Chiropractic Partners
RESTORING HEALTH AND WELLNESS

Chiropractic Partners
3319 Durham-Chapel Hill Blvd.
Durham, NC 27707
Phone: (919) 383-9890

NEW PATIENT INTAKE

First Name ______________________ MI ______ Last Name ______________________

Address ____

City ______________________ State ________ Zip ____________________

Home Phone ______________________ Cell Phone ______________________

Date of Birth _____/_____/_______ Age _______ SSN# _______ - _______ - _______

Gender: ☐ Male ☐ Female Email: ______________________________

How did you hear about our office? ______________________________________

EMERGENCY CONTACT

Name ______________________ Relationship ____________ Phone ______________

CURRENT MEDICATIONS

Name of Medication	Start Date	Name of Medication	Start Date
◊ ____________	________	◊ ____________	________
◊ ____________	________	◊ ____________	________
◊ ____________	________	◊ ____________	________
◊ ____________	________	◊ ____________	________

ALLERGIES

◊ ______________________ ◊ ______________________
◊ ______________________ ◊ ______________________
◊ ______________________ ◊ ______________________

COORDINATED CARE

For the purposes of coordinating care, we recommend that we send records to your referring/primary physician.

☐ I do not want my records sent to my physician ☐ I give permission to release my records to the listed physician(s)

Physician: ______________________ Facility: ______________________

Physician: ______________________ Facility: ______________________

Patient Signature: ______________________________

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/20[illegible]

Patient Name________________________ Date________________

1. Describe your symptoms ________________________________

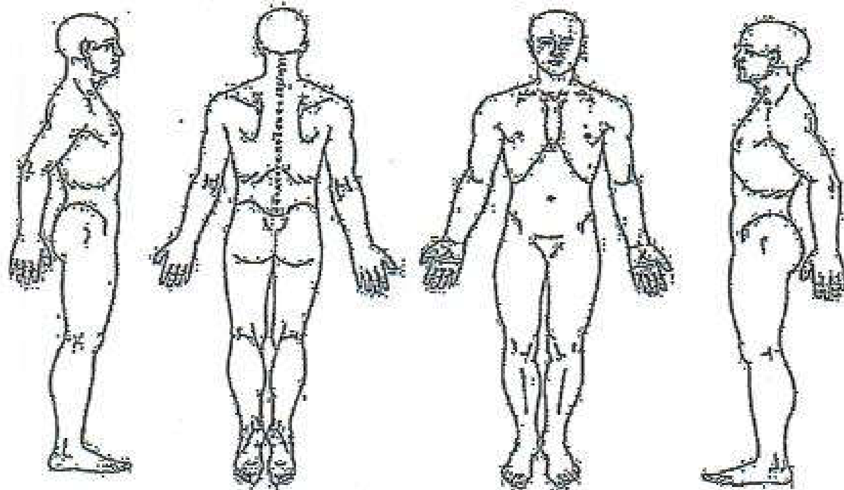
____

a. When did your symptoms start? ________________________________

b. How did your symptoms begin? ________________________________

2. How often do you experience your symptoms?
   ① Constantly (76-100% of the day)
   ② Frequently (51-75% of the day)
   ③ Occasionally (26-50% of the day)
   ④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
   ① Sharp ④ Shooting
   ② Dull ache ⑤ Burning
   ③ Numb ⑥ Tingling

4. How are your symptoms changing?
   ① Getting Better
   ② Not Changing
   ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?
   ① No One ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. What treatment did you receive and when? ________________________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays date: __________ ③ CT Scan date: __________

② MRI date: __________ ④ Other date: __________

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ② Other Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. What is your occupation?

① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student ⑦ Retired ⑧ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

Patient Signature________________________ Date________________

Patient Name: ______________________________ Date: ____________

MEDICAL CONDITIONS

☐ Hypertension	☐ Bowel Problems	☐ Dizziness/Vertigo	☐ Weight Loss/Gain
☐ Heart Disease	☐ Constipation	☐ Difficulty Swallowing	☐ Difficulty Sleeping
☐ Stroke	☐ Nausea/Vomiting	☐ Skin Disease	☐ Head Injury
☐ Cancer	☐ Poor Appetite	☐ Immune Disorder	☐ Osteoporosis
☐ Easy Bruising/Bleeding	☐ Bloody Stools	☐ Thyroid Disease	☐ Broken bones
☐ Asthma	☐ Gout	☐ Diabetes	☐ Shortness of Breath
☐ Shortness of Breath	☐ Arthritis	☐ Fevers/Chills/Sweats	☐ Numbness
☐ Blood Clots	☐ Swelling of Legs	☐ Aneurysm	☐ Balance Issues

Other: ______________________________

SURGERIES (Please list type of surgery and approximate date)

◊ ____________________ ◊ ____________________
◊ ____________________ ◊ ____________________
◊ ____________________ ◊ ____________________

FAMILY HISTORY

	Parent	*Sibling*		*Parent*	*Sibling*		*Parent*	*Sibling*
• Arthritis	☐	☐	• Cancer	☐	☐	• Psychiatric	☐	☐
• Cholesterol	☐	☐	• Diabetes	☐	☐	• Stroke	☐	☐
• Heart Problems	☐	☐	• Hypertension	☐	☐	• Thyroid	☐	☐

SUBSTANCE USE

	Present	*Past*		*Present*	*Past*		*Present*	*Past*
• Alcohol	☐	☐	• Tobacco	☐	☐	• Heroin	☐	☐
• Opioids	☐	☐	• Marijuana	☐	☐	• Cocaine	☐	☐
• Barbituates	☐	☐	• Amphetamines	☐	☐	• Other ____________		

On occasion we may wish to send prescribed exercises via email, for which we utilize an online company called WebExercises®. Additionally, the lab results for our BrainSpan™ testing can be emailed by request. Be aware that communication via email is not encrypted and therefore comes with some degree of risk of being read by someone else. We will never email either of the above mentioned items without your express permission. You have the option of requesting paper copies of these documents.

☐ I would like to utilize any WebExercises® sent to me via email and understand the innate associated risk

☐ If I have lab work performed and request the results via email, I understand the innate associated risk

INSURANCE POLICY FOR OFFICE OF DR. MICHAEL KRASNOV, D.C.

- **COMMERCIAL INSURANCE**

We will file your insurance; however, it is your responsibility to understand your insurance plan. Although we verify benefits as a service to you, we cannot guarantee your insurance will pay according to the benefits quoted to us and therefore there are **no guarantees of payment** from your insurance company. Unless otherwise prohibited, **any balance not paid by your insurance company within 90 days of our billing date is your responsibility.**

Payment of deductible, coinsurance, copays, and any non-covered services, based on the information provided to us by your insurer, is due and payable **at the time of service**

- **PERSONAL INJURY**

If your condition is due to a motor vehicle accident, we retain the right to file **ANY** available insurance, such as Medpay or health insurance. You will be responsible for any non-covered balance. If you retain an attorney we agree to work with or there is a liable insurance company, we will wait to receive payment from them for up to one year from completion of treatment. **Any balance is immediately due and payable** under the following conditions: 1) you terminate care without your doctor's approval, 2) you fail to notify us that you are no longer represented by the attorney we have on record, 3) you receive payment in whole or in part for our services from a third party Including MedPay and do not promptly use it to settle any balance due, of 4) you fail to cooperate with our efforts to receive third party reimbursement. Until we can verify your insurance coverage and/or legal representation, you may be asked to pay for your services in full.

- **WORKER'S COMPENSATION INJURY**

Almost all employers carry industrial insurance to cover treatment of your Worker's Comp injury. There is no out of pocket expense to the patient on **APPROVED** job-related injury claims; however we must receive from your employer and/or employer's insurance carrier approval **prior to** your examination and treatment for this direct billing. Patient without prior approval are required to pay for their services at the time of service. Any payments made by the patient prior to approval are reimbursed after this office receives payment from the insurance carrier.

- **MEDICARE**

Medicare **only pays for spinal manipulation** and only if they consider it medically necessary. They ***do not*** cover any other services.

SIGNATURE (*Medicare patients only*): ______________________ Date: __________

- **CASH**

If you do not wish us to file any type of insurance, and you pay us in full at the time of service, will be set up as a "cash" patient. This entitles you to a discount off our regular rates. If you have insurance and ask us not to file your insurance, you can change your mind in the future, but past visits will not be filed.

THERE IS A $25 RETURNED CHECK FEE FOR ALL RETURNED CHECKS

I understand the above information and agree to pay any amount not covered by my insurance carrier or liable party, unless otherwise prohibited. I agree to pay any costs associated with collecting payments over 30 days past due. This includes any late fees, interest, attorney's fees, and court costs.

All durable medical equipment, electro-stimulation pads, supplements, miscellaneous supplies, and video rentals which may not be covered by my insurance plan must be paid for upon receipt. Returns cannot be accepted on any supplies and products that are not in new condition. Returns must be made within 14 days of purchase. Refunds for items made within 14 days of purchase. Refunds for items paid by check will be issued after the check clears.

We request the courtesy of 24-hour advance notice if you are unable to keep your appointment. Failure to do so on a repeated basis may result in the loss of scheduling privileges.

PRINTED NAME: ______________________

PATIENT SIGNATURE: ______________________ Date: __________