

Hawaii Physical Therapy & Chiropractic Clinic, Inc.

261 Waiuanue Avenue ♦ Hilo, Hawai'i 96720

Telephone: (808)961-5663 ♦ Fax: (808)969-3767 ♦ Website: www.hiptchiro.com

ELECTRONIC HEALTH RECORDS INTAKE FORM

In compliance with requirements for the government EHR incentive program

Name:		Birth Date:		SSN:	
Primary or Cellular No.:		Home No.:		Work No.:	
Mailing Address:			City:		State:
Email:	Marital Status: M, S, D, W		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Student: <input type="checkbox"/> FT <input type="checkbox"/> PT
Occupation:			Employer:		
Emergency Contact:			Relationship:		Phone:
Preferred method of communication for patient reminders (Check One): <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> No Reminders Preferred					

Insurance Carrier:

Present ALL Insurance Cards to Front Office Reception!

Smoking Status: Every Day Smoker Occasional Smoker Former Smoker Never Smoked Smoking Start Date (optional):

CMS Requires Providers to Report Both Race and Ethnicity:

Patient's Race: (Check One): American Indian or Alaskan Native Asian Black or African American
 Native Hawaiian or Pacific Islander White (Caucasian) I Decline to Answer
 Ethnicity (Check One): Hispanic or Latino Not Hispanic or Latino I Decline to Answer
 Preferred Language: English Other: _____

Medication Name:

Dosage and Frequency (i.e. 5mg. once a day, etc.)

Medication Name:	Dosage and Frequency (i.e. 5mg. once a day, etc.)

Do you have any medication allergies? Yes No

Medication Name	Reaction	Onset Date	Additional Comments:

Do you have any environmental allergies? Yes No If yes, please list:

AGREEMENT:	I understand that I am financially responsible for all charges whether or not paid by said insurance, including deductible, co-payment, and/or non-covered services. I understand that payment is due at the time of service.
AUTHORIZATION:	I authorize the release of any medical information necessary to process my claims, I further authorize payment of insurance benefits directly to Hawaii Physical Therapy & Chiropractic Clinic, Inc. for all services rendered.

I choose to decline receipt of my clinical summary after every visit (these summaries are often blank as a result of the nature and frequency of chiropractic care).

Signature: _____ Date: _____
 (Patient or Responsible Person, Parent/Guardian)

OFFICE USE ONLY

Height:	Weight:	Blood Pressure:	Pulse:
Date Scanned into EHR:	Scanned By:	Acct No.:	

HEALTH HISTORY FORM

Name: _____	Date: _____
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Current Problem: Please describe the problem(s) that brings you into our clinic today:

Neck pain Headache Mid back pain Low back pain Other:
 Marked Morning Pain or Stiffness Pain at night Pain wakes you up at night Abnormal Weight: Gain Loss

Date Problem Began: _____	Is This? <input type="checkbox"/> Work-related <input type="checkbox"/> Auto-related
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How Problem Began: _____

How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%

Circle two numbers below to indicate your pain at its best and at its worst:

Current complaint (how you feel today):

0	1	2	3	4	5	6	7	8	9	10
(No Pain)										(Unbearable Pain)

What treatment have you already received for this problem/condition? Acupuncture Chiropractic Massage Naturopathy Osteopathy

Physical Therapy Psychology Vocational Rehab Counselor Other Specialist : (Please list, e.g. Neurologist, Orthopedist): _____

Name of your current Primary Medical Physician: _____

Name of other doctor(s) who have treated you for your condition: _____

Place a check mark in the appropriate "Yes" or "No" box to indicate if you have EVER been diagnosed or received treatment with following:

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No Ankylosing Spondylitis <input type="checkbox"/> Yes <input type="checkbox"/> No Aortic Aneurysm <input type="checkbox"/> Yes <input type="checkbox"/> No Arterial Blockage <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please ✓ below) <input type="checkbox"/> Bone <input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Lung <input type="checkbox"/> Lymphoma <input type="checkbox"/> Ovarian <input type="checkbox"/> Prostate <input type="checkbox"/> Skin <input type="checkbox"/> Uterine <input type="checkbox"/> Other: _____ Deep Venous Thrombosis <input type="checkbox"/> Yes <input type="checkbox"/> No (Blood Clots in Legs) Degenerative Osteoarthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Depression <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness/Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No Gout <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Valve Condition <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No Hyper or Hypo Thyroid <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Polio <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No (No. of births _____) Prostate Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Tumors/Growths <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No Urinary Incontinence <input type="checkbox"/> Yes <input type="checkbox"/> No Visual Disturbances <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____
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Are you pregnant? Yes No Due Date: _____

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems Stroke

EXERCISE:	WORK ACTIVITY:	HABITS:
<input type="checkbox"/> None <input type="checkbox"/> Daily <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	<input type="checkbox"/> Sitting <input type="checkbox"/> Light Labor <input type="checkbox"/> Standing <input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level Drinks/Week _____ Cups/Day _____ Reason _____

Have you had any surgeries? (Please List):	Within the last 12 months	More than 12 months ago
_____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> Yes, date: _____

Injuries you have had:	Description: Injuries	Date(s):
Motor Vehicle Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No Work-related Injuries: <input type="checkbox"/> Yes <input type="checkbox"/> No Sports Injuries: <input type="checkbox"/> Yes <input type="checkbox"/> No Other : _____	_____ _____ _____	_____ _____ _____

HAWAII PHYSICAL THERAPY & CHIROPRACTIC CLINIC, INC.

Harvelee H. Leite-Ah Yo, D.C., R.P.T. & Kanani J. Leite-Ah Yo, P.T., D.P.T.

261 Waiuanuenue Avenue, Hilo, Hawai'i 96720 ♦ (808)961-5663 ♦ Fax (808)969-3767

WELCOME LETTER

Dear Valued Patient:

Welcome to Hawaii Physical Therapy & Chiropractic Clinic, Inc. We are pleased and delighted to have you as a new patient and we look forward to providing you with the highest quality care. Your physician has referred you to our clinic to assist in your healing and recovery. In order for us to most effectively assist you on the road to recovery, we kindly request that you observe the following guidelines and policies:

ATTENDANCE:

To assist you in your care, consistent and timely attendance is extremely important. If you must cancel, please call immediately prior to your appointment. **To avoid a \$25.00** cancellation/no show fee, please call 24 hours in advance. In fairness to other patients, we would like to have the opportunity to fill these time slots. Please be aware that our answering machine is always on when our office is closed and the date and time of your call is automatically recorded. Be sure to reschedule a cancelled appointment within the same week. If you are more than 15 minutes late for your appointment, it may be necessary to be rescheduled.

CHILDREN IN THE GYM AREA:

For your child's safety, children who are not being seen as patients, will not be allowed in the gym area. We do realize that occasional situations may arise in which you must bring your children, but it should not be a common occurrence.

DRESS:

It is important that you dress appropriately for your treatment sessions. We recommend shorts/sweats/yoga pants, t-shirt and athletic shoes. For treatment of shoulder, upper and mid back symptoms, tank tops and spaghetti strap tops are appropriate.

PERSONAL HYGIENE:

We are a manually-based clinic and your treatment may consist of soft tissue mobilization, joint mobilization and massage. We would greatly appreciate clean personal hygiene (i.e. clean feet, use of deodorant or organic alternatives).

FEES AND INSURANCE BILLING:

As a courtesy to you, we bill your insurance company for the services you receive. However, any co-payment and or deductibles are due at the time of service. We will also verify your benefits for our services, however, please remember that eligibility is advisory only and **does not**, guarantee benefits. We do not accept third party billing.

CELL PHONES:

Except in emergency situations, please keep cell phones off or on vibrate mode as your therapist will require your full attention.

Our staff is committed to providing you with the best care possible and we hope that you will be satisfied with our services. We appreciate your honest feedback regarding your experience with us. We will do everything possible to speed your recovery and facilitate a positive experience. We thank you for the opportunity to serve you.

Sincerely,

Dr. Harvelee Leite-Ah Yo & Staff

Patient's Signature

Date Signed

INFORMED CONSENT DOCUMENT

Patient Name: _____ Date: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign, if anything is unclear.

THE NATURE OF CHIROPRACTIC ADJUSTMENT: The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. The Doctor will use that procedure to treat you. The Doctor may use her hands or a mechanical instrument upon your body in such a way as to move your joint. That may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

THE NATURE OF PHYSICAL THERAPY: Physical therapy is a dynamic and conservative treatment practice that incorporates exercise, manual mobilizations, modalities and many other health, wellness & fitness principles in the restoration, maintenance and promotion of optimal physical function.

Analysis ♦ Examination ♦ Treatment: As part of the analysis, examination and treatment, you are consenting to the following procedures: **(Please initial each procedure you are consenting to).**

_____	Spinal Manipulative Therapy	_____	Mobilization (soft tissue/joint)
_____	Vital Signs	_____	Range of Motion Testing
_____	Orthopedic Testing	_____	Basic Neurological Testing
_____	Muscle Strength Testing	_____	Postural Analysis
_____	Therapeutic Exercises	_____	Manual/Mechanical Traction
_____	Ultrasound	_____	Laser Therapy
_____	Electrical Stimulation	_____	Hot/Cold Therapy
_____	Palpation	_____	Facilitative Taping
_____	Other: (Please explain): _____		

In this office, if your Doctor or physical therapist is unavailable, another clinic doctor or physical therapist may be assigned to treat you on that day.

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor’s attention, it is your responsibility to inform the Doctor.

THE PROBABILITY OF THOSE RISKS OCCURRING: Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare. These problems occur so rarely that there are no available statistics to quantify their probability.

THE MATERIAL RISKS INHERENT IN PHYSICAL THERAPY: Physical therapy involves the use of many different types of physical evaluations and treatments. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent associated physical risks. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your physical therapist will be glad to answer them. The physical therapist may use a variety of procedures and modalities to help obtain optimal function. I, the patient, acknowledge that participation in physical exercise involving flexibility, strength, balance, agility, and aerobic exercise, including the use of equipment and devices, may be a potentially hazardous activity. If you have a condition that would otherwise not come to the physical therapist’s attention, it is your responsibility to inform the physical therapist.

TREATMENT BURNS: Some of the machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone’s skin has a different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

SORENESS: It is common for chiropractic adjustments, soft tissue/joint mobilization, manual/mechanical traction, massage therapy, therapeutic exercise, treatment modalities and procedures, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your Doctor or physical therapist about it.

OTHER PROBLEMS: There may be other problems or complications that might arise from chiropractic and/or physical therapy treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic and/or physical therapy is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure of any symptoms, disease or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

THE AVAILABILITY OF NATURE OF OTHER TREATMENT OPTIONS: Other treatment options for your condition may include:

- ◆ Self-administered, over-the-counter analgesics and rest
- ◆ Medical care and prescription drugs, such as, anti-inflammatory, muscle relaxants and pain-medication
- ◆ Hospitalization
- ◆ Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED: Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective, the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.**

I have read, or have had read to me, the above explanation of:

chiropractic adjustment and related treatment;

physical therapy and related treatment.

I have discussed it with: Dr. Harvelee Leite-Ah Yo, D.C., R.P.T., or Kanani Leite-Ah Yo, P.T., D.P.T. and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Print Patient’s Name:	
Today’s Date:	
Patient’s Signature: Parent or Guardian Signature: (if a minor)	