the Number According to Frequency: **1=Never, 2=Rarely, 3=Occasionally, 4=Frequently, 5=Constantly**

General & EENT		Musculoskeletal		Neurological	
Weakness	1 2 3 4 5	Muscle Aches	1 2 3 4 5	Headaches	1 2 3 4 5
Fatigue	1 2 3 4 5	Fibromyalgia	1 2 3 4 5	Migraines	1 2 3 4 5
Fever	1 2 3 4 5	Arthritis	1 2 3 4 5	Dizziness	1 2 3 4 5
Chills	1 2 3 4 5	Joint Pain	1 2 3 4 5	Numbness	1 2 3 4 5
Night Sweats	1 2 3 4 5	Joint Stiffness	1 2 3 4 5	Tingling	1 2 3 4 5
Fainting	1 2 3 4 5	Low Back Pain	1 2 3 4 5	Seizures	1 2 3 4 5
Asthma	1 2 3 4 5	Neck Pain	1 2 3 4 5	Vertigo	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Mid Back Pain	1 2 3 4 5	Trembling	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5	Weak Grip	1 2 3 4 5
Earache/Infection	1 2 3 4 5	Elbow Pain	1 2 3 4 5	Incoordination	1 2 3 4 5
Shortness Breath	1 2 3 4 5	Shoulder Pain	1 2 3 4 5	Paralysis	1 2 3 4 5
Wheezing	1 2 3 4 5	Hip Pain	1 2 3 4 5	Memory Loss	1 2 3 4 5
Ear Ringing	1 2 3 4 5	Knee Pain	1 2 3 4 5	Speech Difficulty	1 2 3 4 5
Skin Changes	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5	Facial Loss	1 2 3 4 5

PATIENT SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Daily Mental Work Load: ❑ None ❑ Light (1-2 hours) ❑ Moderate (3-4 hours) ❑ Heavy (5+ hours)
Daily Physical Work Load: ❑ None ❑ Light (1-2 hours) ❑ Moderate (3-4 hours) ❑ Heavy (5+ hours)
Weekly Exercise Habits: ❑ No Exercise ❑ Light (1 day/wk) ❑ Moderate (2-3 days/wk) ❑ Heavy (4+ days/wk)
Use of Alcohol (Beer, Wine, Liquor): ❑ Never ❑ Rarely ❑ Moderate ❑ Daily
Use of Tobacco/Smoking: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily
Use of Drugs: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily : Type/Frequency: _____

FAMILY MEDICAL HISTORY

List Any Diseases or Illnesses Which Run in Your Family

	Age if Living	Age at Death	Disease/Illness	Cause of Death	State of Health
Father					
Mother					
Brother(s)					
Sister(s)					
Spouse					
Children					

The questions on this form have been completed by me and accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility throughout the course of any future recommended treatment to inform this doctor's office of any changes in my medical status. I also authorize the healthcare staff of this office to perform any necessary services I may need today and in the future.

SIGNATURE of Patient, Parent or Guardian: X_____ Date: _____/_____/_____

Provider APN/MD Signature: _____ Date: _____/_____/_____