Martin Borge, D.C. **Patient Intake Form**

___1050 Northgate Drive Suite 350 San Rafael CA 415-526-3808 **___ 65 Third St Suite 15 Point Reyes Station CA 415-663-9333**

Today's Date________________________________

We welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

This is a Fee for Service office. *We expect payment at the time of service unless other arrangements have previously been made.*

Full Name:_____________________________________ ***Date of Birth***:__________________________

Mailing **Address:** ____

City: ____ ***State:*** ____ ***Zip:*** ______________________

Home Tel (___) ___ - ____ OK to leave a message? Y N
Work Tel (___) ___ - ____ OK to leave a message? Y N
Cell Tel (___) ___ - ____ OK to leave a message? Y N Appt Reminders? Y N

Employment: FT___ PT ___ Retired ____ Not Employed: ___ Occupation: ___________________
Please be specific in describing your work ____

Email Address: ___________________________ OK to contact by email? Y N Appt Reminders? Y N

Insurance: ________________________________ Please discuss with Dr.Borge. Complete separate form

Marital Status: Single Married Divorced Legally Separated Widowed Not Applicable

Emergency Contact Name: ___________________________Telephone _______________________
Relationship: ______________________

Briefly describe the reason for your visit ____
____

On a scale of zero to ten, with ten being the worst and zero being no pain, how would you rate your current pain? _1__2___3__4__5__6__7__8__9___10___ Circle one

Major Operations and/or Hospitalizations: (*Please list surgeries and/or hospitalization reasons and dates*)
____
____
____

Medical History & Conditions to advise the doctor of. Check all that apply.
Heart Disease ______High Blood Pressure______ Low Blood Pressure______ Lungs _____________
Kidney ___________Liver ____Gall Bladder ____Urinary Tract ____________ Circulatory__________
Digestion_________ Neurological ___________ Concussion_________

Others not listed: ____

Please also **complete page 2 and** the following ***Informed Consent*** Form

Current Medications: (*Please include any non-prescriptions as well such as aspirin, supplements etc.*)

Medication Name	Dose	Frequency of Use
1. ____________________	______________________	______________________
2. ____________________	______________________	______________________
3. ____________________	______________________	______________________

If you need more room, please list additional medications on back of page.

Allergies: (*Please list any allergies you may have to medications and food*)
____
____

Height: ____________________ **Weight:** ______________ *Scale is in office*

Demographics Details Required for Electronic Health Records:

Race:

Asian
American Indian or Alaska National
Black or African American
Native Hawaiian
Other Pacific Islander
White
Declined

Ethnicity:

Hispanic or Latino
Not Hispanic or Latino
Declined

Smoking Status:
Please circle one/more

Never Smoked
Current Everyday Smoker: Qualify: Heavy Smoker Light Smoker
Current Some Day Smoker
Former Smoker

Patient Signature ***Today's Date***

____

If Patient is under 18 years of age, Name and Signature of Parent or Guardian Today's Date

____

Please review and sign Informed Consent form attached.

Thank you *for taking the time to complete this information.*

Informed Consent for Chiropractic Treatment of your Pain*

*This consent form complies *with California Chiropractic Code of Regulations, Title 16, Division 4, Article 2, Section 319.1.*

The nature of Chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may occasionally feel a slight click of the joints during the adjustment procedure. Chiropractic treatment also includes activity advice, exercise, hot or cold packs or electric stimulation. Your Chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold and electrical stimulation.

Serious bodily harm is extremely rare and not an inherent risk of Chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, Chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves or spinal cord although these would be extremely unlikely with the non-force procedures used at this office. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or Chiropractic care. Your Chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your Chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture or previous severe injury.*

Other options for the treatment of pain include: *do nothing - live with it, over-the-counter medications, physical therapy, medical care, injections or surgery.* There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of Chiropractic treatment, and may use the space below for this purpose.

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____

My signature below confirms that I have read the paragraphs above and that I understand what my Chiropractor has told me about possible risks of Chiropractic treatment and that I have had an opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my Chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

____

Patient Name and Signature Today's Date

____If

Patient is under 18 years of age, Name and Signature of Parent or Guardian Today's Date

Martin Borge, D.C. **Form updated April 2013**

Practicing Non-Force Chiropractic in Point Reyes Station and San Rafael CA