ETHOS MEDICAL GROUP

PATIENT INTAKE FORMS

How did you learn about Ethos Medical?_____ Date:_____ /_____ /_____

First Name: _____ Last Name:_____

DOB:_____ /_____ /_____ Sex: ☐Male ☐Female Preferred Method of Contact: ☐Phone ☐Text ☐E-Mail

Address *(Street, Apt/Unit)*: _____APT#____ City: _____

State: _____ Zip Code: _____ Preferred Method of Contact: ☐Phone ☐Text ☐E-Mail

Cell Phone: _____ E-Mail: _____

Marital Status: ☐ Single ☐ Married # of Children: _____ Occupation:_____ How long?_____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Info: Cell Phone: _____ E-Mail: _____

What's the number one complaint you'd like help with?_____

When did the issue begin? _____

How would you describe the pain or discomfort? Dull, Numb, Sharp_____

Does it travel or stay in one place?_____

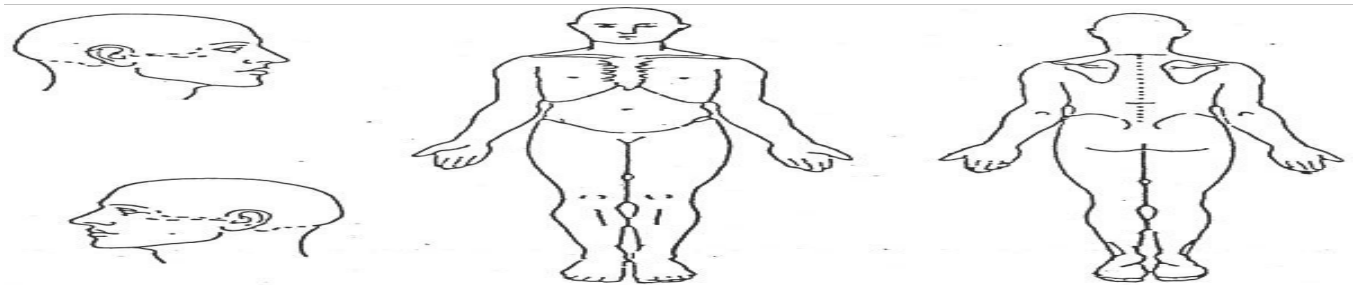
On a scale of 1-10, where is it now? _____ Is it constant or does it come and go? _____

Have you had any Imaging for these complaints? ☐U/S ☐X-Ray ☐CT ☐MRI Date(s): ____ /____ /_____

If Injury/Accident:☐Other ☐Motor Vehicle Accident ☐Work Injury If Yes, Date:____ / ____ / _____

Have you consulted another Provider or received care? ☐No ☐Yes If Yes, Date: ____ /____ /_____

Please mark (X) on the picture below where you have any discomfort, pain, or other symptoms:



Please mark any of the following that may suffer or are more difficult/less enjoyable because of your complaints:

☐ Quality Family Time ☐ Productivity/Focus/Work ☐ Sitting/Driving ☐ Focus/Mood ☐ Hobbies ☐ Standing

☐ Sleep Quality ☐ Housework ☐Self-Care/Bathing ☐ Travel/Vacation/Leisure ☐ Exercise/Sports ☐ Walking

Please mark below what you have tried in the past that has NOT fixed your complaints:

☐ Medications ☐ Acupuncture ☐ Homeopathy/Herbal ☐ Personal Training ☐ Exercise ☐ Heat/Ice

☐ Injections ☐ Physical Therapy ☐ Chiropractic ☐ Massage Therapy ☐ Surgery ☐ Supplements ☐ Other_____

What do you feel prevented those things from resolving the problem fully?_____

What would an ideal outcome look like for you?_____

What does your life look like if this gets resolved?_____

What other options are you seriously considering? ☐ Medications ☐ Injections ☐ Surgery ☐ Other_____

What concerns you most about those other options?_____

Type of care you would like the Doctor to discuss:

- □ Relief: Short term symptom relief only
- □ Correction: Addressing the root cause for lasting results
- □ Wellness/ Prevention: Maintain my overall level of health and prevention of future options
- □ All of these are important to me

Where do you believe your overall Quality of Life is *today* on a scale of 1-10 (10 is optimal): _____
Where do you *want your life and health* to be in the *future* (1-10): _____
How *committed* are you to do what it takes to regain your health? (1-10): _____
What are your expectations for your visit
today?_____

Self-Ratings: **0 - Inadequate 5 - Moderate 10 - Optimal**

Energy <--0---1---2---3---4---5---6---7---8---9---10--> Focus <--0---1---2---3---4---5---6---7---8---9---10-->
Sleep <--0---1---2---3---4---5---6---7---8---9---10--> Family <--0---1---2---3---4---5---6---7---8---9---10-->
Mood <--0---1---2---3---4---5---6---7---8---9---10--> Career <--0---1---2---3---4---5---6---7---8---9---10-->
Digestion <--0---1---2---3---4---5---6---7---8---9---10--> Friends <--0---1---2---3---4---5---6---7---8---9---10-->

What is your current Level of HEALTH today (1-10):_____
Where do you want your future Level of HEALTH(1-10):_____
How much time is required to reach that goal:_____
Your commitment to reaching that goal(1-10):_____

What's your timeline for taking action on this IF care is offered to you today:

- □ Just gathering information
- □ I need to discuss with my spouse, significant other:
- □ I am ready to start today

Prior Chiropractic Experience: Have you been to a chiropractor in the past? □ Yes □ No
Year?_____ Doctor/Clinic Name: _____Positive experience □ Yes □ No
How long were you under care?_____

Medications & Health History:

Any Broken/Dislocated Joints or Bones? □No □Yes *If Yes,* List the Areas and Dates below:
_____

Any Surgeries (including cosmetic)? □No □Yes If Yes, List the Procedures and Dates Below:
_____

List ALL Medications you take on a regular basis *(prescribed, OTC, supplements, herbs, etc)*:
_____
_____

FEMALE PATIENTS: *(Patient Initials*: _____) Are you pregnant? □No □Yes Date of Last Menstrual cycle: _____

PRIVACY AUTHORIZATION HIPAA AND PHI

Our goal is to make your experience with us exceptional. Your signature below verifies that you have been given the option to review and understand our notice of HIPAA/PHI patient privacy practices. You agree that we may contact you via email, phone,or mail regarding your care and to keep you up to date on events taking place within the office. We will not share your information. We use audio, video, and photos at functions, during training and in office for research studies, testimonials, and/or social media.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

I authorize Ethos Medical to discuss my medical condition with the following individuals: *(name, relationship, phone number)*

_____ _____

_____ _____

ASSIGNMENT OF INSURANCE BENEFITS

Your Insurance Company: We will verify your insurance before your exam, we will discuss anyinsurance coverage, along with any expected contributions towards our Medical Providers recommendations for the Testing and Exams required to get a diagnosis, and any prescribed treatment. As a courtesy, we will file directly to your insurance company foryour exam and any recommended treatment. All fees for today's exam, scans, and any x-rays will be due in full today. All fees will be discussed with you *prior to any services being performed* today.

The undersigned patient and or responsible party, in addition to continuing personal responsibility and consideration of treatments rendered, assigns to Ethos Medical the following rights:

RELEASE OF INFORMATION

You are authorized to release information concerning my condition and treatment to my insurance company, or insurance adjuster,for purposes of processing/appealing my claim for benefits and payment of services.

ALL PAYMENTS FOR SERVICES WILL BE MADE PAYBALE TO: ETHO REGENERATIVE MEDICAL GROUP, PLLC.

I hereby grant Ethos Regenerative Medical Group, PLLC the power to endorse my name upon any checks, drafts, or other negotiableinstrument representing payment from any insurance group, company representing payment for treatment, consultations and all health care rendered.

Printed Name *Signature of the Patient, Parent or Guardian* *Date*