Sheehan Chiropractic
We help you get your head on straight

(https://www.laurasheehan.com)

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Profile Information — Step 1 of 3

You are completing the intake form: **Intake form (January 2021)** for **

Please take a moment to fill out our online intake form before your visit. All information is kept completely confidential.

Only staff members can edit this information on an intake form.

First Name – *Required*

First Name

Last Name – *Required*

Last Name

Preferred Name (if different)

Pronouns

They/Them/Theirs

Prefix / Title

Mobile Phone – *Required*

🇺🇸

Please provide at least one phone number. Your mobile number can be used to look up your Account and receive text message appointment reminders.

Home Phone

🇺🇸

Country – *Required*

United States

Street Address – *Required*

Suite Number (i.e. Suite #100)

City – *Required*

State – *Required*

Postal / Zip – *Required*

Date of Birth – *Required*

Gender

Refers to current gender which may be different than what is indicated on your insurance policies or medical record.

Sex

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record.

Personal Health Number

Occupation

Employer

Guardian

Emergency Contact

Emergency Contact Phone

Emergency Contact Relationship

Family Doctor

Family Doctor Phone (if known)

Family Doctor Email (if known)

Name of referring professional

Referring professional phone (if known)

Referring professional email (if known)

How did you hear about us?

How did you hear about us?

Please check that all required questions have been answered.

Continue

Questionnaires — Step 2 of 3

You are completing the following intake forms: Intake form (January 2021)

Intake form (January 2021)

Medical Information Release Form (HIPAA Release Form)

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to: – *Required*

- [ ] Spouse
- [ ] Child(ren)
- [ ] Parent/Guardian
- [ ] Other
- [ ] Information is not to be released to anyone

Please call or text – *Required*

- [ ] My mobile number
- [ ] My home
- [ ] My work

If unable to reach me: – *Required*

- [ ] You may leave a detailed message
- [ ] Please leave a message asking me to return your call
- [ ] Please do not leave a message
- [ ] I prefer text over personal phone call

Patient Information

Spouse's Name:

Number of Children:

Current Health Conditions

Reason for visit: *– Required*

When did it start?

Have you received care for this problem? If yes, please explain:

How did the condition(s) first begin?

What makes the problem better?

What makes it worse?

Is the condition:

- [ ] Getting Worse
- [ ] Improving
- [ ] No Change

Is the condition:

- [ ] Intermittent (on and off)
- [ ] Constant
- [ ] Unsure

Does anyone else in your family have this condition?

Describe the pain:

- [ ] Aching
- [ ] Dull
- [ ] Deep
- [ ] Sharp
- [ ] Burning
- [ ] Throbbing
- [ ] Numb
- [ ] Tingling
- [ ] Other

Rate your pain level

0 1 2 3 4 5 6 7 8 9 10

On the scale below, please indicate your pain or discomfort you have RIGHT NOW.

0 NO PAIN 1 2 3 4 5 6 7 8 9 10 UNBEARABL PAIN

On the scale below, please indicate your pain at its BEST in the past week.

0 NO PAIN 1 2 3 4 5 6 7 8 9 10 UNBEARABL PAIN

On the scale below, please indicate your AVERAGE pain in the past week.

0 NO PAIN 1 2 3 4 5 6 7 8 9 10 UNBEARABL PAIN

On the scale below, please indicate your WORST pain in the past week.

0 NO PAIN 1 2 3 4 5 6 7 8 9 10 UNBEARABL PAIN

For Women Only:

Are you pregnant?:
Due Date:
Are you currently nursing?

Please check the type of care desired so that we may be guided by your wishes whenever possible. – *Required*

- [ ] Relief Care
- [ ] Corrective Care
- [ ] Maintenance Care
- [ ] Check here if you want the Doctor to select the type of care appropriate for your condition

Your Health Goals

Describe your health goals:

Chiropractic History

Have you ever visited a chiropractor before?

☐ Yes ☐ No

For what reason did you visit a chiropractor and did it help?

Health History

Indicate if YOU or any IMMEDIATE FAMILY members have any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke

☐ Cancer

If you selected yes to any of the previous, please specify who has/had the condition:

For each of the conditions listed below, please check the box if you have had the condition in the past or currently:

☐ Headaches

☐ Neck pain

☐ Upper back pain

☐ Midback pain

☐ Low back pain

☐ Shoulder pain

☐ Arm pain

☐ Wrist pain

☐ Hand pain

☐ Upper leg pain

☐ Hip pain

☐ Knee pain

☐ Ankle/Foot pain

☐ Jaw pain

- [ ] Joint swelling
- [ ] Arthritis
- [ ] Rheumatoid arthritis
- [ ] General fatigue
- [ ] Vision problems
- [ ] Ringing in the Ears
- [ ] Memory problems
- [ ] Broken bones
- [ ] Pacemaker
- [ ] Dizziness
- [ ] High Blood Pressure
- [ ] Heart Attack/disease
- [ ] Chest pain
- [ ] Stroke
- [ ] Angina
- [ ] Kidney Stones
- [ ] Kidney disorders
- [ ] Loss of Bladder Control
- [ ] Painful Urination
- [ ] Bladder infection
- [ ] Prostate Problems (Men only)
- [ ] Abnormal weight change
- [ ] Loss of appetite
- [ ] Abdominal pain
- [ ] Ulcer
- [ ] Hepatitis
- [ ] Tumor
- [ ] Gall Bladder problems
- [ ] Sensitivity to light
- [ ] Cold hands/feet
- [ ] Liver disease
- [ ] Thyroid problems
- [ ] Asthma

- [ ] Sinus problems
- [ ] Diabetes
- [ ] Excessive thirst
- [ ] Frequent urination
- [ ] Tobacco Use
- [ ] Drug/Alcohol dependence
- [ ] Allergies
- [ ] Depression/Anxiety
- [ ] Lupus (SLE)
- [ ] Epilepsy
- [ ] Dermatitis/Eczema/Rash
- [ ] Concussion
- [ ] Hormonal replacement
- [ ] Birth Control Pills
- [ ] Pregnancy
- [ ] Cancer
- [ ] Muscular incoordination
- [ ] Loss of balance
- [ ] Loss of concentration
- [ ] Anemia
- [ ] Osteoporosis
- [ ] Other

Traumas: Physical Injury History

Have you every had any significant falls, surgeries, accidents or injuries as an adult?

- [ ] Yes
- [ ] No

If yes, please explain:

Have you ever been hospitalized?

- [ ] Yes
- [ ] No

If yes, why?

Notable childhood injuries?

Youth or college sports?

Describe any car accidents you've been in:

Exercise Frequency:

☐ 1-2x/week ☐ 3-5x/week ☐ Daily ☐ Never

What types of exercise do you perform?

How do you normally sleep?

☐ Back ☐ Side ☐ Stomach

Do you wake up:

☐ Refreshed ☐ Stiff & Tired

Do you commute to work?

☐ Yes ☐ No

How many minutes per day do you commute to work?

How many hours per day do you typically spend sitting?

Toxins: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each: (1=never, 5=high)

Alcohol

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Water

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Sugar

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Dairy

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Gluten

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Caffeine

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Processed Foods

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Artificial Sweeteners

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Sugary Drinks

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Cigarettes/Tobacco

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Recreational Drugs

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Fast Food

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Allergies:

Current Stress Levels

Select an option...

Medication List

Sports and hobbies, current and past, reasons for quitting

Diet, habits, exclusions and supplements

Surgeries/outcomes

Back Continue

Consents — Step 3 of 3

You are completing the following intake forms: Intake form (January 2021)

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- [x] I would like email notifications of new, cancelled, and rescheduled appointments

News and Special Promotions

- [ ] Yes, I would like to receive news and special promotions by email

Intake form (January 2021) — Consents

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in Dr. Sheehan's day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee of the full amount of the appointment. We will waive the first time offense and are understanding if it is a legitimate reason. Please do your best to be at all appointments on time.

- [ ] I am aware of the Cancellation Policy. – *Required*

Informed Consent for Chiropractic Treatment of your Pain

The nature of Chiropractic treatment: The doctor will use her 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 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, 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 injuries, 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 risk. You are encouraged to ask questions regarding possible risks of Chiropractic treatment.

- [ ] My signature below confirms that I have read the paragraphs above and that I understand what my Chiropractor has told me aboutr 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. *– Required*

HIPAA: Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. Sheehan Chiropractic Services is required to maintain the privacy and confidentiality of your protected health information, and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your health information: Treatment: We may disclose your health information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. For example: "On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Sheehan Chiropractic Services." "It is our policy to provide a substitute health care provider, authorized by Sheehan Chiropractic to provide assessment and/or treatment to our patients, with advanced notice, when possible, in the event of your primary health care provider's absence due to vacation , sickness, or other emergency situation."

Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.

Workers Compensation: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies: As required by law, we may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health: We may disclose your health information to public health authorities for purposes relating to : preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting elder abuse, domestic violence, or to the FDA regarding food or drug reactions and reporting disease or infection exposure.

Judicial and Administrative proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons: We may disclose your health information to coroners or medical examiners.

Organ Donation: We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and/or tissues.

Research: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Governmental Agencies: We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership: In the event that Sheehan Chiropractic is sold or merged with another organization, your health information or record, will become the property of the new owner.

Your Health Information Rights: You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised that Sheehan Chiropractic is not required to agree to the restriction requested. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery upon your request. You have the right to inspect and copy your health information. You have the right to request that Sheehan Chiropractic amend your protected health information. Please be advised that Sheehan Chiropractic is not required to agree to amend your protected health information. If a request to amend your health information has been denied, you will be provided with an explanation of your denial reasons and information about how you can disagree with the denial. You have a right to receive an accounting of disclosures of your protected health information made by Sheehan Chiropractic. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices: Sheehan Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of it's legal duties and privacy practices. Sheehan Chiropractic has the right to amend this Notice of Privacy Practice but until such amendments take place, Sheehan Chiropractic is required by law to comply with this notice. If you have any questions about any part of this notice please call 415-618-1031 and speak to Dr. Laura Sheehan or make an appointment within 2 working days to have a personal conference. Complaints about your privacy rights or how Sheehan Chiropractic handled your health information can be directed to Laura Sheehan at 415-681-1031.

☐ I have read this Privacy Notice and sign this in acknowledgement. – *Required*

Philosophical Agreement

Wellness exists when all systems, organs, tissues and cells of the body functions at 100% under the direction of the Innate Intelligence.

The Nervous System is the medium used to control and coordinate all body functions. Normal free transmission of neurological impulses between the brain and body is necessary for normal life expression, which is wellness.

Subluxations of the spine caused by: abnormal motion of a vertebra, abnormal nerve function, muscular imbalances (spasm, tightness, etc), improper cell function, pathological process (bone, ligament, disc, life force energy flow) can lead to a start of disease and ill-health, which in time may lead to abnormal life expression, symptoms, sickness and loss of potential wellness.

Chiropractic adjustments remove interference to the nervous system caused by the subluxations of the spine. This leads to improved neurology and life expression. Each individual can then function and express life better, have a greater resistance to illness and disease and gain the potential to heal and recover.

Chiropractic is not a form of medicine. Medicine specializes in the treatment of diseases. Chiropractic specializes in the restoration and expression of life as we remove subluxations that directly interfere with proper function.

I do not diagnose, prognose, treat or cure disease. I do not attack or suppress symptoms. If, during care, you become concerned about your symptoms or your condition, I suggest that you seek the help of a symptom, sickness and disease care professional. My goal is to free the interference caused by subluxations and release the innate power of the body.

☐ I, the undersigned, have fully read and understand the above statement and agree to receive chiropractic care with this understanding. – *Required*

Payment is Responsibility of Patient

INSURANCE: All services are rendered and charged to the patient receiving care and not to an insurance provider. Regardless of the insurance carrier, you are responsible for payment at the time services are rendered. You will be supplied with statements, reports or any other documents that you need to receive reimbursement from a third party. Please be advised that some services we provide are not reimbursable by insurance companies (e.g. Heart Rate Variability HRV assessment). Please note that all services, supplements and supplies are 100% non refundable.

COPAY, DEDUCTIBLES & CO-INSURANCE: All patients are responsible for their co-payments, deductibles and past due balances at the time of service.

MISSED APPOINTMENTS: Many people benefit from care and therefore, appointment times are valued. With the exception of unexpected emergencies, we require that you notify us at least 24 hours in advance to avoid any appointment charges. Failure to do so will result in a full session being charged for the appointment time that you reserved. This charge is the responsibility of you, the patient, and will not be reimbursed by an insurance policy.

RETURNED CHECKS: There will be a $25 service fee for any check returned for insufficient funds.

PLEASE NOTE THAT ANY BENEFIT INFORMATION FURNISHED IS NOT A GUARANTEE OF PAYMENT NOR A DETERMINATION OF MEDICAL NECESSITY AND FINAL CLAIM DETERMINATION WILL BE MADE UPON RECEIPT AND REVIEW OF THE CLAIM. THE PATIENT IS RESPONSIBLE FOR ALL BALANCES OUTSTANDING.

☐ I understand that I am ultimately responsible for payment of services provided. – *Required*

Signature

◉ **Draw** ○ **Type**

Please check that all required questions have been answered.

Submit Intake Form

(https://jane.app)