Dr. Poane's Chiropractic Office
drpoane.com

# Functional Health Protocols

## *Initial Intake Form*

## Welcome to Our Office!

Name_____ Today's date _____SS# _____
Address _____ City _____ Zip _____
Home phone_____ Cell phone: _____Age _____Birth Date _____
Marital: M S W D Employer & phone: _____(In case we need to contact you)
Who is your family medical doctor? _____ Your E-mail:_____
Name of spouse _____Emergency Contact Name and phone # _____
*If you are a new patient to our office,* whom may we thank for referring you? _____

Please list (in any order) the **symptoms** that bother you the most and or ***the reason why you are coming to us***:

1. 2. 3. 4.

Please list **medications** you are currently taking and why you are taking them. *Use another piece of paper if more space is needed.*

1. 2. 3. 4.

Please list (in any order) **nutritional supplements** you are taking: *Use another piece of paper if more space is needed.*

1. 2. 3. 4.

Please tell your **Story** by answering the questions below, if it applies to your chief complaint (s):

1. What helps your symptoms? _____
2. What have you tried that does not help?_____
3. What aggravates your symptoms?_____
4. How long have you had the symptoms?_____
5. How bad are the symptoms. 1 is Least - 10 is worse? _____
6. How frequently do you experience the symptoms? _____
7. Do any of your symptoms / condition run in your family? _____
8. What tests have you had for any of your symptoms? _____
9. What did other doctors have to say about your symptoms / condition? _____
10. Anything else you would like to add? *Use another piece of paper if more space is needed.* _____

_____

_____

**Use the back of this form if you need more space or email your Story /questions to Dr. Poane: drpoane@gmail.com**

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# Biopsychosocial

Name:_____ Date: _____

## Social :

1. What is your occupation?
2. Have you lost work because of this condition? ___ If yes, how many days or what dates? _____
3. Is this condition due to injury or sickness arising out of employment? _____ auto accident? ___ other?__
4. Do you exercise? If so, where and what type:
5. Do you smoke? no / yes packs / day? _____ No. of years? _____
6. Do you drink alcohol? no / yes = heavy moderate light times per week_____
7. Do you have small children: no / yes how many?_____
8. Have you ever been in an auto accident? No / yes = When?_____
9. Have you ever seriously injured yourself from a fall or other trauma? _____
10. What operations have you had and when? _____
11. Serious illness and when? _____

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Circle your sleeping position(s): stomach, half stomach half side with one knee up, back, side
Do you sit at a desk frequently? Yes / No
Does your back hurt when you vacuum? Yes / No
Do you drive more than 20 minutes per day on the high way? Yes / No
Do you have to lift or reach for items (any items) on a daily basis? Yes / No

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## REVIEW OF SYSTEMS:

*Please explain any "YES" answers*

### *Do you have or have you had significant problems with (your):*

1. Eyes, ears, nose or mouth? no / yes _____
2. Heart or lungs? no / yes _____
3. Stomach, digestion (heart burn, indigestion, bloating), bowels, bowel movement or gastrointestinal tract? no / yes _____
4. Genitourinary system: please circle symptoms or conditions you now have or have in the past:
   ***Female:*** fibroids, breast pain, cancer, PMS, pain associated with period, frequent yeast infections, Heavy flow _____
   ***Male:*** urinary difficulties, difficulty stopping or starting urination, prostate enlargement, cancer etc? _____
5. Muscles, ligaments, bones, arthritis, .....? no / yes _____
6. Nerves, i.e. MS, pinched nerve, shaking, tripping, unsteady walk....? no / yes _____
7. Skin , sores, wound care, .....? no / yes _____
8. Psychiatric, i.e. bipolar, frequent depression,.....? no / yes _____
9. Do you seek professional counseling? no / yes _____
10 Is stress a factor in your life?_____
11 Hormone issues, lupus, autoimmune conditions, diabetes? _____
12 Blood or lymphatic problems? no / yes _____
13 Are you currently loosing weight for unknown reasons? no / yes _____
14.Do you have allergies or sensitivities to anything? no / yes _____
15 Other? _____

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## Family History:

1. Are there health related conditions that run or may run in your family, i.e. back problems, heart disease, cancer, alcohol, etc.. ? no / yes - explain:
2. Does or did your mother, father or siblings have allergies or sensitivities?

Name:
Starting Date:

# Food Diary

**Day 1 Day 1 Day 1 Day 1 Day 1 Day 1 Day 1 Day 1 Day 1 Day 1 Day 1 Day**

Meat Vegetables Fruit Bread Cake, candy, gum, sweets Drink

Number of Bowel Movements _____ Stress level: low 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 high

**Day 2 Day 2 Day 2 Day 2 Day 2 Day 2 Day 2 Day 2 Day 2 Day 2 Day 2 Day**

Meat Vegetables Fruit Bread Cake, candy, gum, sweets Drink

Number of Bowel Movements _____ Stress level: low 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 high

**Day 3 Day 3 Day 3 Day 3 Day 3 Day 3 Day 3 Day 3 Day 3 Day 3 Day 3 Day**

Meat Vegetables Fruit Bread Cake, candy, gum, sweets Drink

Number of Bowel Movements _____ Stress level: low 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 high

**Day 4 Day 4 Day 4 Day 4 Day 4 Day 4 Day 4 Day 4 Day 4 Day 4 Day 4 Day**

Meat Vegetables Fruit Bread Cake, candy, gum, sweets Drink

Number of Bowel Movements _____ Stress level: low 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 high

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Dr. Robert Poane
One Barrington Pl., Suite 108 Bel Air, Maryland 21014
410 - 420 - 7676

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You may refuse to sign this Acknowledgment.***

I, **X**_____, have received a copy of this office's Notice of Privacy Practices.
(please print your name)

**X** **X**
(please sign your name acknowledging receipt) (today's date)

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We attempted to obtain the patients acknowledgment of receipt of our Notice of Privacy Practices, but the Acknowledgment could not be obtained for the following reason: ___ Individual refused to sign ___ An emergency situation prevented us from obtaining the signature, ___ Other:

Dr. Poane's representative signature and date verifying that the patient did not sign the Acknowledgment:

# Financial Policy

**AUTHORIZATION TO PAY PHYSICIAN**: I hereby authorize and direct the _____ insurance company to pay by check made payable to R. T. Poane LLC at One Barrington Place, Suite 108, Bel Air, Maryland 21014, the medical and surgical expense benefits allowable, and otherwise payable to me under my insurance policy, as payment towards the total charges for professional services rendered. To assist in collections, I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney in this case. I agree to pay, in a current manner, any balance of said professional service charge over and above this insurance payment (except where prohibited by contract). This is a direct assignment of my rights and benefits under this policy, of which a photo copy shall be considered as effective and valid as the original.

Any balance owed after 30 days shall accrue interest at a rate of 2% per month. Should collection efforts be required, I shall be responsible for reasonable attorney fees, court costs, and any out of pocket expense.

I understand that I am ultimately responsible for payment in full to this office. I also understand that because of insurance delay's I may receive a bill months after my care has ended, but if I suspend or terminate my schedule of care, as determined by my treating doctor, fees for professional services will be immediately due and payable.

Please print your name: **X**_____

I (patient, guardian or parent Signature Authorizing care) **X**_____

understand and agree to the Financial policy above. Today's date: **X**_____

## 1. It is my responsibility to know if my medical insurance (or other responsible party), will pay for chiropractic and other services or products I receive in this office.

## 2. I will not rely or depend on Dr. Poane's Chiropractic Office to handle my insurance or financial affairs.

The two sentences above are written in common language. I admit and confess I understand them to mean I am responsible for payment if my insurance or other responsible party does not pay for the care I choose to receive in this office.

**X**_____
(Patient or guardian signature) Today's date: **X**_____