Taylor Made Integrative Therapy
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# New Patient Intake Form

**Prefix**: ____ **Patient's Name**: _____ **D.O.B.** : ___/___/____
**Gender**: _____ **SSN**: _____-_____-_____ **Marital Status**: _____
**Address**: _____ **City**: _____ **St**: ___ **Zip**: _____
**E-mail**: _____ **Occupation**: _____
**Phone**: _____ **Cell**: _____ **Preferred Contact**: Phone Cell Email
**How did you hear about us?** _____

## HIPAA Information

**Pref Language**: _____ **Race**: Nat Amer / African Amer / Asian / Caucasian / Other _____
**Ethnicity**: Hispanic/Latino Non-Hispanic/Latino

## Emergency Contact Information

**Name**: _____ **Relationship to Pt**: _____
**Phone**: _____ **Email**: _____

## Injury Information & Medical History

Describe your injury, how it occurred, and goals for treatment: _____

_____

**How did your injury occur?** Gradual Traumatic Chronic Unknown
**When did your injury occur?** < 14 days 2-12 weeks 3 mo – 1 year More than 1 year
**On a scale from 1-10 (1-very little pain, 10-worst) how would you rate your pain?**
1 2 3 4 5 6 7 8 9 10

**How would you describe your pain?**
Dull Sharp
Ache Stabbing
Radiating Numbness
Tingling Burning
Throbbing Spasm

**When does your pain occur?**
Morning
Afternoon
Night
All the time

**What makes your pain worse?**
Sitting
Standing
Rest
Activity
Nothing

**What makes your pain better?**
Medication
Heat/Ice
Rest
Activity
Nothing

**Prior treatment for this injury:**

Surgery: _____

Specialist: _____

Hospitalized: _____

Advised to have surgery: Y / N

P.T. or Chiropractic care: _____

**Diagnostic Test, Results, and Date for this injury:**

MRI: _____

X-Ray: _____

EMG: _____

CT Scan: _____

Bone Scan: _____

**Treatment for any other serious injuries/conditions:** _____

_____

**Amount of water intake/day?** _____ cups/oz

**Activities/Hobbies:** _____ **Times/Week:** _____

**List all medications:** _____

_____

**List all supplements/vitamins:** _____

_____

**Please list any medication allergies?** _____

# PRIVACY PRACTICES AND CONSENT FOR USE OF PROTECTED HEALTH INFORMATION (HIPAA)

By signing this document, you consent to the use or disclosure of your protected health information (PHI) by Taylor Made Integrative Therapy for the purpose of diagnosing or providing treatment to you, obtaining payment for your health care bills or to conduct health care operations. You understand that your diagnosis or treatment by the Taylor Made Integrative Therapy staff may be conditioned upon your consent as evidenced by your signature on this document.

My "protected health information" means health information collected from your and created or received by your physician, another health care provider, a health plan, your employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

You have the right to request an electronic or paper copy of your medical records. You may also ask to correct any health information that you believe is incorrect or incomplete. If we disagree with this change we will notify why within 30 days. You have the right to request a restriction as to how your protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Taylor Made Integrative Therapy is not required to agree to the restrictions that you may request. You have the right to revoke this consent, in writing, at any time, except to the extent that Taylor Made Integrative Therapy has taken action in reliance on this consent.

Information transmitted via text, FAX or Email may be privileged and confidential. There is some risk that any protected health information that may be contained in such transmissions may be disclosed to, or intercepted by, unauthorized third parties. Please be aware that FAX and email communications can be intercepted in transmission or misdirected. Your use of FAX or email to communicate protected health information to us indicates that you acknowledge and accept the possible risks associated with such communication. Taylor Made Integrative Therapy's electronic software will be used as much as possible as it is HIPAA compliant.

You understand you have a right to review Taylor Made Integrative Therapy's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in your treatment, payment of your bills or in the performance of health care operations of the clinic. The Notice of Privacy Practices for Taylor Made Integrative Therapy is posted. This Notice of Privacy Practices also describes your rights and Taylor Made Integrative Therapy duties with respect to your protected health information.

Taylor Made Integrative Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. You may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature: _____

Date: _____

# Informed Consent to Treatment

**Please read this entire document prior to signing it. It is important you understand the information in this document. Please ask questions anything is unclear to you. As with any treatment, there are risks to every benefit. It is important that you understand the information below so you are aware of all complications and risks associated with the treatment you may receive at Taylor Made Integrative Therapy. As a part of the analysis, examination, and treatment you are consenting to the following procedures.**

- **Manual Therapy/Myofascial Release**

The licensed chiropractor will apply pressure to the muscles and joints to resolve the underlying fascial injury to restore normal range of motion, strength, and function. Risks include discomfort, soreness, and bruising for up to 3 days. Everyone has different pain tolerances and it is important to let your provider know if the discomfort during treatment is too much.

- **Active Rehab Exercises**

Active Rehab Exercises involve self-myofascial release instruments, stretches, and strengthening exercises. They are designed to help stabilize, strengthen, and reinforce proper biomechanical movement and function. Exercises are generally low resistance and high repetition. Risks include soreness, aggravation of injury, increased heart rate and blood pressure.

- **Spinal/Extremity Joint Manipulation**

In a few cases, the doctor may make the decision that spinal or joint mobilization would be beneficial to help resolve your injury. If joint manipulation is used, the doctor would use his hands to distract and move the joint in to the normal range of motion. For the spinal mobilization, a quick thrust at low amplitude may be used or pressure into the joint with mobilization of the spinal segment may be used. You may feel or hear an audible pop like cracking your knuckles, but it should be pain free. When a joint is not in the proper position, muscles may spasm as they try to hold it from going further out of place. Correcting the joint position will allow those muscles to relax. Risks include pain or discomfort, very rarely fractures or dislocation, strain/sprain, disc herniation. In the neck, a stroke or vertebral artery injury may result but these are very rare and normally in older patients or patients with severe cardiovascular disorders. The doctor will try to rule out any contraindications prior to care.

- **Cryotherapy**

Cyotherapy includes icing, ice packs, ice baths, and ice massage and will be performed by the patient at home. It is designed to decrease inflammation and swelling and to help numb the pain of the injury and speed recovery. Risks include reddening of the skin, burning sensation, and blistering. These are minimized when done properly.

- **Kinesio-taping**

Kinesio-tape is a stretchy tape material that will help brace an injured muscle without restricting its motion; it can help lift the fascia to aid in increased blood flow and lymphatic drainage for recovery; it can also help reduce pain sensation by distracting the tactile senses in the nervous system. Risks include skin/allergic reactions, itching, and blistering.

- **Alternative Treatment Options**

Other treatment options may include prescription and/or over-the-counter medications, rest, joint/muscle injections, hospitalization or surgery. If you chose to use one of the other treatment options, you should be aware that there are risks and benefits of such options and you may wish to discuss those with your primary care physician.

The risks of remaining untreated may allow the formation of adhesions further reducing mobility and causing the condition to worsen. Over time this process may complicate treatment requiring more extensive treatment later, surgery, or other serious intervention.

If you would like any procedures excluded from care, please list them below. Please be aware that removing procedures that the doctor deems necessary may mean a longer treatment plan or that the condition will not fully resolve.

If the patient is a minor, please have a parent or guardian who is authorized to select and approve health care services for this minor sign below authorizing a licensed provider of Taylor Made Integrative Therapy to perform treatment. Therapy provider. As of this date I have the legal right to select and authorize health care services for

_____ _____

Patient Name Patient Signature

_____ _____

Name of Patient's Legal Representative Signature of Patient's Legal Representative

_____ -

Date

**Please do not sign this section until Dr. Taylor has covered these questions verbally!!!!**

Taylor Made Integrative Therapy wants our patients to be as comfortable as possible during treatment. Since we share the GO Wellness Center with other practitioners, we keep the door closed while examining and treating our patients in order to maintain privacy. If you would like to have a female staff member present, we can arrange it.

Dr. Taylor has verbally discussed with me that the most effective way to treat my injuries is on the skin and we may be working on sensitive areas around the chest and pelvis. At no time will these areas be exposed.

I give consent for Dr. Taylor to treat all areas discussed in my treatment plan on the skin: _____

-or-

I choose to be treated over the clothing around the chest and pelvis: _____