Chiropractic Sports & Wellness PC New Patient Questionnaire

Patient Information (Please Print) *Please provide a photo id & a copy of your insurance card to the front desk*

Name_____ Date _____ Birth Date _____/_____/_____

Address_____ City_____ State_____ Zip_____

SS#_____ Ethnicity (please check one) ☐Hispanic **or** ☐Non-Hispanic Sex _____

Race_____ Preferred Language _____ Height _____ Weight _____

Home Phone(_____)_____ Cell(_____)_____ Cell Provider_ _____

Work Phone(_____)_____ E-mail Address_____

Employer _____ Occupation _____ #years _____

Spouse or Parent's Name_____ Birth Date_____ Phone #_____

Emergency Contact_____ Phone #_____ Relation_____

Whom may we thank for referring you to us? _____ **OR**

How did you find us: Internet?_____ Yellow Page Ad?_____ Other? _____

Name of local primary Physician: _____ May we contact them?_____

Insurance Information

Primary

Insured's Name_____Insured's DOB_____/_____/_____

Patient's Relation to Insured: ☐ Self ☐Spouse ☐Child

Secondary

Insured's Name_____Insured's DOB_____/_____/_____

Patient's Relation to Insured: ☐ Self ☐Spouse ☐Child

Auto Injury / Work Injury / Personal Injury

Insurance type: ☐ Auto ☐Work ☐Lien

Insurance Company:_____ Policy #_____ Claim#_____

Date of Accident: _____/_____/_____ State of Accident: _____

I, the undersigned, have insurance coverage and assign directly to Chiropractic Sports & Wellness PC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Patient Signature_____ Date_____/_____/_____

Confidential Patient Questionnaire

Symptoms

Main Complaint_____ How Bad? _____ How Often?_____

When did it start? _____Getting Worse? _____ Getting Better? _____

What activity bothers it the most? _____

When is it at its best?_____ When is it at its worst?_____

Rate the pain - (0 is pain free - 10 is unbearable pain) 0 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?_____ Positive Experience?_____

Other type of physician or therapist?_____ Positive Experience? _____

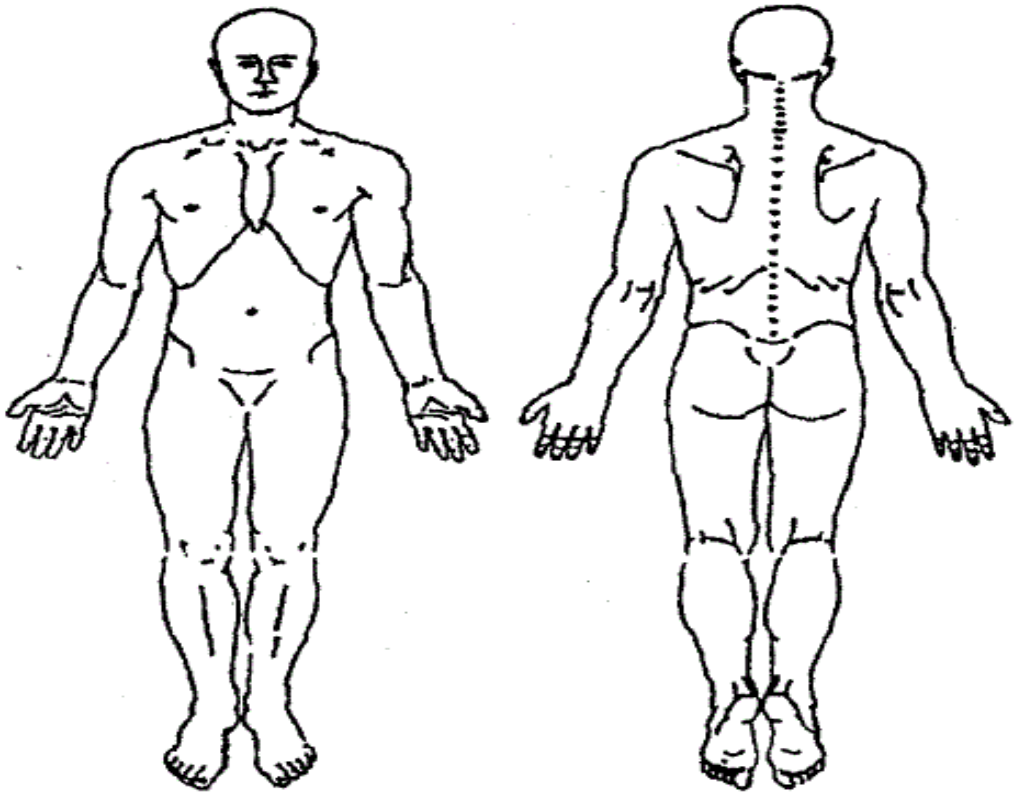
Secondary Complaint(s) _____

_____

PAIN DRAWING

Using the symbols given below, mark the area on you body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
ΔΔΔΔ	=====	OOOOO	XXX	/////	.....



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Health History

Tobacco or Alcohol Use-(please check)

Tobacco Use? ☐Yes ☐No ☐Quit

If yes, type, quantity per day, & how long? _____

Alcohol Use? ☐Yes ☐No

If yes, how many drinks per week?_____

Female Only –

How many children?_____ Pregnant?_____ Taking Birth Control Pills?_____

Nursing? _____ Date of last Menstrual Cycle_____ Date of last Mammogram _____

Please check all that apply to you: ☐ NO MEDICAL PROBLEMS

Lungs/Pulmonary:

☐Asthma or Hay Fever ☐COPD ☐Embolism ☐Tuberculosis
☐Emphysema ☐Sleep Apnea ☐Respiratory Arrest Other:_____

Cardiac/Heart and Peripheral Vascular Disease:

☐Chest Pain/Angina ☐High Blood Pressure ☐Irregular Heart Beat ☐Heart Attack
☐Peripheral Artery Disease ☐Heart Murmer ☐Bleeding Disorder ☐Deep Vein Thrombosis
☐Congestive Heart Failure ☐Valve disorder Other: _____

Neurologic Disorder:

☐Stroke/TIA ☐Parkinson's ☐Cerebral Palsy ☐Peripheral Neuropathy
☐MS ☐Polio Other: _____

Bone & Joint Disorders:

☐Arthritis ☐Gout ☐Osteomyelitis ☐Rheumatoid Arthritis
☐Lupus ☐Ankylosing Spondylitis ☐Other: _____

Gastrointestinal Disorders:

☐Ulcer ☐Diverticulitis ☐Hepatitis-Type____ ☐Liver Disease
☐Acid Reflux ☐Irritable Bowel ☐GI Bleed
☐Inflammatory Bowel Disease Other:_____

Genitourinary Disorders:

☐Urinary Tract Infection ☐Kidney Problems ☐Bladder Problems ☐Other:_____

Metabolic & Other Disorders:

☐Diabetes ☐Skin Disorder ☐Depression ☐Anxiety
☐Thyroid Problems ☐Any Skin Ulcer ☐High cholesterol ☐Dental Issues
☐Other: _____
_____

Family History

	Diabetes	Heart	Blood Pressure	Kidney	Cancer	Stroke	Other:
Mother	☐	☐	☐	☐	☐	☐	☐_____
Father	☐	☐	☐	☐	☐	☐	☐_____
Brother	☐	☐	☐	☐	☐	☐	☐_____
Sister	☐	☐	☐	☐	☐	☐	☐_____
Grandmother	☐	☐	☐	☐	☐	☐	☐_____
Grandfather	☐	☐	☐	☐	☐	☐	☐_____

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Surgery and Drugs

Previous Surgeries and Dates: _____

_____

_____

_____

_____

List ALL Medications you are currently taking: **Please Print** *(If you have a list please give it to the front desk)*

Allergies (Prescription Drugs and Environmental)	Current Medication (Exclude Supplements)

What supplements do you take? _____

_____

What kind of exercise do you do and how much? _____

Notice of privacy practice summary

This summary discloses how health information about you may be used.

Chiropractic Sports & Wellness PC uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care you received. It will not disclose your information to others unless you tell us to do so or unless the law authorizes us to do so.

Chiropractic Sports & Wellness PC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues and may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have a right to request restriction, request a report and retain a copy of your health record, request communication of your information by alternative means at alternative location, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Chiropractic Sports & Wellness PC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact 307-635-7727.

I, the undersigned, attest that I have read and understand the above and that all the above questions have been answered accurately, and I understand that giving incorrect information can be dangerous.

Patient Signature_____ Date_____/_____/_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As will all type of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement or symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medication, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measure and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: ___/____/_____
Parent or Guardian: _____ Signature: _____ Date: ___/____/_____
Witness: _____ Signature: _____ Date: ___/____/_____

Medicare Informed Consent

Relative Contraindications:

Do you have any of the following conditions? (Please check all that apply)

❑Joint Hyper mobility ❑Osteoporosis/Osteopenia ❑Benign Bone Tumors ❑Bleeding Disorders ❑Blood Thinners ❑Progressive Radiculopathy

NOTE: *If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust* ***may be contraindicated*** *in your condition. By signing below, you consent to care and agree to inform this office if another health care provider tells you that you have one of these conditions.*

_____ _____

Patient Signature Date

Absolute Contraindications:

Do you have any of the following conditions? (Please check all that apply)

❑Rheumatoid Arthritis ❑Ankylosing Spondylitis ❑Ligament Laxity ❑Joint Dislocation ❑Recent/Unstable Joints ❑Unstable/Missing Dens at C2 ❑ Spinal Cancer ❑Spinal/Joint Infection ❑Myelopathy/Cauda Equina Syndrome ❑Vertebrobasilar Insufficiency Syndrome ❑Arterial Aneurysm

NOTE: *If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust* ***is absolutely contraindicated*** *in the region of the spine that is affected. By signing below, you agree to inform this office if another health care provider tells you that you have one of these conditions.*

_____ _____

Patient Signature Date

****Have you received the Pneumonia Vaccination? ☐Yes or ☐No**

Notice Of Non-Coverage For Medicare Services

It is important that you understand that Medicare does **NOT** pay for **ALL** chiropractic services. Medicare only pays for chiropractic care that **THEY** consider medically reasonable and necessary.

Medicare will not pay for certain services in this office, including but not limited to:

1. Initial or Re-exams
2. X-rays;
3. Physical Therapy;
4. Nutritional Supplements;
5. Any tests performed in our office:
6. Maintenance care

Payment of services:

You will be required to pay the balance of your yearly deductible, co-payment and 100% of all non-covered services. Supplemental insurance may cover services that Medicare does not cover. If you are unable to pay any portion of your deductible or co-payments, please let us know immediately so that we can work out financial arrangements out with you.

_____

Print Patient Name

_____ _____

Patient Signature Date