DALY INTEGRATED
MEDICAL GROUP

NEW PATIENT INTAKE FORM

Patient Name _____ DOB _____ Date _____

Email _____ SSN _____ ☐ Male ☐ Female

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone _____ Cell Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Employer Name _____ Occupation _____

Spouse or Patient's Guardian Name _____ Spouse's Employer _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

In case of a medical emergency, if the patient is of school-age 15+, the below indicates my coseny to treat my child/dependent in my absence.

_____ _____

Parent or Guardian Signature *Date*

RESPONSIBLE PARTY

Person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

E-Mail _____ Cell Phone _____

Driver's License # _____ SSN _____ DOB _____

Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical insurance? ☐ Yes ☐ No If yes, complete the following:

Name of the insured _____ Relationship to Patient _____

SSN _____ DOB _____ Name of Employer _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company_____ Group # _____ Union or local # _____

Automobile accident? ☐ Yes ☐ No If yes, date of accident? _____ Claim # _____

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ASSIGNMENT OF HEALTH PLAN 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 **Daly Integrated Medical Group, LLC**, 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 assign the benefits of insurance under my personal injury protection coverage, or other first-party automobile insurance coverage. 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 an 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 of this document is to be considered as valid and as enforceable as the original.

CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed providers who now, or in the future work at Daly Integrated Medical Group. I understand, and am informed that, in the practice of medicine and chiropractic, there are some risks to treatment including but not limited to:

- Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.
- Therapeutic Modalities and procedures: additional pain and discomfort.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. By signing below, I agree to the above 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.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or decline the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____	_____	_____
Patient's Name	*Patient's Signature*	*Date*

HEALTH HISTORY

Chief Complaint: _____

(Reason for Visit)

History of Present illness:

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the condition: _____

Is this condition getting progressively worse? ☐ Yes ■ No ☐ Unknown

Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain) 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

Please describe your symptoms: _____

(Example: dull, sharp, achy, numb, burning, cramping, etc.)

What makes the problem worse? _____

What makes the problem better? _____

What time of day is it worse? ☐ Morning ☐ End of Day ☐ Night ☐ Various Times

What percentage of the day is the condition present? 10% ○ 20% ○ 30% ○ 40% ○ 50% ○ 60% ○ 70% ○ 80% ○ 90% ○ 100% ○

Does it interfere with any of the following? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ None

Have you seen other doctors for this condition? ☐ Yes ■ No - If yes, who? _____

Type of Treatment: _____ Are you satisfied with the results? ☐ Yes ☐ No

What other associated problems have you been having?

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Patient Social History:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Tobacco Use: ■ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Drugs: ☐ Never Type/Frequency: _____

Excessive exposure at home or work to any of the following? ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne Irritants ☐ Noise

Have you ever had the following? (Mark "yes" or "no" - leave blank if you are uncertain.)

Measles ☐ Y ☐ N	Anemia ☐ Y ☐ N	Back Issues ☐ Y ☐ N	Hepatitis ☐ Y ☐ N
Mumps ☐ Y ☐ N	Bladder Infections ☐ Y ☐ N	High Blood Pressure ☐ Y ☐ N	Ulcer ☐ Y ☐ N
Chicken Pox ☐ Y ☐ N	Epilepsy ☐ Y ☐ N	Low Blood Pressure ☐ Y ☐ N	Kidney ☐ Y ☐ N
Whooping Cough ☐ Y ☐ N	Migraine Headaches ☐ Y ☐ N	Hemorrhoids ☐ Y ☐ N	Thyroid Disease ☐ Y ☐ N
Scarlet Fever ☐ Y ☐ N	Tuberculosis ☐ Y ☐ N	Bleeding Tendency ☐ Y ☐ N	Diphtheria ☐ Y ☐ N
Diabetes ☐ Y ☐ N	Asthma ☐ Y ☐ N	PTSD ☐ Y ☐ N	Small Pox ☐ Y ☐ N
Cancer ☐ Y ☐ N	Hives/Eczema ☐ Y ☐ N	Pneumonia ☐ Y ☐ N	Polio ☐ Y ☐ N
HIV/AIDS ☐ Y ☐ N	Rheumatic Fever ☐ Y ☐ N	**Any Other Diseases:**	
Glaucoma ☐ Y ☐ N	Infectious Mono ☐ Y ☐ N		
Arthritis ☐ Y ☐ N	Hernia ☐ Y ☐ N		
Bronchitis ☐ Y ☐ N	Venereal Disease ☐ Y ☐ N		
Blood/Plasma Infusion ☐ Y ☐ N	Mitral Valve Prolapses ☐ Y ☐ N		
Stroke ☐ Y ☐ N			
Last Date of Chest Xray:			

Hospitalizations, Surgeries, and Serious Illnesses:

Description	**Date**	**Hospital, City, State**

Current Medications and Supplements (include nonprescription)

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Family Medical History:

Relative	Age	Disease	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Review of Systems:

Indicate below if you have experienced any in the last 1-2 months; 1 = Never, 2 = Rare, 3 = Occasional, 4 = Frequent, 5 = Constant

Eyes, Ears, Nose, Throat, Respiratory		Muscular and Skeletal	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5
Sore Throat	1 2 3 4 5	Joint Pain	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5
Shortness of Breath	1 2 3 4 5	Pain between shoulder blades	1 2 3 4 5
Wheezing	1 2 3 4 5	**General**	
Neurological		Fatigue	1 2 3 4 5
Headaches	1 2 3 4 5	Malaise	1 2 3 4 5
Migraines	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Dizziness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Numbness	1 2 3 4 5	Irritability	1 2 3 4 5
Tingling	1 2 3 4 5	Constipation	1 2 3 4 5
Pins/Needles in Hands or Feet	1 2 3 4 5	Diarrhea	1 2 3 4 5
		Forgetfulness	1 2 3 4 5

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Acknowledgment:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____	_____	_____
Patient's Name	*Patient's Signature*	*Date*
_____	_____	_____
Provider's Name	*Provider's Signature*	*Date*

DALY INTEGRATED
MEDICAL GROUP

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ DOB _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?
   No pain — Worst pain possible

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?
   No interference — Unable to carry out activity

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?
   No interference — Unable to carry out activity

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?
   Not at all anxious — Extremely anxious

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?
   Not at all depressed — Extremely depressed

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?
   Have made it no worse — Have made it much worse

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?
   Completely control it — No control whatsoever

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. JMPT 1999; 22 (9): 503-510.

DALY INTEGRATED
MEDICAL GROUP

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ DOB _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?
   No pain — Worst pain possible

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?
   No interference — Unable to carry out activity

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?
   No interference — Unable to carry out activity

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?
   Not at all anxious — Extremely anxious

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?
   Not at all depressed — Extremely depressed

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?
   Have made it no worse — Have made it much worse

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?
   Completely control it — No control whatsoever

◯ 0	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. JMPT 2002; 25 (3): 141-148.