UPDATE: CHIROPRACTIC

PATIENT FULL NAME: ____

DOB: ______________ TODAY'S DATE: __________ GENDER: M F X

Address____

City______________________________ State __________ Zip ______________

Phone: ________________________ ☐ Cell ☐ Home ☐ Work **Email:** ______________________________

Message OK? ☐ Y ☐ N ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Retired

Employer: ________________________ **Occupation**: __________________________ **Phone:** _________________

Emergency Contact: ____________________________ **Relationship:** _______________ **Phone:** _________________

INSURANCE INFORMATION ☐ **No Change**

Primary Insurance Company: _________________________ **Policy Holder:** ☐ Self ☐ Spouse ☐ Parent

ID#: ____________________________________ **Group#:** ______________________________

Policy Holder DOB: __________________ **Policy Holder Employer:** __________________________

Current Complaint: Please answer the following questions.

Is this visit due to a motor vehicle accident? ☐ Y ☐ N **Is this visit due to an on-the-job injury?** ☐ Y ☐ N

Please describe your current problem & how it began: ____

____

Date problem began: __________________ **Have you seen anyone for your current problem?** ☐ **No** ☐ **Yes**

Is the pain? ☐ Better ☐ Worse ☐ Same as the Onset

Have you had any recent x-rays/images taken? ☐ Y ☐ N **When?** ____________ **Where?** __________________

What have you tried at home to help alleviate your symptoms? ____

What makes your symptoms better? ____

What makes your symptoms worse? ____

Are your symptoms worse during certain times of the day? ☐ Y ☐ N **If yes, when?**_____________________________

Do your symptoms interfere/affect your sleep? ☐ Y ☐ N **Do your symptoms wake you up at night?** ☐ Y ☐ N

Have you ever had this condition in the past? ☐ Y ☐ N **If yes, please explain:** __________________________

____

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Health History: Please answer the following questions.

In general, would you say your overall health right now is: ☐ **Excellent** ☐ **Very Good** ☐ **Good** ☐ **Fair** ☐ **Poor**

Please list any new medical problems: ____
____

Please list any surgeries/hospitalizations since last visit: ____

How do you sleep? ☐ Back ☐ Stomach ☐ Side **Other:** ____

Do you sleep with a comfortable pillow? ☐ Y ☐ N **Do you sleep in a comfortable bed?** ☐ Y ☐ N

Do you wear: ☐ Heel lifts ☐ Sole lifts ☐ Orthotics Arch supports ☐ Negative Heels ☐ Platform Shoes ☐ Braces

Please list all prescription medications & supplements you are taking: __________________________________
____

☑ Any of the following you are currently experiencing or have experienced in the last month:

- ☐ Alcohol/Drug Dependence
- ☐ Recent fever
- ☐ Fainting / Dizziness
- ☐ Headaches / Migraines
- ☐ Numbness in groin or buttocks
- ☐ Pain Unrelieved by Position/Rest
- ☐ Pain in Morning
- ☐ Pain during the day
- ☐ Pain at Night
- ☐ Marked morning pain/stiffness
- ☐ Urinary Problem
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Abnormal Weight Gain Loss
- ☐ Vision Disturbances
- ☐ Pregnant? Weeks: ________
- ☐ Tobacco Use
- ☐ Alcohol
- ☐ Drug Dependence
- ☐ Heart Disease
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Depression / Anxiety
- ☐ Taking Birth Control
- ☐ Corticosteroid Use
- ☐ Artificial Joints
- ☐ Pacemaker

☑ If you have EVER experienced:

- ☐ Seizures
- ☐ Cancer/Tumor
  List: ________________________
- ☐ Broken Bones
- ☐ Concussion: How many? _____
  When: ______________________

☑ FAMILY HISTORY

- ☐ Heart Problems / Stroke
- ☐ Cancer
- ☐ Thyroid Disorder
- ☐ Rheumatoid Arthritis
- ☐ High Blood Pressure

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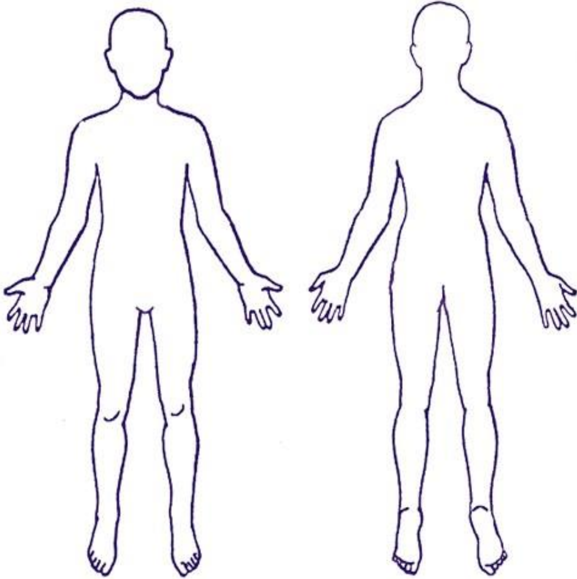
PATIENT NAME: ____________________________________ DOB: ____________ DATE: ____________



Tell us where you hurt:

Mark the areas on your body where you feel pain on the diagram to the right.

*If your pain radiates, draw an arrow from where it starts to where it stops.

Use the symbols listed below

>>>>	Ache
XXXX	Burning
====	Numbness
////	Stabbing
0000	Pins/Needles
~~	Throbbing

How often are your symptoms present? (Please check the appropriate box)

☐ 0 – 25% ◆ ☐ 26 – 50% ◆ ☐ 51 – 75% ◆ ☐ 76 – 100%

In the past week, how much has your pain interfered with your daily activities?

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

No Interference — Unable To Carry Out Activities

SYMPTOM RATING SCALE

Please circle the number(s) in each box that best describes your symptoms.

0= No Symptoms
10 = Unbearable

What is your symptom intensity **RIGHT NOW**?

0 1 2 3 4 5 6 7 8 9 10

What is your symptom intensity **AT ITS WORST**?

0 1 2 3 4 5 6 7 8 9 10

What is your **TYPICAL** symptom intensity?

0 1 2 3 4 5 6 7 8 9 10

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CHIROPRACTIC INFORMED CONSENT

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use this procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click". You may feel a sense of movement.

ANALYSIS ▪ EXAMINATION ▪ TREATMENT

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Basic Neurological Testing
- Electrical Stim
- Hot/Cold Therapy
- Mechanical Traction
- Orthopedic Testing
- Palpation
- Postural Analysis
- Range of Motion Testing
- Spinal Manipulative Therapy
- Ultrasound
- Vital Signs

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT

Chiropractic adjustments and therapeutic procedures are considered safe and effective methods of care. However, any procedure may have complications. The most common side effects include soreness, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. While rare 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. I will make every reasonable effort to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS

If you chose to use one of the "other treatment" options, you should be aware that there are risks and benefits you may wish to discuss these with your primary medical physician. 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-killers
- Hospitalization
- Surgery

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 may complicate treatment making it more difficult and less effective.

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 the chiropractic adjustment and related treatment. I have discussed it with **Mary Coleman, DC** 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.

Signature: ____ Date: ______________________

RELATIONSHIP TO PATIENT: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Legal Representative

Office Staff Signature: ______________________________ Date: _____________

PATIENT NAME: ___________________________________

DOB: _____________ **DATE:** ____________

CLINIC ACCOUNT POLICY

- Payment is expected as the time of service for services rendered at NW Family Wellness.
- We will bill your insurance company when possible. We request that you pay your Co-Pay, Coinsurance, Deductible or non-covered service fee(s) at the time of service.
- If your insurance policy requires a referral for chiropractic care, you are responsible for obtaining this referral prior to your visits. Any care that is not covered by the referral is your financial responsibility.
- We make every effort to get accurate information from your insurance company to estimate costs. Additional charges may be incurred after the claim is processed by your insurance company.
- Information received from your insurance company **IS NOT A GUARANTEE OF BENEFITS**. You are responsible for all charges incurred in this office.
- If you have had a personal injury (automobile accident), we will bill your personal injury protection carrier (your auto insurance). The insurance company may not cover 100% of the billings and you are responsible for any difference. We will keep you updated on the payment activity on your account and ask that you keep us updated on any new information you may receive regarding your account.
- Personal injury accounts (automobile accidents) require the injured party to complete paperwork with their insurance company in order for us to bill for services rendered. If you choose not to fill out this paperwork, you will be required to pay at time of service for your care, you are then solely responsible for any reimbursements through your insurance company.
- Patients paying at the time of service will receive our discounted Time of Service pricing. If you choose to pay at Time of Service, **WE DO NOT BILL FOR THESE SERVICES**. If, at a later date, you ask that we bill your insurance, the discount will be reversed prior to the submission of any billing.
- Our fee schedule is available by request.
- We require 24-hour notice if you need to cancel your appointment. Effective August 1, 2017, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a "No Show".
- When two or more "No-Shows" occur a $50 fee will be charged, fee due before rescheduling.

I have read and understand the above account policy.

Signature: ____ Date: ______________________

RELATIONSHIP TO PATIENT: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Legal Representative

________________________________ ______________

Office Staff Signature Date

NW FAMILY WELLNESS CENTER NEW PATIENT REGISTRATION

PATIENT NAME: ___________________________________ **DOB:** _____________

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I, ____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan ad direct my treatment and follow-up among the health care providers who may be directly or indirectly involved in providing my treatment.
- Obtain payment from 3rd party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

____
Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the Acknowledgement
- ☐ An emergency situation prevented us from obtaining Acknowledgement
- ☐ Other (Please Specify) ____

____ ______________________
Staff Signature Date